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President Bush's Emergency Plan for AIDS Relief (PEPFAR)

Country Operational Plan (COP)
For Mozambique

Plan Period: FY2004

	Name	Title	E-mail
U.S. Embassy Contact	Helen La Lime	Ambassador	lalimehm@state.gov
HHS In-Country Contact	Alfredo Vergara	CDC GAP Director Mozambique	vergaraa@cdcmz.org
USAID In-Country Contact	Jay Knott	Director, USAID Mozambique	jknott@usaid.gov

Date approved by Chief of Mission: **March 31, 2004**
Date submitted to the Office of the Global AIDS Coordinator: **March 31, 2004**
Date approved by Global AIDS Coordinator:

COP_Mozambique_March 31, 2004.doc

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Introductory Overview

Attached is the FY 2004 Country Operational Plan (COP) for the U.S. Mission in Mozambique. The COP details this Mission's initial contribution to the President's Emergency Plan and the "2-7-10" goals.

Of all southern Africa countries, Mozambique presents both the greatest challenges and possibly the greatest opportunity to become the next Uganda-like success in turning around the HIV/AIDS threat. The epidemic's advance is still at a level that offers a real chance to contain its spread and impact, especially given geographic-dependent patterns in prevalence. The people of Mozambique have traditions of mutual aid and community service that provide a strong platform for improving HIV/AIDS-related prevention, care and support, and treatment. The U.S. Government is taking a lead role in Mozambique's fight against HIV/AIDS, particularly as one of the few donors to target communities and individuals directly. The U.S. Mission in Mozambique is convinced that successful implementation of this initial COP and substantial subsequent support under the Emergency Plan's five-year strategy will be essential elements in Mozambique's success.

It is imperative to remember a few of the major constraints that inevitably influence the design and the definition of progress and success for the Emergency Plan program in Mozambique. These include: Very limited human resource capacity (many rural areas have one physician for over 60,000 people), poor health infrastructure (even many provincial referral hospitals have inadequate water and electricity supplies), low access to health care (overall estimated between 40% and 60% of the population), and only recent gearing up in response to the epidemic (VCT began to be available outside of Maputo in 2001, PMTCT began only in 2002). Given these constraints, an appropriate ratio must be reached between emergency implementation and building long-term capability, in order for Mozambique to be able to both scale up and continue to respond to the epidemic in the years to come. It is important during the first two years of the Emergency Plan to employ reasonable means to help develop national and community systems and institutions that will have a direct impact on the success of the fight against AIDS in Mozambique.

Mozambique's key HIV/AIDS statistics[1]:

14.9%	HIV prevalence among people aged 15-49 years in 2004
14.6%	HIV prevalence in pregnant women in 2002
1,400,000	Estimated number of HIV-infected people in 2004
2,000	Estimated number of individuals on anti-retroviral

[1] See Table 1 for more detail and sources.

	therapy at end-2003
228,000	Estimated number of maternal orphans due to AIDS in 2004
16.7%	Projected 2008 HIV prevalence for ages 15-49
1,800,000	Projected 2008 PLWHA
418,000	Projected 2008 maternal orphans due to AIDS

USG targets for FY 2004, all of which contribute directly to Mozambique's national targets for the scale-up of prevention, care, and treatment services, include 90,000 *individuals receiving care and support (including over 60,000 orphans and vulnerable* children) and 8,000 patients receiving multi-drug anti-retroviral therapy. Five-year Emergency Plan targets for Mozambique are 506,000 infections averted, 550,000 PLWHA and OVC receiving care and support, and 110,000 HIV+ Mozambicans receiving treatment.

USG agencies in Mozambique already are managing Track 1.5 activities totaling more than [redacted] as well as more than [redacted] of Emergency Plan support provided to Mozambique through Track 1 awards. These activities address all the Emergency Plan technical areas except other prevention (where ongoing 2004 activities were funded from prior year monies) and some cross-cutting areas. Urgent priorities in these areas - as well as in the areas where Emergency Plan support has already started -- will be addressed through Track 2 activities as described in this COP. It is also important to note that FY 2003 resources provided under the President's PMTCT Initiative were made available for Mozambique only in early FY 2004; and that even though substantial funding for laboratory activities supporting ART were allocated through Track 1.5, most FY 2004 funding for treatment scale-up is provided through a Track 1 activity.

During an intensive two-week visit at the end of February, the inter-agency Core Team for Mozambique helped the Mission clarify the technical and program elements for an excellent COP, one which addresses urgent priorities for service scale-up in Mozambique, meets Emergency Plan guidelines, and mobilizes and integrates the strengths of all USG agencies at post. Together with the Core Team, the Mission identified a number of policy and program concerns that are being addressed, including:

- Resolve program redundancies. CDC, USAID, State, DOD, and Peace Corps have resolved the redundancies and overlaps that characterized the earliest drafts of the COP. Working together, Agencies postponed some activities to 2005, reduced or eliminated others, and agreed to joint programming in several areas as the COP was finalized. The COP now reflects the particular attention the Mission paid to ensuring the efficient delivery of technical assistance, training, and direct services, to ensure Mozambique receives the full benefit of the [redacted] of Emergency Plan resources provided this year.

- Assure coordination with other stakeholders. We have applied the same principles and approach in our coordination efforts outside of the U.S. Mission, i.e., with all key stakeholders, to guarantee maximum efficiency in terms of activities and costs. As this plan was developed in March, the Mission clarified roles, responsibilities, and priorities for USG assistance through dozens of meetings on the Emergency Plan -- some involving the Ambassador and Agency heads and others at technical levels -- including with the Minister of Health, the Director of the National AIDS Council, the Ministry of Women and Coordination of Social Action (MMCAS), all of the bilateral and multilateral HIV/AIDS donors, all existing implementing partners and many potential new partners, and (through working trips as far north as Zambezia province) the Mozambicans benefiting from USG-supported services. That said, the universe of stakeholders in Mozambique's HIV/AIDS response is both complex and expanding rapidly. Successful coordination will require consistent and regular attention, with significant implications for USG agency staffing. Yet the U.S. Mission in Mozambique is convinced that through the Emergency Plan the USG already has helped create an environment that will continue to foster substantive and frequent communication among stakeholders and allow all contributors to the national response to take full advantage of opportunities for joint programming.

- Ensure involvement of faith-based organizations and new partners. The COP clearly demonstrates Mission commitment to involving faith-based organizations (FBOs) and new partners, and scaling up the important contributions they are making to the 2-7-10 goals. It is only in the technical areas of PMTCT+, safe injections, and strategic information that the COP does not yet include either new partners or partnerships with FBOs. Many of the FBO implementing partners are locally based, Mozambican organizations. The Mozambique Mission's five-year strategy will provide further detail on the vital role of FBOs in prevention, care, and treatment scale-up, as well as the Mission's approach to attracting new partners.

- Link prevention, care and treatment interventions. The Mission has designed an FY 2004 plan that links prevention, care, and treatment interventions among USG agencies, across the implementing partners, between the USG and other donor agencies, and between the USG and the Government of Mozambique (GRM). USG technical assistance (and the direct involvement of Agency staff) were instrumental in the development and completion of the Ministry of Health (MOH) National Strategic Plan for HIV/AIDS/STI in 2003; and intensive USG participation is still ongoing as the National AIDS Council (NAC) completes a new multi-sectoral National Strategic Plan for the Combat of HIV/AIDS in 2004. These efforts have laid the cornerstones for erecting in Mozambique an effective continuum of prevention, care, and treatment services, through an Integrated Network for HIV/AIDS model with community linkages, that mobilizes the best of both government and civil society.

- Mobilize community support. Community leadership and sustained community action are essential to Mozambique's national response -- because of the limited reach and resources of public services, but even more importantly because without a supportive community environment the behavior changes that are essential for prevention, care, and treatment will not occur. USG agencies and implementing partners in Mozambique have long, deep experience and close partnerships at community level; these are being focused, strengthened, and expanded. Particular emphases include building facility-to-community linkages for new services such as PMTCT and ARV treatment, which will improve treatment effectiveness and uptake, and mobilizing community-based measures to reduce stigma and address gender aspects of the epidemic.

- Strengthen policy and advocacy. The Mission has identified priority areas where policy changes are needed and has concrete plans for initiating dialogue on these with GRM counterparts. For example, a USAID-UNICEF-WFP-UNAIDS-sponsored "Rapid Assessment, Analysis, and Action Planning of the Response to Children Orphaned and Made Vulnerable by HIV/AIDS" started in Mozambique on March 29, with a final report expected on June 1, 2004. This assessment will provide essential and as yet unavailable information on the OVC situation in Mozambique, thus fostering substantive policy discussions and decisions. This assessment is also expected to help identify technical assistance and training needs within MMCAS and within the NGOs on the front line of OVC care and support.

- Focus on anti-retroviral treatment. The COP describes substantial Mission support to MOH expansion of treatment. New partnerships are bringing strong M&E systems which will provide critical feedback to MOH and implementing partners on ways to improve the quality and effectiveness of ARV provision. Because these programs are new, the FY 2004 COP emphasizes increased laboratory service capacity as a prerequisite to increasing treatment numbers. New ART sites planned for 2004 fall in major provincial referral hospitals where a large proportion of AIDS patients seeking care, including TB patients, are seen. Information and experience gained during this initial phase will enable continuous monitoring and evaluation of the appropriateness of ARV treatment implementation, so treatment guidelines (in particular treatment failure strategies) can be regularly reviewed, the feasibility of expanding services through syndromic ARV distribution and management in areas where laboratory capacity is weak can be evaluated, and targeted resistance testing can be undertaken in collaboration with WHO (capacity development to undertake more extensive resistance testing and surveillance also will be considered).

- Undertake a human resources assessment and consider use of allied health professionals. Human capacity development is one of the major obstacles to

Emergency Plan success in Mozambique and therefore one of the Mission's highest priorities. By the end of FY 2004, and feeding into the five-year strategy, the Mission will have a detailed analysis of the broad array of needs, and a clear idea of what specific contributions the USG can make, to increase the quality and quantity of human resources directly necessary for scale-up of prevention, care, and treatment services. Areas to be explored include, among others: In-service and pre-service training needs for health staff; recruitment, retention, and management barriers to service provision; and potential for appropriate telemedicine technologies for training and support. This year, the Mission will initiate assistance to the Catholic University of Mozambique (UCM) to improve the training and practical experience of medical school students in HIV/AIDS treatment and care services through scholarships and institutional partnerships, and also continue dialogue with U.S. and third-country organizations that could provide allied health professionals to augment the capacity to administer ARV drugs.

- Support human resource development in communications. The USG will provide technical assistance and training to strengthen the capability of NAC to serve its leadership and coordination roles. In the area of communications to promote behavior change for prevention and to promote service uptake, focused and inter-linked assistance will be provided to strengthen MOH, NAC, MMCAS, and NGO partners. This assistance will enhance the national response to HIV/AIDS by improving information and education campaigns as well as developing other means of delivering behavior change messages at both the national and community levels. In addition, the successful capacity building within NAC will improve the flow of donor and government funds provided for the national response and reduce the risk of ineffective programming.

- Assure full-time coverage for Emergency Plan reporting. A senior technical advisor within USAID (noted as "Program Management and Reporting Officer" in Table 5.1) will have primary responsibility for Emergency Plan reporting for Mozambique. This person will lead a team comprised of CDC, State, Peace Corps, and other USAID staff with direct technical responsibilities, including for M&E, in the various activity areas of the Emergency Plan.

The COP requests an FY 2004 total funding level of [redacted] (see Table 6). About 10.7% of this total is for PMTCT activities, 7.5% for abstinence/faithfulness behavior change efforts, 12.8% for OVC, 16.2% for treatment (ART, PMTCT+, and lab; this is in addition to the substantial treatment funding provided to Mozambique under Track1), and 14.7% for management costs. An unresolved concern of the Mission centers on whether the Emergency Plan will count the considerable support for PMTCT and VCT as prevention investments or attribute these to care or treatment categories (since these services are the first steps to getting HIV+ individuals into care and treatment, as well as

to preventing new infections). The Mission looks forward to learning the Global AIDS Coordinator's decision on how these services will be attributed.

The U.S. Mission in Mozambique is confident that with full funding of the team and the activities described in this COP, and the support of the inter-agency Core Team, the USG will retain leadership and be a positive, catalytic force on HIV/AIDS in Mozambique. Looking forward, our objective will be to meet or exceed the Emergency Plan targets each and every year. The Mission relies on the Office of the Global AIDS Coordinator to meet the program's funding needs and provide timely policy guidance. The Mozambique team, from top to bottom, looks forward enthusiastically to responding to the challenge to reduce the transmission of HIV and mitigate the impact of AIDS in Mozambique.

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Table 1. Overview of HIV/AIDS in Country

1.1 Country Profile

a. Population (millions): 17,480,000* (2003 est.)

b. Area (sq mi): 801,590 km²
(roughly twice the size of California; north-to-south coastline about the same distance as Maine to Florida)

c. Per Capita GDP (US$): 246***

d. Adult Literacy Rate (%): 42 (1997 census est.)

e. Per Capita Expenditure on Health (US$): 9** (2000 est.)

f. Life Expectancy (years): 42.3** (2002 est.)

g. Infant Mortality (per 1,000 births): 125**** (2003 est.)

h. Under 5 Mortality (per 1,000 births): 180**** (2003 est.)

Source(s): *World Factbook; **World Bank 2004 World Development Indicators; ***Calculation based on Republic of Mozambique 2003 Article IV Consultation Staff Report (IMF) dated 5 March 2004; ****2003 DHS (preliminary, 98% complete)

1.2 HIV/AIDS Statistics

Overall 15-49 prevalence: 14.9% (2004 projection based on 2002 sentinel surveillance)

a. HIV prevalence in pregnant women: 14.6 (2002 sentinel surveillance)

b. Estimated number of HIV-infected people: 1,400,000 (2004 projection based on 2002 sentinel surveillance)

c. Estimated number of individuals on anti-retroviral therapy: 2,000 (end-2003)

d. Estimated number of AIDS orphans: 228,000 maternal orphans due to AIDS (2004 projection based on 2002 sentinel surveillance)
Note: The USAID-UNICEF-WFP-UNAIDS-sponsored "Rapid Assessment, Analysis, and Action Planning of the Response to Children Orphaned and Made Vulnerable by HIV/AIDS" starts in Mozambique on 29 March; the report, expected 1 June 2004, will provide more information of the OVC situation in Mozambique.

Source(s): National Statistics Institute, Mozambique (a,b,d); Ministry of Health (c)

1.3 Characteristics of the HIV/AIDS Epidemic

a. Populations at comparative high risk: Migrant workers and their partners; commercial sex workers; uniformed services and their partners; truckers, transporters, and itinerant merchants, and their partners; youth especially young women

b. Risk factors related to comparative high risk: poverty, illiteracy, gender, age, inaccurate risk perception, malnutrition and disease burden, social instability, low levels of schooling, proximity to transport corridors

c. HIV/AIDS prevalence by gender: Male 12.8%; Female 16.7% (15-49 years (2004 projection based on 2002 sentinel surveillance)

d. HIV/AIDS prevalence by age groups (0-14 yrs; 15-24 yrs; 25-49 yrs): (extrapolations based on 2002 sentinel surveillance)
- 0-14: 2004 estimate male 1.0%, female 1.0%, total 1.0%; 2008 projection male 1.3%, female 1.3%, total 1.3%
- 15-24: 2004 estimate male 4.5%, female 13.6%, total 9.1%; 2008 projection male 5.1%, female 15.7%, total 10.4%
- 25-49: 2004 estimate male 19.9%, female 18.9%, total 19.4%; 2008 projection male 22.8%, female 21.2%, total 21.9%

e. HIV/AIDS prevalence by urban versus rural: N/A

f. ANC surveillance trends: selected data from some of the now-36 sentinel sites nationally --
- Maputo: 1994 2.7%; 1998 9.9%; 2000 13.0%; 2002 18.0% (urban, Maputo Corridor, capital city, south)
- Xai-Xai: 2000 18.3%; 2002 23.7% (urban, home of migrant mine workers, south)
- Chimoio: 1994 10.7%; 2000 24.7%; 2002 24.3% (urban, Beira Corridor, center)
- Tete: 1994 18.1%; 2000 22.3%; 2002 21.7% (urban, Tete Corridor between Zimbabwe and Malawi, center)
- Milange: 2000 19.0%; 2002 14.0% (rural, border with Malawi, center)
- Alto Molocué: 2001 5.0%; 2002 6.7% (rural, center)
- Beira: 1996 22.3%; 2000 31.2%; 2002 35.7% (urban, Beira Corridor, center)
- Caia: 2001 7.7%; 2002 12.0% (rural, center)
- Nampula: 2000 5.0%; 2002 11.7% (urban, Nampula Corridor, north)
- Cuamba: 2000 10.4%; 2002 10.3% (urban, Nampula Corridor, north)
- Mavago: 2001 2.0%; 2002 3.7% (rural, north)
- Pemba: 2000 8.7%; 2002 11.3% (urban, north)

g. BSS surveys trends: (1997 DHS and 2003 DHS preliminary data)
- Age at first sexual intercourse: In 2003, 16 years for females aged 20-49; almost 18 years for males aged 20-64; in 20-24 year old females, overall 16.0, rural 15.7, urban 16.5, no education 15.7, secondary education 17.5; in 20-24 year old males, overall 16.8, rural 16.7, urban 16.9, no education 16.3, secondary education 17.3
- Use of condoms: In 1997, 0.9% of females and 3.4% of males reported condom use with last partner; in 2003, 6% of women and

12% of men reported condom use with last partner; in 2003, condoms were most frequently used in non-cohabiting relationships, with 23% use reported among females and 32% among males

- In 2003, females and males with secondary education are twice as likely to know at least two ways of preventing HIV than those with no education
- Married women with just one partner (2003 only): overall 96.1% of married women, rural 96.7%, urban 94.7%, no education 97.0%, secondary education 92.6%, 15-19 93.3%, 20-24 95.9%
- Married men with just one partner (2003 only): overall 77.8% of married men, rural 82.2%, urban 67.1%, no education 88.3%, secondary education 56.8%, 15-19 68.9%, 20-24 60.8%
- Unmarried women with no partner (2003 only): overall 46.2% of unmarried women, rural 57.3%, urban 36.6%, no education 61.7%, secondary education 28.3%, 15-19 51.9%, 20-24 31.6%
- Unmarried men with no partner (2003 only): overall 31.1% of unmarried men, rural 42.1%, urban 23.7%, no education 53.1%, secondary education 18.4%, 15-19 38.5%, 20-24 12.2%
- Mean number of sexual partners among unmarried women (2003 only): overall 0.6; no education 0.4; secondary education 0.8; 15-19, 0.5; 20-24, 0.8
- Mean number of sexual partners among unmarried men (2003 only): overall 1.3; no education 0.9; secondary education 1.5; 15-19, 1.0; 20-24, 1.8

h. DHS surveys trends (specify years compared): 1997 and 2003 (2003 still preliminary data, 98% complete)

- People who know about AIDS: 1997, male 93.9%, female 82.2%; 2003, male 98%, female 96%
- People who know how to avoid AIDS:
  - Have one partner: 1997, male 23.9%, female 27.5%; 2003, male 71.4%, female 56.7%
  - Use a condom: 1997, male 30.8%, female 15.4%; 2003, male 71.6%, female 56.7%

i. HIV/AIDS epidemic projections: **2008 projections** based on 2002 sentinel surveillance:

- National 15-49 prevalence: overall 16.7%; male 14.4%, female 18.8%
- PLWHA: 1,800,000
- Maternal orphans due to AIDS: 418,000

j. STI statistics: (source: Chief of STI Dept, MOH)

Note: STIs are diagnosed clinically in Mozambique

- Cases notified 2002: total 412,091, male 175,135, female 236,956
- Cases notified first semester 2003: total 230,001, male 97,513, female 132,488; plus 71,628 partner referral tests

- Antenatal testing for STI 2002: of 640,036 pregnant women, 318,811 were tested for syphilis, of which 29,484 (9.2%) positive
- Antenatal testing for STI first semester 2003: of 311,320 pregnant women, 173,835 tested for syphilis, 12,472 (7.2) positive

k. TB statistics: (source: MOH, "Mozambique Drug Resistance Surveillance Protocol 2004")
Estimated risk of TB infection is 1.7%, corresponding to about 94 new smear-positive cases per 100,000 population per year. Given Mozambique's estimated population of about 18 million, about 15,236 smear-positive cases would be expected each year. Out of 26,117 new TB patients registered in 2003 (almost double the number of 1991), 6.5% were retreatment cases. TB case detection rate of new positive smears is estimated to be 84.3%. HIV+ rate among TB patients was 16.7% in 1994 and 32% in 1998. Among HIV+ TB patients, 24% show some form of resistance to standard drugs. Nationwide, the TB lab network in 2002 consisted of 214 laboratories performing direct smear staining and 2 culture labs.

Source(s): As noted

Table 2. National HIV/AIDS Response

2.1 National HIV/AIDS Coordinating Body	Type of organization (government, NGO, FBO, OVC) , purpose of each national coordinating body, and description of membership
National AIDS Council	Cross-sectoral council, headed by Prime Minister, membership includes other ministers and representatives of private sector and civil society, with execution through an Executive Secretariat comprising both a central headquarters and decentralized units in each of Mozambique's provinces. Mandated to lead the national response, mobilize and coordinate partners and resources, and monitor and report on progress and challenges. USAID has provided institutional support to NAC since its creation in 2000, focused on establishing sound, transparent financial and administrative management systems, creating a database and "operations room" for information exchange on actions and actors in the national response, and office equipment including computers, back-up generator, radio communications with field offices, etc.
Ministry of Health	MOH is the lead in all clinical aspects of the national response. With substantial technical assistance from USG (CDC) as well as other contributors to the Sector-Wide Approach in Health (see 2.3 below), MOH has developed a strategy for scale-up of comprehensive HIV/AIDS/STI care and treatment services (see 2.2 below). MOH also directs the epidemiological surveillance of the disease (with CDC TA and support from USAID's POLICY Project).
Ministry for Women and Coordination of Social Action	Responsible for coordinating national activities directed at OVC, vulnerable women, families affected by HIV/AIDS, the elderly, the disabled, and drug addicts; for conceiving and ensuring implementation of policies and guidance for activities directed at these groups; and for advocacy for these groups.
NGO AIDS, TB, and Malaria Impact Mitigation Association (NAIMA+)	Association of international NGOs working in HIV/AIDS in Mozambique. With some 40 members, including many USG implementing partners such as World Vision, Save the Children, CARE, and others. A few Mozambican NGOs participate as observers. NAIMA representatives participate in the Country Coordination Mechanism for the Global Fund in Mozambique as well as in other HIV/AIDS coordination groups.
Mozambique National Association of AIDS Service Organizations (MONASO)	Network of all NGOs working on HIV/AIDS, with a strong emphasis on providing support to Mozambican NGOs. (Contrast with NAIMA+ above.)
National Network of PLWHA Organizations (RENSIDA)	A loose network of PLWHA service and support organizations active in all provinces of Mozambique.
Christian Network against AIDS	Legally registered in 2003 and based in Maputo. Members include most major churches linked with the Christian Council of Mozambique. Provides a forum for FBOs to coordinate, share information, and mobilize resources for increased efforts in the battle against HIV/AIDS, with special emphasis on behavior change to prevent new infections, on reducing stigma, and on care and support of those in need, including OVC. Many of Mozambique's churches that are independent evangelical sects are not yet part of this network.

2.2 Time Period Covered in National HIV Strategic Plan(s) or document(s)	Title of National HIV Strategic Plan(s) or document(s) that outline priorities and objectives
2000-2002	National Strategic Plan for the Combat of HIV/AIDS 2000-2002, National AIDS Council. Priorities: prevention focused on youth and highly mobile populations and their partners; improvement in quality and coverage of VCT and care and treatment of PLWHA; impact reduction through support to PLWHA and children affected by the epidemic; Emphasis on prevention and services in commercial corridors; development of a comprehensive package including BCC, VCT, community mobilization, care and support for PLWHA, and STI treatment. The Plan requires all government ministries and agencies, as well as all provinces, to prepare action plans to address HIV/AIDS within their own workforces and within the programs and services they manage. Preparation of a new national strategy began in 2003, planned as a participatory national process led by NAC and supported by UNDP. Development has been delayed due to organizational and staffing disruptions in NAC and a late 2003 change in approach; the new strategy is now to be completed end-May 2004. It is expected to center on the MOH strategic plan (see below) and incorporate other sectoral considerations and objectives but articulate a guiding vision and identify gaps and priorities for action. Integrated and coordinated monitoring of the national plan is an objective but remains an area requiring technical assistance and training.
2004-2008	National Strategic Plan for HIV/AIDS/STI, Ministry of Health, approved Mar 2004. Presents integrated and comprehensive approach to scale up prevention, care, and treatment services through existing health facilities and linkages with community support groups – to be provided through an Integrated HIV/AIDS Network model. Key objectives include: reduce sexual transmission (through STI control, condom distribution, and behavior change in youth); reduce mother-to-child transmission; avoid medical transmission (blood safety, bio-security); reduce impact on health workers (health and psycho-social care); increase the survival and quality of life of PLWHA (expand VCT, improve OI care, expand ART, promote community support initiatives, provide psycho-social services); and improve information about HIV/AIDS (ensure reliable epidemiological profiles and projections, evaluate effectiveness and impact of services). USG (CDC) technical assistance was instrumental in the development and completion of this strategic plan. The plan incorporates support from the GT-SWAP donors (see 2.3 below), the Clinton Foundation, and the Global Fund.
2003-2004	Ministry for Women and the Coordination of Social Action (MMCAS), Sector Plan to Fight HIV/AIDS. This plan prioritizes building the capacity of communities/families to protect and care for vulnerable children and women affected and infected by HIV/AIDS, building the capacity of women to deal with the impact of HIV/AIDS, and responding to the needs of MMCAS target groups (described in 2.1 above). MMCAS convened Mozambique's first National Conference on OVC and HIV/AIDS in November 2003 as a first step in meeting Mozambique's commitments under the UNGASS priorities. A late-2003 draft "Strategic Framework for the Protection, Care, and Support of Children Orphaned and Vulnerable Due to HIV/AIDS" will be modified based on findings of the national OVC assessment in 2004.

2.3 Major Donor/Partner Organizations	Primary activities supported that are related to PEPFAR goals	Estimated 2004 Budget
Partners Forum on HIV/AIDS	Established in 2003; brings together bilateral and multilateral donor agencies as well as representatives of key NGO groups, to exchange information, coordinate support, and provide an efficient forum for multi-agency dialogue with NAC on policies and programs related to the national response to HIV/AIDS	N/A
Technical Group for Sector-Wide Approach in Health (GT-SWAP)	*Established in 1999 as a donor-MOH working group to help improve* management, effectiveness, and transparency of donor assistance provided for health. Meets twice a month at MOH; donors also meet weekly to prepare for the joint MOH mtgs. Health Sector-wide Approach (ProSaúde) is supported by a range of donor funding mechanisms: project funding provided to NGOs, direct funding to MOH, donor contributions to several pool arrangements (e.g. pharmaceuticals, "common fund" for health), and general budget support. Donors participating in the GT-SWAP (besides USG through CDC and USAID) include Switzerland, Norway, Netherlands, Finland, EU, DFID, Ireland, Denmark, and others. HIV/AIDS elements of the SWAP also are supported through the Clinton Foundation and the Global Fund.	N/A
Gender Working Group, HIV-AIDS Sub-Group	Established in 2003 to ensure that HIV/AIDS policies, plans, and programs incorporate and reflect gender-differentiated factors and impacts of the epidemic. Members of this sub-group include USAID, Netherlands, Italy, Canada, Finland, DFID, UNAIDS, EU.	N/A
U.N. Agencies	Active in HIV/AIDS programs, especially in advocacy and policy areas, and coordinated through a U.N. Theme Group on HIV/AIDS. UNAIDS manages coordination and (with CDC) assists in monitoring national response. Sectoral support to the national response is provided by WHO (health and epidemiology), UNICEF (youth prevention, OVC, education), UNESCO (studies of cultural/social factors, youth exchanges), and WFP (food assistance to affected families). UNAIDS, UNICEF, and WHO played major roles in development of Mozambique's Global Fund proposal. UNDP supports VCT, provides technical and institutional support to NAC, and funds preparation of the new national strategic plan. UNIDO strengthens public-private partnerships for HIV/AIDS prevention in the transport sector.	N/A

Multi-Sectoral Nucleio for OVC	Established by MMCAS (see 2.2 above) in 2003. Meets quarterly to advise and assist MMCAS to ensure support and services to OVC affected by HIV/AIDS. Members include "focal points" from ministries (education, health, youth and sport), NAC, NGOs, and donors (USAID, UNICEF, UNAIDS, WFP). A technical sub-group addresses implementation.	N/A
Business Against AIDS Forum	An effort of the private business sector, which in early 2004 united the informal Business Against AIDS commission (created in 2000 under the auspices of the Mozambique Confederation of Business Associations) and Directors Forum on HIV/AIDS (created in 2002 under the Mozambique-USA Chamber of Commerce). Objectives are to mobilize and provide technical and financial support to small and medium size firms to protect their workforces through prevention, care, and treatment programs, and to provide business planning assistance related to HIV/AIDS. Members include more than 70 companies of all sizes including international corporations (such as Coca-Cola, BP, and Unilever) as well as Mozambican companies throughout the country.	N/A

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Table 3. President's Emergency Plan In-Country Coordination and Targets for 2004-2008

3.1 President's Emergency Plan In-Country Coordination

Within USG: The strategizing and decision-making for the U.S. Mission Mozambique contribution to the Emergency Plan are led by the Ambassador. In 2003 she convened a PEPFAR Working Group which meets frequently, is currently chaired by the USAID Director, and includes active participation of all Agencies (State, USAID, CDC, DOD, and Peace Corps) at both technical and policy levels. As evidenced by the activities described in Table 4 below, FY04 PEPFAR planning has strengthened inter-Agency collaboration and led to new and productive roles and relationships as well as higher-profile advocacy and participation of the U.S. Mission in the area of HIV/AIDS.

Between USG and other international partners:

- Global Fund: USG coordinates with Global Fund managers both within Mozambique (the Ministry of Health and the National AIDS Council are the designated Principal Recipients) and at GF headquarters. Strengthening Mozambican capacity to manage, plan, coordinate, and implement the national response to HIV/AIDS is a key part of Mozambique's approved GF program and also is a priority of USG support under PEPFAR. The HIV/AIDS component of Mozambique's 5-year GF proposal was budgeted at [redacted] when submitted in 2002; in early 2003 the GF approved an initial tranche of $54 million for the first two years, including the HIV/AIDS component, but agreements with Principal Recipients are only being concluded at end-March 2004 and funds are not yet flowing. As there are significant new developments in HIV/AIDS in Mozambique since the GF proposal was prepared, adjustments are expected in GF-supported activities to take account of programs that already are underway in the context of MOH and NAC strategies. CDC was a major contributor to the preparation of Mozambique's GF proposal and continues to be involved in technical discussions and planning related to GF implementation.
- World Bank-MAP: Approved in 2003 for a WB/IDA grant of [redacted] GRM contribution), MAP in Mozambique has 5 components: community and civil society initiatives [redacted] managed by NAC); strengthening and scaling up health services for HIV/AIDS [redacted] managed by MOH); government multi-sector response [redacted] channeled through NAC to various government agencies); capacity building for civil society response [redacted] managed by NAC); and institutional development for program management [redacted] managed by NAC). USAID worked closely with WB design missions during the development of the MAP and continues to coordinate with WB and NAC through mechanisms described in Table 2.3 above. WB/MAP resources for MOH are included within the MOH Strategic Plan for HIV/AIDS/STI. In late 2003 WB provided an additional [redacted] under its Treatment Acceleration Program (TAP) toward MOH plans for treatment scale-up.
- Other (specify): See Table 2.3 above.

Between USG and host government: The USG program for HIV/AIDS works closely with the Government of Mozambique (GRM) at all levels (central, provincial, and in targeted areas at local level) to address the policy, advocacy, financial, and technical challenges which constrain Mozambique's ability to halt the epidemic. A wide array of policy and program contacts is maintained by the Ambassador and U.S. Agencies at post. As evidenced by the activities described in Table 4 below, close collaboration is a feature of the significant financial and technical support provided by USG to Mozambican government agencies with mandated HIV/AIDS roles and responsibilities. Importantly, these USG-GRM collaborations are .within the broader context of the massive donor assistance provided to Mozambique not only for HIV/AIDS but more generally to sustain Mozambique's success in economic growth and poverty reduction.

Between USG and other in-country organizations: The multi-sector response in Mozambique is a complex and fluid one, with new potential partners emerging constantly and existing organizations of all stripes adding HIV/AIDS to their agendas. USG Agencies work with dozens of in-country partners, both directly and through a range of coordination mechanisms and umbrella groups (some of which are described in Table 2), and has contacts with many more through meetings, conferences, and field visits.

3.2 President's Emergency Plan Targets for 2004 – 2008

Target Area	2004	2005	2006	2007	2008	2009	2010
Total # Infections averted	Per "Additional Guidance for FY04 COP & SI Planning (3/15/2004), these cells have not been filled in						
# Infections averted: PMTCT							
# Infections averted: Other (not PMTCT)							
Total # receiving Care and Support	USG 90,321	145,000	255,000	430,000	PEPFAR 550,000	N/A	
# OVC receiving Care and Support	USG 61,081	80,000	125,000	180,000	200,000		
# receiving Palliative Care[1]	USG 29,240 MOH 730,494	65,000 MOH 913,953	130,000 MOH 1,053,219	250,000 MOH 1,320,240	350,000 MOH 1,534,705		
# receiving ART	8,000 MOH 7,924	15,000 MOH 20,805	40,000 MOH 57,954	80,000 MOH 96,418	PEPFAR 110,000 MOH 132,280		

Notes:
Per "Additional Guidance for FY04 COP & SI Planning (3-15-2004):" FY04 targets cover January 19, 2004 through March 31, 2005: FY05, FY06, FY07, FY08 targets cover respective fiscal year (October 1 – September 30). # OVC receiving Care and Support plus # receiving Palliative Care add up to Total # receiving Care and Support. Palliative Care includes clinic-based as well as home- and community-based services/support and is not limited to end-of-life care

1 In 2004, palliative care includes home-based care (HBC) directly provided by USAID partners World Vision, World Relief, Foundation for Community Development, and Health Alliance International, plus non-ART clinical care through HAI. This number does not, however, reflect substantial CDC contributions to MOH targets and programs for non-ART clinical care and HBC. MOH targets for palliative care include STI diagnosis, STI treatment, OI care, and HBC.

Mozambique's 2004 national targets relevant to PEPFAR areas (per MOH Strategic Plan for HIV/AIDS/STI 2004-2008):

	PMTCT*	AB**	Blood	Inject	Other**	VCT	ClinC	PallC	OVC**	ART	Lab	SI
Total # sites	60		111	6	1,000	50	60	60		14	5	14
# new sites	49			5		2	53	9		7	1	14
Total # clients	185,966*		80,000		684,828	72,000	34,311	11,355		7,924		
# new clients										6,424		
# persons trained	300			224	60	700	60	300		60	15	30

** Of 185,966 PMTCT clients, 35,858 HIV+ women to receive prophylactic treatment and 1,963 multi-drug ART*

*** National targets are not available for OVC, AB, or Other Prevention (except for STI control)*

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Table 4. Implementing Partners, FY 04 Objectives, Activities, Budget

Table 4.1	Prevention of Mother-to-Child Transmission (PMTCT)
4.1.1 Current status of program in country	The National PMTCT Program is a relatively new effort led by the government of Mozambique (GRM). In 2003, the Ministry of Health (MOH) created the PMTCT Office, assigned full-time PMTCT technical staff, re-activated the National PMTCT Task Force, and revitalized smaller working groups for implementation issues, to improve coordination, oversight, and harmonization of PMTCT approaches. Development is underway of a PMTCT training curriculum for trainers and service providers. A functional data collection system for PMTCT, integrated into the national monitoring and evaluation efforts, is being designed. As ART became a more realistic option in Mozambique, the issue of nevirapine (NVP) resistance in women receiving a single dose for PMTCT has become important, particularly since this drug is one component of the first line of triple therapy. In November 2003 national and international experts reviewed existing data and made recommendations that take into account feasibility and availability of ARV agents and laboratory support: triple combinations for treatment or short-course use in pregnant women are favored when available, and single agent prophylaxis with NVP will be provided where these options are not feasible. National guidelines promote exclusive breastfeeding and early weaning of the exposed infant. The MOH National Strategic Plan for HIV/AIDS/STI projects PMTCT by end-2004 at 60 sites serving 35,858 women, with 3-6,000 women and newborns receiving NVP. At end-2003 only 14 sites were providing PMTCT, to 4-5,000 women. Most existing (as well as planned) sites are set up and provide services with support of international NGOs, e.g. Medecins sans Frontières (MSF), Family Health International (FHI), Sant'Egidio, Health Alliance International (HAI), Population Services International (PSI), World Vision, CARE. USG contributes 2003 PMTCT Presidential Initiative and PEPFAR funding for PMTCT capacity development at MOH as well as service delivery through NGO partners. Through partners, USG will support 31 new sites identified by MOH as priorities for 2004. Thus 50% of the 60 PMTCT sites expected to be operating by end-2004 are directly attributable to USG support. Challenges: Newness of program; need for decentralized training capacity and harmonized materials in local languages; need for harmonized BCC materials/messages; need for systematic infant follow-up and progress on infant feeding issues. USG efforts to ensure consistency with MOH strategy has slowed start-up of some partner-provided services since the MOH PMTCT Program is still being designed even while implementation is expanding.

4.1.2 How new activities will contribute to PEPFAR targets; linkages to other activities	New infections will be averted through reduced HIV transmission from HIV+ mothers to newborns; HIV+ women under the PMTCT program, as well as their partners and children, will be referred to available ART, clinical, and home-based care; and community education and mobilization will inform and motivate women and reduce stigma, thereby increasing use of PMTCT services. Per MOH guidelines, PMTCT services are embedded in and form an essential part of general health services (ante-natal and post-natal care, family planning, immunizations, growth monitoring) for mothers and infants. In relation to other HIV/AIDS services, PMTCT is included in the MOH HIV/AIDS Integrated Network model, which is followed and supported by all major funders in Mozambique (e.g. Global Fund, World Bank MAP/TAP, Clinton Foundation, and major bilateral donors). Other donors/agencies supporting PMTCT are UNICEF, WHO, Spanish Cooperation, Medecins sans Frontières (Luxemburg and Switzerland), Medicos do Mundo (Portugal and Spain). USG staff meet monthly with USG-funded PMTCT partners and MOH PMTCT Program staff to discuss progress, improve coordination, and ensure adherence to MOH guidelines and protocols. In provinces with more than one implementing partner, USG ensures coordination (on e.g. formative assessments, BCC messages and approaches, and training of service providers) to ensure consistency and avoid duplication of effort in PMTCT.

4.1.3 Existing activities initiated prior to FY 04

Partner	FY 04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT S/GAC)	Track (1, 1.5, 2)
MOH (CoAg 03) (CoAg Suppl. 04) FBO? No	Functioning MOH PMTCT coordination team and office by July 2004	• Hire PMTCT Program Coordinator and 3 Regional Supervisors; furnish, stock, computerize offices • Hire PMTCT Trainer, provide office equipment	HHS/ CDC	[redacted] [redacted]	FY03 PMTCT FY04 PMTCT	 1.5

MOH (CoAg 03) FBO? No	Develop and pilot comprehensive PMTCT training materials by end-FY04	• Contract short-term in-country technical expert/s • Develop pre-service PMTCT training curriculum • Develop and reproduce PMTCT training materials for 100 facilitators and 500 trainees • Pilot national PMTCT training of trainers (TOT) targeting 33 provincial core facilitators	HHS/ CDC		FY03 PMTCT	
MOH (CoAg 03) FBO? No	Train 40 provincial facilitators and 120 health workers in PMTCT service provision by end-FY04	• Conduct provincial PMTCT training courses • Conduct provincial and site level supervisory visits	HHS/ CDC		FY03 PMTCT	
MOH/CDC (CoAg 03) FBO? No	Develop a national PMTCT evaluation plan by end-FY04	• Develop written targeted evaluation plan with prioritized list of evaluations needed to support PMTCT implementation and scale-up	HHS/ CDC		FY03 PMTCT	

MOH (CoAg 03) (CoAg Suppl. 04) FBO? No	Determine physical infrastructure and equipment/material needs for 20 PMTCT sites, define *minimum* standard equipment, and equip 5 sites, by end-FY04	• Conduct needs assessment at 20 recently identified PMTCT sites • Renovate and/or procure equipment/materials for 5 priority sites	HHS/ CDC		FY03 PMTCT FY04 PMTCT	1.5
CARE FBO? No	Establish PMTCT site in Nampula by end-FY04	• Establish and implement PMTCT services at Nampula Provincial Hospital	HHS/ CDC		S/GAC	1.5
CDC FBO? No	Develop and disseminate PMTCT supervision guidelines and tools by end-FY04	• Develop and distribute PMTCT supervision guidelines and tools to all provinces	HHS/ CDC		FY04 PMTCT	2
MOH/CDC (CoAg Suppl. 04) FBO? No	Develop PMTCT IEC/BCC strategy and start IEC material production by end-FY04	• Develop/adapt IEC/BBC materials to support facility and community based PMTCT activities • Begin IEC material reproduction and distribution	HHS/ CDC		FY04 PMTCT	1.5
MOH (CoAg Suppl. 04) FBO? No	Revise PMTCT training materials to reflect best obstetric and pediatric practices by end-FY04	• Identify and contract in-country senior obstetric and pediatric experts	HHS/ CDC		FY04 PMTCT	1.5

MOH (CoAg Suppl. 04) FBO? No	Conduct 3 provincial PMTCT program planning meetings by end-FY04	• Conduct PMTCT planning meetings in 3 provinces with key personnel to identify lessons learned and develop operational plan for 2005	HHS/ CDC		FY04 PMTCT	1.5
Family Health International (FHI) FBO? No	Establish 3 new sites in Zambezia; strengthen MOH provincial capacity to coordinate and oversee PMTCT; improve MCH services linked to PMTCT; strengthen linkages to care, treatment, support; increase service uptake	• Conduct formative assessment on PMTCT knowledge/attitudes • Establish provincial working group for PMTCT and design implementation plan in collaboration with provincial MOH and NGO PMTCT partners • Develop provincial campaign for BCC in collaboration with NAC, MOH, implementing partners • Train health care providers and counselors per MOH guidelines • Conduct facility needs assessments and prepare sites for start-up of services	USAID		FY03 PMTCT	

Population Services International (PSI) FBO? No	Establish 5 new sites, increase knowledge of PMTCT risk and options among women, partners, and community, and increase social acceptance of PMTCT services and related behaviors	• Develop/disseminate BCC messages in the community through an array of media • Conduct facility needs assessments and prepare sites for start-up of PMTCT • Train health care providers and additional counselors at sites *per MOH guidelines* • Identify/mobilize community partners to promote acceptance of PMTCT services	USAID		FY03 PMTCT	

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Health Alliance International (HAI) FBO? No	Establish 6 new sites (incl. 1 PMTCT+) in Manica and Sofala; enroll 500 new clients in each new and existing site in these provinces; develop best practices and minimal service delivery packages as basis for national scale-up	• Mobilize/educate pregnant women through array of media • Build community support services for women testing positive in antenatal care settings • Conduct facility needs assessments and prepare sites for start-up of PMTCT • Provide technical assistance and policy support at national level for roll-out of IHN incl. PMTCT • Introduce short-term triple therapy as PMTCT strategy , demonstrate rapid expansion of comprehensive care and treatment approach, and assess and document lessons learned	USAID		FY03 PMTCT	

Save the Children/U.S. (via Elizabeth Glaser Pediatric AIDS Foundation) FBO? No	Establish 6 new sites in Gaza and Nampula, providing full range of information and services to reduce MTCT (prevention among pregnant women and partners, safer infant feeding, NVP access, support for HIV+ women	• Train health providers and counselors at selected sites per MOH guidelines • Train community activists on practices and services to reduce MTCT • Develop, in collaboration with MOH, NAC, and NGO partners, BCC campaign to increase awareness of PMTCT services • Conduct facility needs assessments and prepare sites for start-up of PMTCT services	USAID	for two years *(pending final approval by EGPAF)*	USAID/W FY03 PMTCT	

4.1.4 Proposed new activities in FY04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
MOH/CDC New partner? No FBO? No	Make training materials and job aids available to 11 provinces and at least 10 collaborating agencies by end-FY04.	• Reproduce training materials, job aids for PMTCT service providers • Reproduce and distribute technical norms and operational manual	HHS/CDC	(FY04 PMTCT under Track 2)
MOH/CDC New partner? No FBO? No	Increase provincial capacity for implementation, training and supervision: Train 54 provincial facilitators and health workers by end-FY04	• Conduct two regional PMTCT TOT courses (30 facilitators) • Conduct one regional PMTCT training (24 health workers)	HHS/CDC	(FY04 PMTCT under Track 2)

Health Alliance International (HAI) New partner? No FBO? No	Strengthen/expand existing USG-funded PMTCT program by establishing 6 new sites, testing an additional 6,200 women, providing prophylaxis for 320, and incorporating malaria control strategies into new and existing sites	In addition to continuing activities described in 4.1.3 above: • Conduct facility needs assessments and prepare new sites for start-up of PMTCT • Train new and existing staff at sites per MOH guidelines • Establish "positive mothers support groups" to provide ongoing psychosocial and peer support	USAID	(Base under Track 1.5) [redacted]
Population Services International (PSI) New partner? No FBO? No	Strengthen/expand existing USG-funded PMTCT program by establishing 5 new sites, testing 1,800 women, providing 200 mother-infant pairs with NVP; increasing knowledge of PMTCT risk/options, and expanding access to support services for HIV+ women and social acceptance of PMTCT	In addition to continuing activities described in 4.1.3 above: • Conduct facility needs assessments and parepare new sites for start-up of PMTCT • Train new and existing staff at sites per MOH guidelines • Design and develop, in collaboration with MOH, NAC, and NGO partners, a national-level BCC campaign for PMTCT	USAID	(Base under Track 1.5) [redacted]
World Vision (WV) New partner? Yes FBO? Yes	Establish 2 new sites, test 5,760 women, provide NVP for 100 mother-infant pairs	• Site preparation, training, and service provision • Pilot integrated approach of PMTCT with VCT and community-based care for PLWHA and OVC (discussed in other sections of Table 4)	USAID	(Base under Track 1.5) [redacted]

Total partners:	8	New partners:	1	FBOs:	1	Total budget:	Track 1.5 Track 2 Total FY04

Note: *Although total funding only includes FY04 requests, activities funded through allocations at the end of FY03 also are listed in 4.1.3, to give e a complete picture of PMTCT activities undertaken and planned in FY04.*

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Table 4.2	Abstinence and Faithfulness Programs
4.2.1 Current status of program in country	The National AIDS Council (NAC) is charged to lead and coordinate all multi-sectoral HIV efforts, including prevention targeting the general population and specific at-risk groups. MOH is a key partner in the development, reproduction and distribution of HIV prevention IEC/BCC messages and materials through all health workers. Community volunteers, most trained by NGOs, are leaders and channels in prevention efforts through health and peer education activities. The recently initiated process to strengthen linkages between community-based prevention activities and those of the public sector will increase coverage and depth of the prevention effort. Collaboration in national IEC/BCC campaigns is maintained through monthly multi-sectoral IEC/BCC meetings chaired by NAC with participation and technical assistance from MOH and NGOs (including FBOs). In 2004 NAC is working with partners to clarify a communications strategy and messages as part of the national strategic plan for HIV/AIDS which is to be completed by end-May. This is expected to include strategies and messages for promoting abstinence and faithfulness which are a priority of FBOs and some other NGOs. A particular effort targets IEC/BCC for youth. By end-2003, 71 Youth-Friendly Health Clinics were providing care and prevention services, including information and motivation regarding HIV prevention. Materials specifically targeting youth and promoting abstinence and delayed sexual debut have been produced and distributed by MOH and numerous NGOs.
4.2.2 How new activities will contribute to PEPFAR targets; linkages to other activities	New infections are averted when adolescents choose to postpone the start of sexual activity or abstain from sexual activity, and when sexually active individuals choose to reduce the number of partners and remain in mutually faithful relationships. The USG provides critical prevention assistance to MOH, to NGOs including FBOs, and to the Ministry of Education's schools, teachers, and pupils, all involved in promoting abstinence, faithfulness, and delay of sexual debut. USG-funded programs working at community level help create a supportive environment for AB through traditional leaders, church leaders, and traditional healers, in order to ensure that personal behavior change for both women and men, including youth, is motivated and supported.

4.2.3 Existing activities, initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1.1.5, 2)
Foundation for Community Development (FDC) and partners FBO? Some sub-grantees are FBOs	Provide effective information and support to community-based partners to enhance individual HIV/AIDS risk perception and prevention skills, with an emphasis on youth	• Develop effective approaches and materials directed at youth • Mobilize and support church-based prevention activities • Provide after-school and out-of-school peer group discussions for youth • Conduct schools-based "Prevention Days" competitions and events reaching 400,000 students through 100 schools	USAID		2003 CSH-HIV (and prior years)	

4.2.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget

MOH/CDC New partner? No FBO? No	Assess health worker HIV prevention attitudes and behaviors, and develop a strategy and implementation plan to help health workers practice ABC and serve as community role models, by end-FY04	• Contract external and in-country experts to design (i) methodology and tools to assess health worker attitudes and behavior regarding HIV and (ii) strategy and implementation plan to help health workers practice ABC and serve as role models • Conduct assessment • Conduct workshop with MOH and donors to present and disseminate findings and implementation plan for FY05	HHS/CDC	(S/GAC under Track 2)
World Relief New partner? Yes FBO? Yes	Provide IEC/BCC and supportive environment at home, at school, and through faith communities to enable youth to abstain from sex until marriage	• Develop materials to guide youth in self-assessment of risk, development of life goals, and AB knowledge and skills • Mobilize and train influencers of youth to guide youth in making wise choices	USAID	(Track 1)
TBD through APS, award(s) June 2004 New partner? TBD FBO? TBD	Expand AB approaches to reach in-school and out-of-school youth and adults in high-prevalence central provinces	• Mobilize and train local partners, leaders, and peer educators • In coordination with NAC, MOH, and other NGO partners, tailor AB-oriented IEC/BCC messages and materials and disseminate them through wide array of media and events in central provinces	USAID	(Base 04 under Track 2)

FDC and partners New partner? No FBO? Some sub-grantee FBOs	Scale up school-based and out-of-school programs in southern provinces, focus IEC/BCC on AB, and expand access to nation-wide toll-free telephone IEC service	• Design and deliver AB communications messages via mass media and peer-led approaches • Hire AB specialist to develop information and train telephone helpline operators to provide youth-oriented AB and reproductive health information	USAID	(Base 04 under Track 2)
FDC New partner? No FBO? No	Reach 1 million young people through radio, film, and print materials promoting AB, and provide a framework for use and discussion in schools and community centers	• Create HIV/AIDS resource centers in schools • With partners, develop film and radio products for dissemination and discussion • Train, supervise, and support peer educators through digital video conferencing, speaker programs, and other events *Note: This is closely linked to USAID assistance described in preceding activity*	State	(S/GAC under Track 2)

TBD for NAC New Partner? TBD FBO? No	Develop and disseminate effective BCC messages and approaches for nationwide AB campaigns and support, based on best practices and NAC communications strategy	• Provide TA to NAC to develop improved, socio-culturally appropriate messages and approaches for AB, based on MOH/NAC workshop and visit (described in 4.13.4 below), formative assessments, and best practices • Provide training for both NAC and NGO/ CBO (incl. FBO) staff, to strengthen consistency and extend use of effective messages *Note: This initial increment focuses on AB as a top priority for improved messages and approaches; this is seen as the first part of a broader, multi-year package of assistance in BCC to prevent new infections and promote use of care and treatment services*	USAID	(Base 04 under Track 2)
TBD New partner? NA FBO? NA	Standardize quality and effectiveness of school-based AB messages, targeting at least 22,000 youth in 42 secondary and technical schools	• Conduct targeted assessments of existing IEC/BCC best practices • Develop and pilot a manual for teacher use • Publish and disseminate manual to Ministry of Education teachers • Train Peace Corps Volunteer teachers to use the manual in the 42 schools where they are placed	Peace Corps	(S/GAC under Track 2)

Total partners	6	New partners	1	FBOs	1	Total budget	Track 1.5	Track 2	Total FY04

Table 4.3	Blood Safety
4.3.1 Current status of program in country	Of the 111 health care facilities currently providing blood transfusion services throughout the country, 17 are located in large hospitals, one being the Maputo Central Hospital Blood Bank which fulfils the function of National Reference Blood Transfusion Center. The National Blood Transfusion Program (NBTP) follows a decentralized model, where all sites collect, screen, and transfuse blood units, making standardization, quality assurance, supervision and data management a challenge. Currently, the NBTP has 230 employees: 201 laboratory technicians, 27 nurses or nursing aides (12%), and two physicians (1%). In 2003, 66,042 transfusions were administered, an increase of 10.3% from 2002; 3,839 transfusion requests (3%) were not met during that time. For 2004, 83,000 blood units are needed to adequately supply the nation and provide for unexpected needs (10%). The most common indications for transfusion are malaria in children (60%) and blood loss due to complications during delivery (20%). All blood donors are routinely screened for syphilis and HIV; there is no screening for Hepatitis B and C. In 2003, HIV prevalence among blood donors was 8.5% and 4.4% were positive for syphilis. A recent study of 1,022 donors at 6 blood banks indicated a prevalence of Hepatitis B of 8.8%. Challenges and needs of the NBTP include: 1)Restructure and reorganize the program towards a network model 2)Develop central level oversight, managerial, and data collection and analysis capacity 3)Expand types of blood products offered 4)Establish systematic and regular training of new personnel and refresher courses for existing personnel 5)Develop a strategy for donor mobilization to attract low-risk donors and increase repeat low-risk donors 6)Improve counseling (for both positive and negative tests) and referrals of patients to clinical services 7)Standardize notification and tracking for donors with positive screening test for syphilis and/or HIV 8)Incorporate routine screening for hepatitis B and C into Blood Bank procedures Recent changes in NBTP management staff have revitalized this important area and offer the opportunity for productive collaborations that will have a major public health impact in Mozambique.

4.3.2 How new activities will contribute to PEPFAR targets; linkages to other activities	Activities described below contribute to the goal of preventing new HIV infections by ensuring that every unit of blood is screened using standardized methodology, by quality technical personnel, within a quality assurance program that has integrated counseling and referral for screen-positive donors (HIV, syphilis, hepatitis). USG assistance focuses on developing NBTP management capacity; restructuring the NTBP towards a network model with efficient supervision, quality assurance and adequate and safe blood supply; and developing and implementing an effective low-risk donor mobilization program. In addition, USG support will provide expert technical assistance to the NBTP through continuation of a collaboration with hemotherapy experts from a lusophone partner institution in Brazil. There is a close working relationship between the NBTP and MOH laboratory services. NBTP staff participated in the development of the MOH HIV/AIDS Strategic Plan for 2004-2008, and there is a high level of awareness of the importance of blood safety among blood transfusion and clinical personnel. This creates an environment conducive for collaboration with a higher likelihood of program success.

4.3.3 Existing activities initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1, 1.5, 2)
CDC Foundation Oswaldo Cruz, FIOTEC Institute, Albert Einstein Israelite Hospital, Brazil FBO? Yes	Conduct a situation analysis of the current state of the NBTP and assist MOH to develop a program proposal for submission by March 1, 2004	• Provide technical assistance for a situation analysis/assessment of the NBTP • Provide technical assistance for the development of a proposal for rapid strengthening of the National Blood Transfusion Services	HHS/ CDC		S/GAC	1.5

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4.3.4 Proposed new activities in FY04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
New Partner? No FBO? Yes	Increase capacity of MOH National Institute of Health Sciences (NIHS) to expand the pool of highly qualified blood bank technicians through improved pre-service training by end-2004	• Provide TA to review existing training curricula and materials for 30 intermediate level blood bank technicians per year • Assess needs and opportunities for development of a one-year university degree training course as continuing education opportunity for existing blood bank technicians; first course (30 participants) to begin January 2005 • Produce recommendations for curriculum development, course contents, training materials needed, and implementation plan	HHS/CDC	(S/GAC under Track 2)
New Partner? No FBO? Yes	Support NBTP to develop a detailed implementation plan for key operational strategies by end-FY04	• Provide TA for development of a detailed implementation plan for rapid strengthening of NBTP • Provide TA to develop nationwide program strategy for low-risk blood donor mobilization • Provide TA for development of a strategy and implementation plan to redesign NBTP as a network model of service provision	HHS/CDC	(S/GAC under Track 2)

MOH (Proposal for 5-year program submitted to HHS/CDC New partner? No FBO? No	Strengthen National Blood Transfusion Services by creating a network model of service provision, setting up quality assurance and data management systems, improving blood safety, and providing training by March 2009	Proposed first year activities: • Develop a strategy and begin activities to create a network model of service provision • Design and start set-up of quality assurance system • Develop mobilization strategies and conduct mobilization activities involving community leaders, schools, and the "Blood Donor Association" of Mozambique • Conduct in-service training in blood bank management, donor recruitment and mobilization, quality assurance, and laboratory testing; total of 59 staff to be trained by end of March 2005 • Improve blood bank HIV testing services and introduce hepatitis screening *Note: A separate HHS/CDC Track 1 solicitation is expected to provide complementary TA for this MOH proposal*	HHS/CDC	(Track 1)
TBD (Proposal deadline 1 March 2004) New partner? Yes/No FBO? Yes/No	Provide technical assistance for rapid strengthening of blood transfusion services		HHS/CDC	(Track 1)

Track 1.5
Track 2
Total FY04
Total budget
1
FBOs
0
New partners
3
Total partners

Table 4.4	Safe Injections and Prevention of Other Medical Transmission of HIV
4.4.1 Current status of program in country	Injection safety and prevention of HIV transmission through medical procedures are overseen by the MOH Nursing Department, which also acts as the Coordinator of the National 'Bio-Safety' Program. The program has received very limited support over the past two years, the most salient including training of 120 nurses in bio-safety procedures (UNDP) and development of a manual on 'Cleanliness, Disinfection and Sterilization' (Spanish Cooperation); no other activities have been carried out. While data regarding medical transmission of HIV and other diseases have not been collected, the situation, in particular at peripheral health facility level, is alarming.
4.4.2 How new activities will contribute to PEPFAR targets and linkages to other activities	Activities in the area of bio-safety will help prevent new HIV infections. A curriculum for basic HIV/AIDS training for nurses and other health professionals is currently being developed, which will include a two-day module on bio-safety. Close collaboration is planned between the Bio-Safety Program and the Laboratory Network and the Blood Transfusion Program. The World Bank (MAP) will provide around [redacted] for procurement of autoclaves and medical and surgical supplies, and [redacted] for hospital waste management over a five-year (2003-2008) period. USG-supported injection safety activities will be linked with the sites providing related USG-supported services, by coordinating site selection with ART, laboratory, and training activities.

4.4.3 Existing activities initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1.1, 1.5, 2)

MOH FBO? No	Improve institutional capacity to manage, train and supervise National Bio-Safety *Program and to* implement a standardized, quality bio-safety program at the 5 USG-supported ART sites by March 2005	• Recruit bio-safety trainer and logistics officer for MOH Bio-Safety Program; procure office equipment and furniture • Define standards and norms and *develop National Bio-Safety* Guidelines • Develop training materials and conduct pilot course on bio-safety for 22 health workers from the 5 new ART sites • Establish 5 bio-safety committees at the 5 new ART sites • Conduct 3-6 supervisory trips to 5 provinces and conduct quality assessment in selected sites • Sponsor training for one senior bio-safety program staff member	HHS/ CDC		S/GAC	1.5
JHPIEGO FBO? No	Improve MOH capacity to manage, train and supervise National Bio-Safety Program and to implement a standardized, *quality bio-safety* program at the 5 USG-supported ART sites by March 2005	• Provide TA for the development of evidence-based operational standards in infection prevention and control for facility-based health care • Provide TA to develop a bio-safety training manual • *Develop tools and conduct* assessments at 5 new USG-supported ART sites; develop an implementation plan for each site.	HHS/ CDC		S/GAC	1.5

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4.4.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
John Snow Inc. (under central Task Order) New Partner? No FBO? No	Prevent medical transmission of HIV through reduction of unsafe and unnecessary injections	• Assess current injection practices • Establish National Injection Safety Group and develop action plan • Design and field-test enhanced injection safety in 2-3 pilot districts, including training, management of equipment and supplies, management of sharp waste • Develop and start implementation of an advocacy and behavior change strategy	USAID	Track 1

Total partners:	3	New partners:	0	FBOs:	0	Total budget	Track 1.5 Track 2 Total FY04

Table 4.5	Other Prevention Initiatives (e.g., provision of condoms, control of STIs, high-risk groups)
4.5.1 Current status of program in country	National STI Control Program: Adequate diagnosis and treatment of STIs is a top priority in the MOH HIV/AIDS/STI Strategic Plan for 2004-2008. STI services are provided at 1,000 health facilities, mostly through outpatient consultation but also through MCH and inpatient services. The number of STI cases notified has risen from less than 350,000 in 1999 to over 500,000 in 2002. As laboratory services for etiological diagnosis are available only at central and provincial hospitals, service providers in most sites use the syndromic approach for diagnosis and treatment. The national target for 2004 is to provide STI treatment to 684,828 clients. A study on "Validation of the Syndromic Approach to Management of STDs and Prevalence Assessment of STDs among Women Attending Family Planning Clinics" is underway by MOH with support from HHS/CDC. Findings from this study will be presented in 2004 and will inform the planned review of national treatment protocols and algorithms. Condom Social Marketing: Mozambique's CSM program, implemented by PSI, is an element of a broader BCC effort which also promotes abstinence, partner reduction, and service provision (VCT, PMTCT, STI). CSM encourages consistent condom use among those most at risk of contracting and spreading HIV, and motivates and enables clients to use condoms and/or reduce partners. Condom distribution through commercial outlets ensures wide availability and prioritizes outlets where high-risk activity takes place. The program emphasizes interpersonal communication through guided peer debates and peer education, complemented by print materials and, where appropriate, outdoor media, radio, and TV. USAID has supported PSI CSM since 1994; the project is national in scope, is a fundamental element of the MOH HIV prevention strategy, and is integrated with other donor activities (DFID funds a portion of the BCC activities and all CSM condom procurement through 2006). High-Risk Groups: With prior-year USAID funding, a Mozambican NGO, the Foundation for Community Development (FDC), through numerous local partners, has implemented an innovative combination of prevention efforts through mass media, public events, school-based and community-based activities (covering three provinces and the capital city), and a nation-wide toll-free information phone line. These activities target high-risk groups including migrant workers and their families, PLWHA, at-risk women, in-school and out-of-school youth, and OVC. Prior-year funding from USAID's Regional HIV/AIDS Program for southern Africa targets truck drivers, uniformed services, migrant workers, and commercial sex workers through peer education and BCC efforts in three high-risk sites (including two border crossings) on the Maputo Development Corridor.

4.5.2 How new activities will contribute to PEPFAR targets, linkages to other activities	Activities to promote prevention and ensure diagnosis and treatment of STIs will reduce new HIV infections. The National STI Program, situated within the MOH National HIV/AIDS Program and the Department of Epidemiology, links with other components of the HIV/AIDS program as well as with surveillance. (The STI Program Director is a key member of the surveillance technical working group.) Some funding for training STI service providers and evaluating the program is provided by the European Union in 2004. Review of STI protocols and algorithms will feed into revision of STI training manuals and surveillance tools. Revised manuals will incorporate training on counseling and referral of STI patients to relevant HIV/AIDS services. (Training for STI service providers at USG-supported sites will begin in early FY05.) Improved STI program records and surveillance will allow measurement of referrals across HIV/AIDS services, of particular interest for high-risk clients. USG community-based prevention activities, implemented through NGO partners, will continue to focus on high-prevalence areas with significant commercial and population importance. New prevention activities targeting high-risk groups will focus where Integrated HIV/AIDS Network services (many funded by USG) will be available, creating vital linkages between formal health facilities and communities in order to increase acceptance of and demand for VCT, PMTCT, and treatment services. CSM will continue to be national in scope, increasingly targeting high-risk groups including mobile populations, uniformed services, women engaged in transactional sex, and STI patients.

4.5.3 Existing activities, initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1, 1.5, 2)

MOH/CDC FBO? No	Complete study on validation of STI syndromic approach and STI prevalence assessment at family planning clinics and disseminate findings by June 2004	• Complete data analysis • Produce report with study findings and recommendations • Conduct national workshop for presentation, discussion and dissemination of findings	HHS/ CDC		FY03	
MOH/CDC FBO? No	Review and complete treatment protocols, algorithms and STI training manuals and incorporate changes to enhance linkage with HIV related services by August 2004	• Provide TA to review existing guidelines, treatment protocols, algorithms and training manuals and integrate STI and HIV services to improve cross-referral and counseling capacity • Ensure that STI protocols and guidelines are harmonized with VCT and HIV guidelines • Review STI data collection tools and registers to include HIV referral information • Reproduce revised guidelines, forms, treatment protocols, algorithms and training manuals	HHS/ CDC		FY03 Base 04	 2

FDC and partners FBO? Some sub-grantees are FBOs	Prevention of HIV infection and promotion of services for prevention, care, and support	• Mass media prevention campaigns and materials • Large-scale public events (music, parades, films, etc.) and peer education • Involvement of PLWHA • Linkages with faith-based *community groups* • Community-based prevention	USAID		FY03 CSH-HIV (and prior years)	
PSI FBO? No	Prevention of HIV infection and behavior change to reduce risk	• National IEC/BCC campaigns • Nationwide program of mass media, face-to-face, and BCC events • Condom social marketing targeting high-risk groups including uniformed services	USAID		FY03 CSH-HIV (and prior years)	

4.5.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget

[redacted] and partners New Partner? No FBO? Some sub-grantees are FBOs	Extend/strengthen understanding of HIV/AIDS, risk perception, and care seeking, targeting high-risk groups	• Develop and implement mass media prevention campaigns • Train more counselors and expand subject matter to extend and responsiveness and hours of popular telephone help-line • Implement targeted face-to-face activities, peer education, and mobilization of community leaders including traditional healers to reach high-risk groups	USAID	(Base 04 under Track 2) [redacted] and (S/GAC under Track 2) [redacted] (plus [redacted] from FY03 CSH-HIV)
		• Provide full-time PCV TA for improved planning and implementation	Peace Corps	(see Peace Corps listing below)

PSI New Partner? No FBO? No	Strengthen and extend nationwide BCC, including CSM, targeting high-risk groups including the military	• Expand share of condom sales through commercial and pharmaceutical wholesalers; focus new outlets close to areas of high-risk activity; sell 19.5 million condoms from Jan 04 to Mar 05 • Continue communications campaign, reaching 16,500 through peer education, 825,000 through print and mass media, and 126,000 through interpersonal communications (theater groups, trained activists) to influence motivation and ability to reduce partners and/or use condoms • Develop new media campaigns to increase accurate risk perception in trusted partner relationships and to encourage delay of sexual debut • Provide full-time PCV TA for improved planning and implementation	USAID Peace Corps	(Base 04 under Track 2) (see Peace Corps listing below)
TBD New Partner? Yes FBO? TBD	Enable new partners at grassroots level to implement modest, targeted prevention programs; develop capacity of the most successful of these partners to expand services	• Provide 10 grants to community-based organizations and NGOs, some of which will be faith-based, to reach 10,000 people with HIV prevention activities and services *Note: Grant opportunities will be advertised in local press. Grantees will be selected by inter-agency PEPFAR team based on ability to contribute to 2-7-10 goals. State, with extensive experience administering small grants, will be responsible for monitoring.*	State	(S/GAC under Track 2)

WR, WV New Partner? FBO? WR and WV		Provide full-time PCV TA to local partner institutions to improve their capacity to plan and implement HIV/AIDS IEC/BCC activities		• Conduct participatory needs assessments • Provide on-the-job TA in organizational and project management		Peace Corps	(S/GAC under Track 2) (includes TA for FDC and PSI listed above) Track 1.5 Track 2 Total FY04
Total partners:	9	New partners:	2	FBOs:	2	Total budget:	

Table 4.6	Voluntary Counseling and Testing
4.6.1 Current status of program in country	The National VCT Program is a collaboration between MOH, many international donors, and the NGOs who are responsible for implementation at the site level. VCT expansion exceeded its 2003 target of 40 sites, with services available in 78 locations by the end of the year, comprising 45 conventional VCT centers, 14 satellites (providing weekly services in remote areas using conventional VCT staff and facilities as a base), 12 sites within PMTCT services, 6 within youth-friendly clinics, and one in a hospital inpatient unit. In 2003, 82,344 people (53% women, 47% men) accessed VCT services, and 20,031 were positive (62% women, 38% men). Demand for VCT continues to rise. A higher percentage of women accessing VCT are referred from other services, while men usually self-refer; minimal, if any, testing of children is done at these sites. 387 persons received VCT training in 2003. Linking VCT services to other program areas is a challenge. Although the national TB program reported that 3,503 patients were referred to VCT in 2003 and 2,186 were positive, there are no data on STI referrals nor any systematic data collection of cross-referral to and from VCT services and STI, TB, and other services. This will be addressed with M&E assistance to MOH. Clinical services for referred patients also need to be developed. While all provinces offer VCT, the northern provinces, with lower HIV prevalence, have the least (Cabo Delgado 1 site, Nampula 3, Niassa 3). Donors include UN (WHO sites), France, Spain, GTZ; NGOs include MSF, PSI, HAI, WV, Medicos do Mundo Portugal, and others. USG funding supports all VCT trainer expenses (including 4 central MOH technical positions), development of the VCT strategic and operational plans within the National HIV/AIDS/STI Strategy, the procurement of all HIV test kits, operational guide development, annual review of training materials, the entire VCT data management system, and data entry and analysis from at least 85% of the sites.
4.6.2 How new activities will contribute to PEPFAR targets; linkages to other activities	Use of increasingly accessible VCT services will both *reduce new infections*, as HIV negative clients are counseled and motivations and measures to remain uninfected are promoted, and *increase access to care and treatment*, as HIV positive clients are identified and referred to services providing ART and OI prevention and treatment. VCT is usually the first service established in an Integrated HIV/AIDS Network. Linkages to PMTCT services and Youth-Friendly Health Clinics are being strengthened and expanded. Services at most VCT sites are supported by international NGOs, and donor funding has been considerable over the past years. The USG-supported quality assurance system for VCT is described and costed in Table 4.14, Laboratory. USG will directly support 15 new VCT sites by end-2004, all priority sites defined by MOH where linkages with other services of the Integrated HIV/AIDS Networks will be available; these 15 VCT sites correspond with PMTCT sites also supported by USG.

4.6.3 Existing activities, initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1 or 2)
MOH CoAg 03 CDC FBO? No	Increase VCT program management and training capacity to expand and improve service delivery by hiring program management staff and training VCT supervisors and service providers by end-2004	• Hire 1 central coordinator and 2 regional trainers/supervisors (center and north) and set up offices • Train VCT staff and counselors (75 new and 100 existing) • Conduct supervisory visits to VCT service sites • Support VCT annual meeting to present data from 2003 and make recommendations for program improvement • Provide training for 18 provincial VCT supervisors • Provide TA for training 75 new and 100 existing VCT staff • Develop supervision guidelines, tools and plan; lead supervisory visits to VCT service sites • Support attendance of central level VCT staff in conferences/ continuing education events	HHS/ CDC		FY03 Base 04	 2

MOH (CoAg 03) CDC FBO? No	Implement a standardized M&E system for 95% of all VCT program sites by end-2004	• Conduct training for 60 site level VCT data managers in 5 training sessions • Provide TA to conduct VCT program process evaluation	HHS/ CDC		FY03 Base 04	 2
MOH (CoAg Suppl. 04) (FBO? No)	Ensure adequate VCT training of 250 PMTCT and Youth-Friendly Health Clinic service providers by end-FY04	• Recruit additional central level VCT trainer • Train 250 counselors for VCT services within PMTCT and Youth-Friendly Health Clinics	HHS/ CDC		S/GAC	1.5

4.6.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
MOH/CDC New partner? No FBO? No	Improve national VCT program data collection, storage, and analysis capacity by July 2004	• Procure and install master computer (high data storage capacity) for National VCT Program data base	HHS/CDC	(Base 04 under Track 2)
MOH/CDC New partner? No FBO? No	Support training of VCT staff and PLWHA support groups, targeting VCT sites at 4 new USG-supported ART sites by end-2004	• Conduct 3 refresher courses for VCT personnel and PLWHA who facilitate support groups of HIV+ persons identified at VCT sites serving new USG ART clinics (total of 60 facilitators trained)	HHS/CDC	(Base 04 under Track 2)

TBD New partner? TBD FBO? TBD	Conduct VCT program evaluation to be completed by August 2004	• Contract external consultants or agency to lead a national VCT program evaluation	HHS/CDC	(Base 04 under Track 2) [redacted]
HAI New partner? No FBO? No	Establish 6 new VCT sites, per MOH priorities and linked to HAI PMTCT sites, including 3 "youth-friendly" sites; counsel and test 17,400 persons; train 67 staff	• Coordinate with NGO partners to establish and strengthen linkages between new VCT centers and other IHN services, particularly PMTCT • Conduct BCC and mobilize communities to increase uptake • Prepare facilities and provide services • Train/retrain VCT and health facility staff	USAID	(Base 04 under Track 1.5) [redacted]
PSI New partner? No FBO? No	Establish 8 new VCT sites, per MOH priorities and linked to PSI or other USG-supported PMTCT sites; counsel and test 17,000 persons; train 25 counselors	• Coordinate with NGO partners to establish and strengthen linkages between new VCT centers and other IHN services, particularly PMTCT • Conduct BCC and mobilize communities to increase uptake • Prepare facilities and provide services • Train counselors	USAID	(Base 04 under Track 1.5) [redacted]
World Vision New partner? Yes FBO? Yes	Establish 2 new VCT sites, per MOH priorities and linked to WV or other USG-supported PMTCT sites; continue and improve services at 2 existing sites	• Coordinate with NGO partners to establish and strengthen linkages between new VCT centers and other IHN services, particularly PMTCT • Prepare facilities and provide services • Train/retrain counselors • Pilot integrated approach with PMTCT and community-based care	USAID	(Base 04 under Track 1.5) [redacted]

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PSI New partner? No FBO? No		Expand VCT in Ministry of Defense at 4 recruit training sites; establish MOD policy for confidentiality		• Train VCT counselors and staff • Procure equipment and supplies, including HIV test kits, for MOD VCT • Conduct IEC/BCC campaign and outreach		DOD/ DHAPP	(S/GAC under Track 2)
Total partners:	5	New partners:	1	FBOs:	1	Total budget:	Track 1.5 Track 2 Total FY04

Note: Although total funding only includes FY04 requests, activities funded through allocations at the end of FY03 also are listed, to give a complete picture of VCT activities undertaken and planned in FY04.

Table 4.7	HIV Clinical Care and Support / Prevention and Treatment of TB and Other OIs (non-ART)
4.7.1 Current status of program in country	Opportunistic Infections (OIs): Services are provided through 1,224 health units providing outpatient consultations and around half provide some inpatient services. In most facilities, no differentiation is made between patients with HIV/AIDS-related illness and other conditions. At 7 Integrated HIV/AIDS Network sites with Day Hospitals (established mostly over the past year), health workers trained specifically on prevention and treatment of OIs provide specialized services for PLWHA. Data on numbers treated for OIs are not available, but work is underway at MOH to set up standardized data collection. HIV/AIDS Nurses Training: A training course and manuals for nurses are being developed, covering HIV transmission and prevention, interpersonal communication, bio-safety with a strong emphasis on management of OIs, nursing care for PLWHA, and home-based care (HBC). The course modules are designed to be used for training of other health professionals involved in HIV/AIDS Integrated Network services. Tuberculosis (TB): 26,117 TB patients were registered in 2002; the number of cases is increasing 15% per year. HIV seroprevalence among TB patients rose from 16.7% in 1994 to 32% in 1998. Since 2000, short-term multi-drug therapy is available at health facilities nationwide. Standard guidelines for diagnosis and treatment are in place. About 75% of TB patients complete their treatment. Targets of the National TB Program include increasing TB success rate to 85%, identifying 70% of all new positive cases/year, decreasing treatment default rates to less than 10%, and increasing DOT coverage to 70%. Constraints include overall health facility coverage of only around 40% of the population, lack of equipment and training of laboratory staff, lack of adequate supervision associated with difficulties of access.
4.7.2 How new activities will contribute to PEPFAR targets, linkages to other activities	Activities described below contribute to providing support and care for PLWHA. Services for OI are provided through Day Hospitals (DH) that are part of the HIV/AIDS Integrated Networks. MOH plans to simultaneously establish DH and ART in 17 sites in 2004, while in additional sites DH will precede ART introduction. Activities are closely coordinated with senior clinicians at the Maputo Central Hospital. Most DH are supported by NGOs. Increased linkages and monitoring of cross-referrals between TB and HIV/AIDS services are needed. Mozambique's Global Fund proposal includes a total of [redacted] for TB. HIV/AIDS nurses training will build capacity among health service providers directly involved in promoting HIV/AIDS prevention and providing care and support to PLWHA; led by the MOH Nursing Department, this effort also involves the Medical Assistance and Human Resources Departments as well as clinicians from Maputo Central Hospital.

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4.7.3 Existing activities, initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1, 1.5, 2)
MOH (CoAg Suppl. 04) FBO? No	Improve OI guidelines and training materials and train 60 health professionals on OI *management by* end-2004	• Review and reproduce OI prophylaxis guidelines • Produce training manual for OI management • Train 60 health professionals *(physicians/technicians)* • Conduct supervision visits after training	HHS/ CDC		Base 04	1.5
CARE FBO? No	Establish one HIV Day Hospital to provide OI services in Nampula Province by end-FY04	• Set up Day Hospital • Recruit medical officer • Provide OI services to HIV+ persons identified through VCT • Provide interventions for PLWHA with poor nutritional status and monitor clinical outcomes	HHS/ CDC		S/GAC	1.5

MOH (CoAg 03) FBO? No	Develop HIV/AIDS nurses training curriculum by end-April 2004 and train 60 nurses by end-FY04	• Develop training materials: facilitators/participants manuals, job aids, photo album for illustration of clinical conditions • Conduct 2 courses with 60 participants to pilot materials and select future facilitators • Conduct supervision visits to staff after training	HHS/ CDC		FY03	
CDC FBO? No	Provide technical assistance to develop HIV/AIDS nurses training curriculum by end-April 2004 and train 60 nurses by end-FY04	• Provide TA/support to develop materials and train facilitators • Support reproduction of training materials • Accompany supervision and evaluation visits subsequent to first two trainings	HHS/ CDC		Base 04	2
CARE (sub-contract to Aga Khan Foundation (FBO? Yes)	Assess available HIV-related services and develop 5-year operational plan for AKF HIV/AIDS program in Cabo Delgado, linked with new USG-supported ART site, by end-FY04	• Conduct baseline assessment of available HIV related services including identifying potential for community-based services • Conduct multi-sectoral workshop with key HIV/AIDS partners to present findings and coordinate future efforts • Produce 5-year operational plan for AKF HIV/AIDS program in Cabo Delgado, linking activities with new USG-supported ART site	HHS/ CDC		S/GAC	1.5

4.7.4 Proposed new activities in FY 04				
Partner	**FY04 Objective**	**Activities for each objective**	**Agency**	**Budget**
CDC/MOH New partner? No FBO? No	Improve linkage between national TB program and HIV services at 17 HIV integrated network sites (including 8 USG-funded ART sites) by end-2004	• Provide HIV/AIDS training to TB program supervisors at 17 HIV Integrated Network sites including 8 USG-supported ART sites	HHS/CDC	(S/GAC under Track 2) [redacted]
HAI New partner? No FBO? No	Improve capacity of health system to care for those already HIV infected and integrate HIV/AIDS services into a cohesive health network providing a continuum of care in Sofala and Manica	• Rehabilitate and expand 2 existing Day Hospitals • Develop patient management system and services that will build capacity for introduction of ART • Improve linkages between DH and peripheral health centers as well as TB care services • Design and pilot an improved referral system for tracking patient flow at 2 sites	USAID	(Base under Track 1.5) [redacted]
[redacted] New partner? Yes FBO? No	Train 2[redacted] physicians in HIV clinical care including basic public health issues, OI prevention/treatment, ART, and basic HIV clinic management	• Train 2[redacted] doctors at DHAPP program (San Diego, CA)	DOD/ DHAPP	(S/GAC under Track 2) [redacted]

Total partners	New partners	FBOs	Total budget	Track 1.5	Track 2	Total FY04
5	1	1	1			

Table 4.8	Palliative Care
4.8.1 Current status of program in country	Current Status: MOH regulates and provides technical support to 56 Home-Based Care (HBC) program sites (20 community groups consisting of 33 separate "partners" including donor and facilitating organizations, with around a third being faith-based organizations and initiatives) providing HBC for about 5000 PLWHAs. MOH also provides standardized training manuals for HBC trainers and volunteers as well as data collection forms and a program assessment tool. MOH plans for 2004 foresee an increase to 11,355 clients served. National Policy on Medical Use of Narcotics: Morphine can only be prescribed by medical doctors at hospital level. Codeine can be prescribed by mid-level practitioners ('Medical Technicians') at health center level. Petidine can be prescribed by 'Medical Assistants' also at health center level. No narcotics are approved for prescription and administration at the level of community-based activities. Collaboration HBC - Traditional Healers (TH): Over the past year, efforts have been made to increase involvement and collaboration with TH. At community level, TH are commonly the first agents consulted for STIs and HIV/AIDS-related illness. The MOH HBC program has collaborated with the Traditional Medicine Department to pilot training of TH. An increasing number of NGO and community-based programs are involving TH in HIV/AIDS care and prevention and providing training and IEC/BCC messages to and through the TH to their clients. Home Visits: Besides HBC described above, NGO (including FBO) programs, through community volunteers, reach a significant number of PLWHA through "home visits," providing psycho-social, economic, and spiritual support to families and individuals affected by HIV/AIDS. Home visits are not MOH regulated but strengthen and complement the MOH HBC program, providing care in areas where the MOH program is yet to be established.

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4.8.2 How new activities will contribute to PEPFAR targets, linkages to other activities	Activities outlined below contribute to substantially increasing the number of PLWHA receiving palliative care and particularly HBC. Those introduced under track 1.5 help assure adherence to medicines including ART, and are closely related to care and treatment targets for ART and clinical care. An assessment of activities involving TH will be conducted; expansion of these activities to cover additional geographic areas and topics will be explored. USG-supported NGOs also are testing practical approaches for integrating HBC with prevention, OVC care, and promotion of VCT and PMTCT services. In the Integrated Network model, day care unit nurses will help supervise and coordinate HBC activities. From the onset of the program, collaboration with numerous donors and NGOs, including international and national NGOs and FBOs at community level, has been important. MOH at central level facilitates overall coordination, trains 'master trainers' and facilitators of partner organizations, and defines and disseminates norms and standards. MOH also provides guidance to donors interested in supporting HBC; for 2004, these include WHO, WFP, Danida, DFID, and GTZ. The Mozambican Christian Council has plans to mobilize increased support for FBOs involved in home visits and HBC. USG, through NGO partners, will extend MOH HBC program to 9 new MOH priority sites in 2004, integrating HBC with VCT, PMTCT, and treatment in order to provide the full range of Integrated HIV/AIDS Network services at these sites. In conjunction with these IHN services, "home visits" will continue through FBOs, reaching a larger number of PLWHA and their families with psycho-social and spiritual support and encouraging them to use the IHN services as they become available.

4.8.3 Existing activities initiated prior to FY04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1, 1.5, 2)

CDC/MOH FBO? No	Support MOH scale-up of HBC to 60 programs linked to HIV Day Hospitals (including USG-supported ART and OI sites) and support ensured quality of services for PLWHA by the end-2004	• Train/certify 20 new and retrain 90 existing provincial trainers/supervisors for HBC • Conduct refresher seminars for 90 provincial HBC trainers • Conduct on-site training mentoring for 100 new trainers and supervisory field visits • Conduct coordination/planning meetings with Provincial Health Departments to clarify roles and responsibilities for HBC service provision and M&E of activities • Conduct annual review of HBC guidelines, program policy, and training materials • Provide support to develop procurement and distribution plan for HBC kits and supplies • Provide support for HBC staff to attend regional/international continuing education events	HHS/ CDC		Base 04	2

MOH (CoAg Suppl. 04) FBO? No	Scale-up HBC to 60 HBC programs by the end-FY04, and provide support to ensure quality of services for PLWHAs	• Provide salary support for MOH/HBC supervisors and trainers • Develop HBC ARV adherence training module; pilot implementation at 1 HBC site • Conduct 3 regional TOT sessions on HBC approaches for ART adherence • Conduct 2 TOT sessions and certify 40 additional provincial trainers/supervisors for HBC • Develop/reproduce new HBC IEC materials to promote acceptance of HBC community volunteers • Develop/test self-assessment tool for HBC monitoring and evaluation to support quality services	HHS/ CDC		S/GAC	1.5
MOH (CoAg Suppl. 04) FBO? No	Create capacity to deliver HBC services among community-based traditional healers by end-2004	• Hire HBC trainer for the Traditional Medicine Program • Train 20 Traditional Healers in HBC	HHS/ CDC		S/GAC	1.5

CDC/MOH FBO? No	Create linkages between MOH HBC and TH programs by introducing HBC to TH by end-2004	• Support MOH HBC central level trainers, facilitate HBC training modules at 3 TH training sessions	HHS/ CDC			Base 04	2
CDC/MOH FBO? No	Assist MOH to evaluate potential role for TH as community-based agents for HBC service delivery and referral by end-FY04	• Visit model HBC-TH program in South Africa to learn best practices, share lessons learned • Conduct assessment of effect of TH as community agents for HIV service provision, identify how to better involve TH in HIV care, prevention, treatment at community level • Evaluate potential role of TH as community-based referral agents	HHS/ CDC			Base 04	2
FDC and partners FBO? Some sub-grantees are FBOs	Provide care for and support PLWHA and their families	• Mobilize, train, and support community-based volunteers • Make home visits to provide psychosocial, material, and personal care assistance	USAID			FY03 CSH-HIV (and prior years)	

4.8.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget

[redacted]and sub-grantees New partner? No FBO? -Some sub-grantees are FBOs	Strengthen community-based care as an extension of HIV/AIDS Integrated Networks	• Mobilize, train, and supervise volunteers to provide HBC including palliative care • Ensure linkages with MOH HBC program for guidance, quality assurance, and M&E • Promote and support leadership in HBC of traditional healers and other local leaders	USAID	(Based under Track 2) [redacted]
World Relief New partner? Yes FBO? Yes	Strengthen community-based care as an extension of HIV/AIDS Integrated Networks	• Mobilize church pastors and churches to engage in HIV/AIDS care and support • Mobilize, train, and supervise volunteers to provide home-based care including palliative care	USAID	(Base under Track 1.5) [redacted]
Health Alliance International New partner? No FBO? Local partner, Kubatsirana, is FBO	Strengthen community-based care as an extension of HIV/AIDS Integrated Networks through a grass-roots faith-based organization (Kubatsirana) in Manica and Sofala	• Extend partnership to build Kubatsirana capacity to provide quality HBC • Conduct needs assessments of 2 new sites • In collaboration with MOH HBC program, train HBC volunteers in palliative care and ARV adherence • Initiate and sustain regular coordination meetings between health provincial health department and Kubatsirana	USAID	(Base under Track 1.5) [redacted]
World Vision New partner? Yes FBO? Yes	Mobilize and equip volunteers to provide home- and community-based care for chronically ill PLWHA	• Train volunteers to assist families with care • Provide direct support to families affected by chronic AIDS-related illness • Provide supplementary food • Provide information and refer patients for clinical diagnosis and care	USAID	(Base under Track 1.5) [redacted]

MOH/CDC New partner? No FBO? No		Disseminate IEC messages to promote acceptance of HBC services and support for PLWHA among at least 100,000 people by end-FY04		• Reproduce and distribute 100,000 leaflets ("Home-Based Care") through trained HBC volunteers and health workers • Reproduce and distribute 100,000 leaflets ("Hand-in-Hand") through trained HBC volunteers and health workers		HHS/CDC	(S/GAC under Track 2) [redacted]
Total partners:	5	New partners:	2	FBOs:	3	Total budget:	Track 1.5 [redacted] Track 2 [redacted] Total FY04 [redacted]

Note. The Mozambique National HBC Program provides not only care and support services for terminally ill patients, but also psycho-social support and preventive services for HIV+ people, which is broader than provision of 'palliative care.' Numerous FBOs that are not direct USG grantees also receive HBC support through MOH/CDC activities, through training of their facilitators and provision of guidelines, manuals and IEC.

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Table 4.9	Support for Orphans and Vulnerable Children
4.9.1 Current status of program in country	Mozambique's response to the OVC challenge is only beginning to get underway. A national OVC conference in November 2003 laid the groundwork for mobilizing and strategically applying resources to relieve increasingly acute OVC problems. A national OVC assessment is underway in 2004. There are no reliable data on the number, location, or condition of OVC related to HIV/AIDS. Given Mozambique's general and pervasive poverty and poor health service coverage, most children are vulnerable, so government and NGO implementing partners consider that making distinctions between OVC due to HIV/AIDS and those due to other causes (natural disasters, other illness) is often not practical and usually not helpful to program implementation.
4.9.2 How new activities will contribute to PEPFAR targets, linkages to other activities	Activities described below will allow USG to rapidly and significantly scale up the previously modest OVC services provided in Mozambique. These programs will reach OVC in a wider geographic area, will focus OVC services in areas most acutely affected, and will improve the quality and consistency of OVC services. Activities will directly provide care to persons affected by HIV/AIDS by relieving suffering, ensuring access to basic services (schooling, health services, and birth registration), protecting children from abuse and neglect, improving their food security and nutrition, providing them with skills for a healthy and productive adult life, and reducing their risk of contracting HIV. These activities also make a substantial contribution to increasing the capacity of Mozambican NGOs, including FBOs and community-based organizations, as well as responsible government institutions, to expand and sustain OVC support services in the future.

4.9.3 Existing activities, initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1.1, 5.2)

FDC and partners FBO? Some sub-grantees are FBOs	Pilot model approaches to ensure effective and sustainable community-based care and support for OVC	• Mobilize community leaders and partners, including FBOs, to identify and help meet the needs of OVC in their communities • Provide access for OVC to nutrition, schooling, health care, and civil rights • Provide equipment for and access to vocational training for OVC	USAID		FY03 CSH-HIV (and prior years)	
Contractor(s) and/or Grantee(s) TBD FBO? TBD	Strengthen and deepen OVC response in Mozambique	• Provide technical assistance and training for OVC assessment, development of strategy/policy, and M&E for OVC response • Provide equipment, training, and/or technical assistance for community-based OVC response in acutely affected areas	USAID		FY03 ESF (carry-over funds, obligation planned June 2004)	

4.9.4 Proposed new activities in FY04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
World Relief New partner? Yes FBO? Yes	Ensure protection, schooling, health, and nutrition for OVC in southern provinces	• Mobilize church pastors and churches to engage in OVC care and support • Mobilize, train, and supervise volunteers to protect and support OVC and child-headed households • Provide full-time PCV TA for improved planning and implementation of OVC services	USAID Peace Corps	(S/GAC under Track 1.5) (see Peace Corps listing below)

World Vision with [redacted] New partner? Yes FBO? Yes	Ensure protection, schooling, health, and nutrition for OVC in Zambezia and Sofala provinces	• Mobilize community leaders and partners, including FBOs, to identify and help meet the needs of OVC in their communities • Provide material and training support to NGOs/FBOs to start and sustain OVC services	USAID	(S/GAC under Track 1.5) [redacted]
TBD - [redacted] for OVC New partner? TBD FBO? Yes, some	Enable new partners at grassroots level to implement modest, targeted programs to serve OVC; develop capacity of the most successful of these partners to expand services	• Provide 3 to 5 grants to community-based organizations and NGOs, some of which will be faith-based, to deliver services to 500 OVC *Note: Grant opportunities will be advertised in local press. Grantees will be selected by inter-agency PEPFAR team based on ability to contribute to 2-7-10 goals. State, with extensive experience administering small grants, will be responsible for monitoring*	State	(S/GAC under Track 2) [redacted]
[redacted] and partners New partner? Yes FBO? No	Scale up basic services to OVC nationwide through partnerships with local NGOs and community-based groups, including FBOs; and provide support to GRM to establish policy and guidelines for OVC services (41,000 OVC in 3 years; 8,000 in 2004)	• Mobilize community leaders and partners, including FBOs, to identify and help meet the needs of OVC in their communities • Provide material and training support to NGOs/FBOs to start and sustain services for 8,000 OVC in 2004 and 41,000 by 2006 • Provide TA to Ministry for Women and Coordination of Social Action (MMCAS) for policy review/revision and planning • Provide full-time PCV TA for improved planning and implementation of OVC services	USAID Peace Corps	(Track 1) (see Peace Corps listing below)

[redacted] New partner? Yes FBO? Yes	Improve income and housing for OVC and the communities who care for them	• Expand micro-finance services to families caring for OVC • Build and improve housing of families caring for OVC • Develop pilot projects to build homes for orphan-headed families • Provide access to HIV/AIDS prevention and care services through partners • Provide full-time PCV TA for improved planning and implementation of OVC services	USAID Peace Corps	(Track 1) (see Peace Corps listing below)
[redacted] World Vision New partner? Yes FBO? WV	Provide full-time PCV TA to local partner institutions to improve their capacity for planning and implementing OVC services	• Conduct participatory needs assessments • Provide on-the-job technical assistance in organizational and project management	Peace Corps	(S/GAC under Track 2) [redacted] (includes TA for WR, SCF/US, and OI/HFH listed above
Total partners:	8	New partners:	5	FBOs:	4	Total budget	Track 1.5 [redacted] Track 2 [redacted] FY04 Total [redacted]

Table 4.10	Anti-Retroviral Therapy (non-PMTCT plus)
4.10.1 Current status of program in country	The introduction of ART is still very new to Mozambique, and only about 2,000 patients are now enrolled. ART is provided at all 7 existing HIV/AIDS Integrated Network sites, supported by 4 international NGOs (HAI, MSF Luxemburg, MSF Switzerland, and Sant'Egidio). To date 100 physicians have received ART training (90 by senior clinicians at Maputo Central Hospital, 10 in South Africa). National treatment protocols are in place. The MOH Strategic Plan for HIV/AIDS/STI foresees expansion to 17 sites and provision of ART to 7,924 PLWHA for 2004. A major constraint to scale-up is the lack of full-time staff to coordinate/oversee ART programs and activities; up to now senior clinicians from Maputo Central Hospital serve this role in addition to their other clinical duties.
4.10.2 How new activities will contribute to PEPFAR targets; linkages to other activities	Activities described below will both: (i) directly support expansion of ART to a total of 9 Integrated HIV/AIDS Network sites and provision of ART to a total of 8,000 clients by end-March 2005; and (ii) strengthen MOH capacity to manage further expansion of quality ART through improved coordination at central level and training for additional medical officers and technicians who will be involved in ART provision. The MOH central level ART Coordinator will also be key for improving the coordination of multiple initiatives supporting scale-up, such as Ireland, Norway, and Canada (through the Clinton Foundation Initiative), the World Bank Treatment Acceleration Program (TAP), and the Global Fund. The establishment of ART support for USG local staff will position the USG as a model employer in Mozambique and prevent the loss of valuable trained employees.

4.10.3 Existing activities, initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1.1, 1.5, 2)

MOH (CoAg Suppl. 04) FBO? No	Improve MOH capacity to coordinate, supervise, and implement HIV treatment and care activities and train 60 health care providers by end-2004	• Hire an ART & OI Coordinator (Physician) to provide leadership and supervision of HIV-related care and treatment • Purchase office equipment and supplies for ART & OI Coordinator • Conduct training for 60 health professionals (physicians and/or medical technicians) • Conduct supervisory visits to staff after training	HHS/ CDC		S/GAC	1.5
John Snow Inc. FBO? No	Improve MOH capacity to manage procurement and distribution of medicines and medical supplies	• Install commodity management software developed under prior USAID funding • Train 1,500 MOH staff at central and provincial level in use of new commodity management system by June 2005	USAID		S/GAC	1.5

4.10.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
MOH/CDC New partner? No FBO? No	Disseminate IEC messages to inform about and encourage compliance to ART to at least 50,000 people by end-FY04	• Reproduce and distribute 50,000 leaflets ("Basic ABC of ART") using trained HBC volunteers and health workers	HHS/CDC	(S/GAC under Track 2)

Mailman School of Public Health, Columbia University (New partner? Yes FBO: Yes, partners include Sant'Egidio Foundation at three sites)	Begin ART services at 9 Integrated HIV/AIDS Network sites, in coordination with sites selected for PMTCT+ and Laboratory support; and provide ART to 8,000 new patients by end-Mar 2005	• Develop implementation plan for 9 ART sites: Mavalane (Maputo City), Xai-Xai (Gaza Province), Inhambane (Inhambane), Chimoio (Manica), Beira (Sofala), Quelimane (Zambezia), Mocuba (Zambezia), Nampula (Nampula) and Pemba (Cabo Delgado); these 9 include 7 new ART sites and 2 of the existing 7 ART sites - to increase number of patients treated with USG support • Revise protocols and training materials to ensure they reflect MOH guidelines • Renovate clinical areas of USG ART sites • Train health care personnel of 7 new ART sites and conduct refresher courses for personnel from 2 existing sites	HHS/CDC	(Track 1)
TBD (through RFP in Aug 2004) New partner? Yes FBO? No	Improve MOH capacity to manage procurement and distribution of medicines and medical supplies to support treatment and care scale-up	• Provide TA, training, and related support to unify MOH commodity procurement, management, warehouse, and distribution systems • Extend improved commodity management beyond provincial warehouses to district and facility level *Note: This provides partial funding for essential health system support which is primarily funded by non-PEPFAR funding.*	USAID	(S/GAC under Track 2)

TBD New partner? Yes FBO? TBD	Develop Brazil linkages to increase availability of medical skills for HIV/AIDS treatment and care	• Support travel for potential Brazil partner organizations to Mozambique to jointly develop with MOH a plan for Brazil support to increase human resources for HIV/AIDS	USAID	(S/GAC under Track 2)
TBD New partner? Yes FBO? No	Establish program for care and lifetime ART for HIV+ U.S. Mission employees and dependents, to protect workforce and serve as a model for other employers	• Survey other U.S. Embassy ART programs for lessons learned and best practices • Establish Mission policy for implementing ART as part of broader HIV/AIDS prevention, care, treatment program • Continue to encourage employees and dependents to determine HIV status and seek care and treatment • *Provide start-up costs for private provision* of ART for local staff and dependents	State	(S/GAC under Track 2)

Total partners:	6	New partners:	3	FBOs:	1	Total budget: Track 1.5 Track 2 Total FY04

Table 4.1.1	PMTCT-Plus (access to care and treatment by women and families through PMTCT)
4.1.1.1 Current status of program in country	By end-2003, PMTCT services existed in 14 sites, and PMTCT+ was available at 2 pilot sites with about 25 women receiving multi-drug ART. Of the 35,858 women targeted for PMTCT in the MOH National HIV/AIDS/STI Strategic Plan, 1,963 are to receive multi-drug ART in 2004. In Mozambique's HIV/AIDS Integrated Network model, HIV+ pregnant women will be referred from PMTCT to the Day Hospitals where ART will be available (MOH plans expansion to 17 sites planned by end-2004); multi-drug ART will therefore not be provided directly within the PMTCT services, but at the Day Hospitals.
4.1.1.2 How new activities will contribute to PEPFAR targets; linkages to other activities	Activities described below will increase the number of HIV+ persons receiving effective combination ART as well as care and support. All PMTCT+ services will be part of the Integrated HIV/AIDS Network model's comprehensive services which include PMTCT, Laboratory, ART, OI, and other HIV/AIDS-related services. PMTCT+ services are coordinated through the national PMTCT program within MOH, the PMTCT Task Force, and general MOH and multi-sectoral HIV/AIDS coordination mechanisms and forums; the USG will continue to participate in and provide support to these. USG funding will specifically support establishment of 2 PMTCT+ reference and training centers by end-2004, which by end-Mar 2005 will enroll at least 50 HIV+ women for multi-drug ART. These centers will provide training to health workers and function as models where PMTCT+ service providers learn about PMTCT+ best practices and quality service provision. USG activities that increase PMTCT and PMTCT+ service delivery, scale-up, management, and supervision also are included in Table 4.1.

4.1.1.3 Existing activities initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAG)	Track (1.1, 1.5, 2)

MOH (CoAg 03) (FBO? No)	Identify sites for 2 PMTCT-Plus reference and *training centers* by end-April 2004	• Conduct visits to select priority sites for the establishment of two PMTCT-Plus centers	HHS/ CDC			FY 03	
CDC (FBO? No)	Identify sites for 2 PMTCT-Plus reference and training centers by end-April 2004	• *Provide TA to MOH for the* assessment, selection and set-up of two PMTCT reference centers	HHS/ CDC			FY04 PMTCT	2
Mailman School of Public Health, Columbia University (FBO? No)	Establish 2 PMTCT-Plus reference and training centers by end of 2004	• Rehabilitate and equip selected reference centers • Train PMTCT staff and facilitators for PMTCT Plus service provision • *Provide PMTCT-Plus services at* the new sites	HHS/ CDC			FY04 PMTCT	1.5

4.1.1.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
MOH / CDC (New partner? No FBO? No)	Increase provincial-level capacity to provide care and treatment for HIV+ infants, by end-March 2005	• Facilitate one-day workshop for PMTCT supervisor and service providers from 11 provinces to introduce the HIV pediatric algorithm	HHS/CDC	(FY04 PMTCT under Track 2)

Total partners:	New partners:	FBOs:	Total budget:	Track 1.5	Track 2	Total FY04
2	0	0				

Table 4.1.2	Strategic Information: Surveillance, Monitoring, Program Evaluation
4.1.2.1 Current status of program in country	The USG and its partners in Mozambique, including MoH and NAC, have committed substantial resources to develop systems for the collection, analysis, and reporting of HIV/AIDS data for program planning, resource allocation, and advocacy. Surveillance and Population Surveys: High-quality sentinel surveillance data were last collected in 2002. These data are analyzed by a multi-sectoral technical working group (with guidance and technical support from USAID's POLICY Project) to produce national and provincial estimates and projections of HIV+ individuals. A DHS was conducted in 2003, increasing behavioral data on sexual practices and health care seeking beyond that collected in a 2001 national youth behavioral survey. Small surveys supported by MOH, NGOs, and universities describing HIV/AIDS sero-prevalence and behaviors among high risk groups have been sporadic and of varying quality. Birth registries are available but death registration occurs for a very small fraction of Mozambicans. Health Management Information System: Existing health information systems for HIV/AIDS were not designed in an integrated fashion. AIDS case reports are available in the MOH Department of Epidemiology; however, these are significantly underreported. Program-level management information systems function in only some program areas; software-based data systems are available at 95% of VCT clinics nationally, distribution of a PMTCT application is planned in 2004, and HBC programs and health facility morbidity and mortality tracking are just beginning. Program Level Monitoring and Reporting, Including Targeted Evaluations: Under leadership of NAC, multi-sectoral government, NGO, and donor participants in an M&E working group have identified program-level indicators for the national HIV/AIDS response. The group has finalized and approved MOH indicators for HIV/AIDS/STI and is advanced in developing indicators across other sectors. MMCAS will develop their database and M&E system for OVC during 2004. Strategic Information and Human Resource Capability: The MOH HIV/AIDS/STI Strategic Plan 2004-2008 was disseminated in late 2003 and MOH staff are assisting NAC to complete an overall strategic plan for the multi-sectoral national response. This will include national indicators (both health and non-health) and incorporate MOH indicators. The MOH operational plan for 2004 includes set-up of an M&E unit in the Department of Epidemiology.

4.1.2.2 How new activities will contribute to PEPFAR targets; linkages to other activities	Strategies for systematically addressing gaps in the existing information about HIV/AIDS and the impact of the national response are of paramount importance in Mozambique, especially given the emphasis on monitoring and results by funding partners including USG. Activities described below will assess existing M&E practices to identify gaps and needs for system strengthening at all levels: data collection forms and tools (in particular an individual patient tracking system), information flow, data analysis, IT systems, training and capacity building, and equipment. USG support will strengthen the national M&E systems that are essential to provide reliable and adequate data to measure the progress of the national response and PEPFAR achievements.

4.1.2.3 Existing activities initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1, 1.5, 2)
MOH (CoAg 03) FBO? No	Finalize HIV/AIDS/ STI Strategic Plan by end of 2003	• Review and finalize planned goals/objectives/strategies for each HIV program component • *Conduct workshop with* participation from all provinces • Contract to organize workshop and help finalize the plan	HHS/ CDC		FY03	
MOH (CoAg 03) FBO? No	Establish functioning national M&E and IT Units within MOH by end-June 2004	• Recruit M&E staff • Recruit IT staff • Purchase computer equipment and furniture for new personnel	HHS/ CDC		FY03	

MOH (CoAg 03) FBO? No	Develop operational plans for 2004 by end of December 2003, and support provinces to implement M&E activities following strategic and operational plans	• Travel to selected provinces to disseminate and discuss plans, indicators, Integrated Network components and to assess adequacy of current tools and data collection systems • Design data collection forms for each Integrated Network component; prepare a plan to integrate indicators for Integrated Network components into MOH Health Information System • Provide TA to provinces to develop their M&E systems • Conduct annual Integrated *Network coordination conference*	HHS/ CDC		FY03	

Mailman School of Public Health, Columbia University FBO? No John Snow Inc. FBO? No	Support MOH to design and develop IT system for monitoring HIV/AIDS/STI activities, by end-FY04	• Provide TA for design, development, set-up of a patient tracking system • Integrate system with other program MOH MIS including PMTCT and VCT • Provide TA to MOH to design information systems (such as for patient tracking) to ensure USG data needs for reporting are met • Provide guidance on future needs for USG efforts in informatics and information systems	HHS/ CDC		Base 04 S/GAC	1.5 2
Mailman School of Public Health, Columbia University FBO? No	Begin assessment of treatment impact on morbidity and mortality, by end-March 2005	• Identify populations receiving ARVs and possibly other populations currently being followed (e.g. HIV+ but not yet on ARVs) in target areas • Collect/analyze HIV/AIDS-related morbidity and mortality data • Share results to assess impact and aid program evaluation	HHS/ CDC		Base 04	1.5
MOH (CoAg 03) FBO? No	Complete and disseminate 2002 surveillance results before end of 2003	• Produce and disseminate 2002 surveillance report	HHS/ CDC		FY03	

MOH (CoAg 03) FBO? No	Prepare 2004 surveillance through sentinel site staff training	• Conduct 3 regional training courses for staff from 36 ANC sentinel surveillance sites (4 staff per site)	HHS/ CDC			FY03	
MOH/CDC FBO? No	Conduct 2004 HIV sentinel surveillance; analyze and report results by end-March 2005	• Purchase laboratory reagents and materials required for surveillance • Provide TA for analysis of findings and production of report	HHS/ CDC			Base 04	2
POLICY Project - The Futures Group FBO? No	Ensure multi-sectoral participation in plans for 2004 sentinel surveillance; build consensus and improve use of sentinel surveillance data and projections	• Provide TA and training for multi-sectoral technical groups at national level and in 3 provinces • Provide TA for development of additional M&E tools for the multi-sectoral national response	USAID			Base 04	2

4.12.4 Proposed new activities in FY04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
TBD New partner? TBD FBO? No	Increase capacity of MOH to electronically compile, manage, analyze HIV/AIDS/STI data	• Procure maintenance contract for existing MOH computer equipment and provide technical oversight • Ensure quality of power source upgrade *Note: This builds on support provided from FY03 funding (described in 4.12.3 above) which included computer purchase*	HHS/CDC	(S/GAC under Track 2)

TBD New partner? TBD FBO? No	Assess existing M&E practices related to national response to HIV/AIDS, by end-FY04	• Assess MOH, NAC, MMCAS M&E systems, roles, practices, and performance; identify gaps and needs for training at central, provincial, district level; define strategies to contract, retain, train staff to respond to M&E requirements for national response	HHS/CDC	(S/GAC under Track 2)
TBD New Partner? TBD FBO? No	Respond to most urgent MOH M&E training needs for Integrated Networks by end-FY04	• Conduct training in MOH sites with most urgent needs	HHS/CDC	(S/GAC under Track 2)
TBD New partner? TBD FBO? No	Strengthen capability of NAC to lead and oversee M&E of national response, including coordination with and technical support to MMCAS other GRM agencies	Based on CDC-led assessment described above: • Provide TA and training to improve M&E capacity of NAC, MMCAS, or other agencies • Assist responsible agencies to conduct targeted evaluations of hot issues	USAID	(S/GAC under Track 2)
TBD New partner? TBD FBO? TBD	Complete assessment of high-risk/high-transmitter populations as basis for improved BCC for prevention of new infections and promotion of HIV/AIDS services	Provide TA and training and work with NAC, MOH, and NGOs to: • Critically analyze existing data on high-risk groups and behaviors • Map findings across transport corridors, urban areas, migration patterns, to identify "hotspots" • Conduct key informant interviews *Note: This activity will build on a CDC-sponsored workshop in behavior surveillance of high-risk groups planned for late 2004*	USAID	(Base under Track 2)

Total partners	New partners	FBOs	Total budget	Track 1.5	Track 2	Total FY04
4	0	0				

Table 4.13	Cross-Cutting Activities
4.13.1 Current status of program in country	U.S. Mission Employees HIV/AIDS Program: U.S. Mission conducts an active HIV/AIDS awareness program with frequent events involving all staff. However, the current FSN health plan does not provide sufficient funding or confidentiality for local employees needing ART. This is addressed in 4.10.4 above. National AIDS Council: Created in 2000 with a multi-sectoral mandate to lead and coordinate the national response, NAC is struggling to meet the expectations of multiple constituencies (government, civil society, donors, and the international community). Past USAID assistance helped NAC establish sound financial and administrative management systems, created a national database of actors and activities in the national response, and provided equipment. Other key NAC donors include Ireland, DFID, Canada, and Sweden, all contributing to a "common fund" for HIV/AIDS response that is managed by NAC; UNDP (and other U.N. agencies), providing technical and staffing assistance; and World Bank (MAP), providing staffing assistance and resources channeled by NAC to government and civil society. NAC also is one of the designated Principal Recipients for Mozambique's Global Fund (along with MOH). Major challenges include attracting, training, and retaining competent staff at central and provincial levels; establishing productive coordination relationships with other government agencies as well as civil society at central and local levels; improving efficiency of fund flows to implementing partners; acquiring additional technical capability to provide leadership for the national response; and adequately monitoring and disseminating knowledge gained to improve HIV/AIDS policies and programs of both government and civil society. Peace Corps: 71 current PCVs work as biology and English teachers and teacher trainers in 42 sites in 7 provinces. All PCVs integrate HIV/AIDS into their lessons. In 2003 over half of the PCVs invited HIV/AIDS specialists and/or PLWHA as guest speakers to their schools. PCVs also are involved in HIV/AIDS initiatives outside the classroom, working with after-school youth groups, out-of-school youth, and local communities on activities such as dramas, debates, community events, and competitions. PCVs coordinate with and mobilize technical assistance from NGOs working in their areas (e.g. PSI, FDC, and Vida Positiva) in these efforts.

4.1.3.2 How new activities will contribute to PEPFAR targets; linkages to other activities	Activities described below will help prevent new infections, promote uptake of new HIV/AIDS care and treatment services, reduce stigma and discrimination, and strengthen Mozambican systems and institutional and social capacity to meet the challenges of a true national response to HIV/AIDS. USAID and State are working together with a local partner to enhance the capacity of private business to provide workplace prevention, treatment, and care services and support for employees and their families. Peace Corps is launching a new 2004 initiative bringing 15 PCVs to work with HIV/AIDS NGOs in Maputo, Gaza, and Inhambane provinces. As shown in 4.5.4 and 4.9.4 above, these PCVs will work as organizational development advisors to build capacity of CBOs and FBOs to engage in HIV/AIDS prevention and response; and also as community health promoters providing non-medical training and technical assistance in conjunction with local health facilities. These efforts contribute to the PEPFAR goals of preventing new infections and providing care for HIV-affected individuals and families. Support to strengthen the capability of NAC to serve its leadership and coordination roles will enhance the national response to HIV/AIDS, improve flow of donor and government funds provided for the national response, and reduce the risk of ineffective programming. Analysis and planning urgently need to start now in order to identify and train the large number of medical and paramedical personal at all levels that will be necessary to scale up clinical care and ART services as envisioned.

4.1.3.3 Existing activities, initiated prior to FY 04

Partner	FY 04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1, 1.5, 2)

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Ernst and Young FBO? No	Complete technical assistance and training for sound administrative and financial management systems for National AIDS Council	Provide TA and training to: • Develop/implement systems and procedures at central/provincial levels for financial, personnel, asset management and for information and IT support • Develop, test, train, supervise use of new procedures manuals • Advise/assist in staff recruitment • Provide on-site supervision, retraining, internal audit services for financial system • Manage "operations room" and database of actors and resources contributing to national response	USAID	for FY04)	FY03 CSH-HIV (and prior years)	

4.1.3.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget

MOH/NAC New partner? No FBO? No	Conduct national workshop with multi-sectoral participation and produce list of key IEC/BCC messages regarding HIV/AIDS prevention, reducing stigma and discrimination of PLWHA, and promoting HIV/AIDS services, by end-FY04*	• Compile, analyze, summarize information from KAB surveys, DHS, other studies to provide evidence base for workshop • Conduct workshop with key partners (including FBOs) in IEC/BCC to formulate messages for prevention, stigma reduction, and HIV/AIDS services promotion • Provide TA to prepare, organize, conduct workshop and to produce workshop report of key messages, best approaches and lessons learned, and recommendations *Note: Additional USAID support to NAC described below will build on this workshop*	HHS/CDC	(S/GAC under Track 2)
MOH/NAC New partner? No FBO? No	Assist MOH/NAC to create links with and learn from successful or model regional HIV/AIDS IEC/BCC programs by end-FY04	• Conduct a joint MOH/NAC visit to the Soul City Communication Initiative Program in South Africa	HHS/CDC	(S/GAC under Track 2)

[redacted] and others TBD New partner? No FBO? No	Produce plan for USG support to develop capacity of Mozambican institutions to increase quality and quantity of human resources directly necessary for scale-up of prevention, care, and treatment activities, by end-FY04	• Conduct an assessment to: •Verify number of human resources needed in the health sector for scale-up •Assess needs of MOH in-service training program to increase quality, planning, standardization of training activities •Assess needs of pre-service training institutions to increase quality and quantity of trained graduates • Conduct pilot activities for eventual tele-medicine tools for human capacity building, especially for strengthening networks supporting patient care	HHS/CDC	(S/GAC under Track 2) [redacted]
[redacted] New partner? Yes FBO? No	Increase number of businesses implementing sound HIV/AIDS prevention, care, and treatment policies and programs	• Provide TA and training to develop approaches and assistance to help small and medium businesses address HIV/AIDS prevention, care, and treatment for employees and their families • Identify and work with companies to pilot and then replicate successful approaches • Mobilize financial resources to help targeted companies implement, and provide TA to guide and monitor *Note: 3-year target is 120 companies implementing established plans, reaching 8,000 employees and 24,000 family members*	USAID (with State)	(Base under Track 2) [redacted]

New partner? Yes FBO? Yes	Assist UCM to improve training and practical experience of medical school students in HIV/AIDS treatment and care services	• Provide scholarship incentives to draw medical students to HIV/AIDS treatment and care both during training and in career • Promote institutional linkages to develop HIV/AIDS medical technicians training program within the medical school to rapidly increase trained personnel for scale-up of national treatment and care	State	(S/GAC under Track 2)
TBD New partner? TBD FBO? TBD	Strengthen technical and program management capability of NAC provincial units	• Provide on-the-job technical assistance and training to 1 or 2 provincial units to improve capacity to coordinate and oversee provincial-level response to HIV/AIDS, especially for prevention and for community-based care and support	USAID	(Base under Track 2)

Total partners:	5	New partners:	2	FBOs:	1	Total budget:	Track 1.5 Track 2 Total FY04

Table 4.14	Laboratory Support
4.14.1 Current status of program in country	The national scale-up of provision of ART (to 17 sites in 2004) and improved OI management are dependent upon improvements to the existing laboratory network. The National Reference Laboratory for HIV testing is being rehabilitated. Its role is to provide nationwide HIV testing quality control and supervision for surveillance and VCT. In 2004 this role will be extended to cover CD4 and viral load testing as well. By January 2004, only 3 laboratories (at Maputo Central Hospital, Beira Provincial Hospital, and the Eduardo Mondlane University School of Medicine in Maputo) had the capacity to perform CD4 counts. Viral load tests are available only at the Maputo Central Hospital laboratory.
4.14.2 How new activities will contribute to PEPFAR targets, linkages to other activities	Expanded laboratory services are crucial for ART scale-up and adequate management and treatment of OIs, TB and STIs. The activities described below make a substantial contribution to reaching PEPFAR goals for Mozambique, both for ART and for providing adequate care to PLWHA. These activities aim to create the capacity to manage care and treatment for HIV+ by establishing a functional national reference laboratory exerting quality control for CD4 and viral load testing, upgrading 5 clinical laboratories, and providing additional support to 3 existing laboratories. Training of personnel addresses two priorities: (1) direct provision of clinical services at 8 laboratories, and (2) improved quality of training personnel to enable continued growth of the laboratory services essential for treatment expansion. USG support to the Maputo and Beira laboratories is provided through a collaboration between MOH and the Sant'Egidio Foundation.

4.14.3 Existing activities, initiated prior to FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget Amount ($)	Budget Source (Base, PMTCT, S/GAC)	Track (1, 1.5, 2)

MOH (CoAg 03) FBO? No	Establish, equip and staff a National HIV Reference Laboratory (NHRL) by end-FY04	• Hire NHRL staff • Furnish, computerize and stock lab office for new personnel • Train 2 NHRL staff in molecular biology techniques and in lab IT systems, respectively	HHS/ CDC			FY03	
MOH/CDC (CoAg 03) FBO? No	Set up a functional national level laboratory quality assurance program, by end-FY04	• Develop and disseminate HIV testing protocols and quality assurance manuals • Conduct supervisory visits to laboratories and HIV testing sites	HHS/ CDC			FY03	
CDC/Association of Public Health Laboratories (APHL)/ Foundation Oswaldo Cruz, FIOTEC Institute, Brazil FBO? No	Conduct National Laboratory Network assessment and formulate recommendations to support national scale-up of ART, by end-March 2004	• In collaboration with MOH, conduct lab network assessment • Produce report and disseminate findings to MOH and donors • Begin design of national lab capacity development plan • Identify sites and design plans for USG-supported laboratories	HHS/ CDC			S/GAC	1.5
MOH/CDC FBO? No	Support nationwide HIV testing in 2004	• Purchase and deliver 150,000 HIV rapid tests to VCT sites nationwide	HHS/ CDC			S/GAC	1.5

APHL FBO? Yes (Sant'Egidio Foundation for 2 of 5 sites)	Provide reagents/ supplies for 6,000 patients on ART and 19,500 patients in care at 6 sites by end-Mar 2005	• Provide lab reagents/supplies for 3 ART sites to support CD4 counts and basic hematology and biochemistry assessments • Provide lab reagents/supplies to increase CD4 counts at 3 existing labs supported by Sant'Egidio in Maputo and Beira	HHS/ CDC		S/GAC	1.5

4.14.4 Proposed new activities in FY 04

Partner	FY04 Objective	Activities for each objective	Agency	Budget
MOH/CDC New partner? No FBO? No	Complete a laboratory assessment of national capacity to respond to treatment and care of PLWHA by end-Aug 2004	• Assess lab needs to scale up ART and to *diagnose/treat opportunistic infections* including tuberculosis • Develop a 5-year plan for laboratory capacity building and service support for ART scale-up and lab services for PLWHA	HHS/CDC	(S/GAC under Track 2)

MOH/CDC New partner? No FBO? No	Assist MOH to expand and equip the National HIV Reference Laboratory (NHRL) to develop and implement nationwide quality assurance/quality control (QA/QC) functions for HIV testing and CD4 monitoring, by end-FY04	• Renovate/refurbish the recently identified additional space in the NHRL • Develop/initiate QA/QC activities for HIV testing and CD4 monitoring: develop serologic panels, distribute testing panels to all HIV testing sites • Purchase lab equipment/reagents to support supervisory, training and QA functions of the NHRL, including: general lab equipment (centrifuges, laminar flow hood, incubators, autoclaves, ovens), specialized equipment to support HIV serology (ELISA, WB, Thermocycler), and reagents for HIV Elisa and WB, P24 antigen and HIV PCR	HHS/CDC	(S/GAC under Track 2)

[redacted] New partner? No FBO? No	Assist MOH to develop in-service training plan for laboratory technicians, review and develop laboratory training materials, and train 40 technicians from 8 ART lab sites; and assist MOH National Institute of Health (NIH) to increase pool of highly qualified lab technicians for ART sites by improving pre-service training capacity by end-2004	• Assist MOH to develop training plan, including course contents, participants, facilitators, teaching materials, etc. • Develop and/or review, and reproduce training materials for at least 3 of the following key areas: HIV diagnosis; HIV laboratory for patient management (CD4, viral load): OI diagnosis, basic hematology and chemistry; bio-safety • Train 40 technicians from 8 ART lab sites in 2 sessions over 3 weeks in basic hematology and biochemistry assays and CD4 counts • Develop training and continuing education plan for lab trainers of MOH/NIH • Provide TA to lab trainers to review existing training curricula • Provide TA to assist MOH/NIH to design/ plan a higher/university-level lab training program to begin in 2005 • Recruit 1-year resident advisor to provide TA for laboratory support and scale-up	HHS/CDC	(S/GAC under Track 2) [redacted]
[redacted] New partner? No FBO? No	Provide in-country mentoring to support set-up and functional readiness of laboratories in 2 new ART sites by Oct 2004 and 3 additional new ART sites by Feb 2005	• Provide in-country mentoring by 2 experienced clinical laboratory specialists in Mavalane and Quelimane • Provide in-country mentoring by 2 experienced clinical laboratory specialists in Chimoio, Xai-Xai and Pemba	HHS/CDC	(S/GAC under Track 2) [redacted]

New partner? No FBO? No	Renovate laboratories at 2 ART treatment sites by Sep 2004 and 3 ART treatment sites by Dec 2004	• Renovate/equip labs at Mavalane Hospital (Maputo City) and Quelimane Provincial Hospital (Zambezia) ART treatment sites • Renovate/equip provincial hospital labs at Chimoio (Manica), Xai-Xai (Gaza), and Pemba (Cabo Delgado) ART sites	HHS/CDC	(S/GAC under Track 2)	
New partner? No FBO? Yes for 1 of 2 sites)	Provide laboratory reagents and supplies for services for 2,000 ART patients and 6,500 PLWHA in care at 2 sites by end-Mar 2005	• Provide lab reagents/supplies for 2 ART sites to support CD4 counts and basic hematology and biochemistry assessments • Contract in-country lab supply procurement/distribution supervisor	HHS/CDC	(S/GAC under Track 2)	
Total partners:	5	New partners: 0	FBOs: 1	Total budget:	Track 1.5 Track 2 Total FY04

UNCLASSIFIED

Table 5.1 U.S. Agency Management and Staffing - U.S. Agency for International Development (USAID)

5.1.1 U.S. Agency Management Items and Activities	Budget
Program design, implementation, management, monitoring, evaluation, reporting staff (costs include compensation, travel, equipment, logistic and administrative support, and ICASS charges for international personnel): a. USPSC Program Mgt and Reporting Officer, 100%, Aug 2004 - Mar 2005, [redacted] b. TAACS Continuum of Care Officer, 100%, Feb-Mar 2005 compensation + admin support, [redacted] c. FSN Clinic-to-Community Outreach Advisor, 100%, Oct 2004 - Mar 2005, [redacted] d. FSN PLWHA Psychosocial Support Specialist, 100%, Jul 2004 - Mar 2005, 100%, [redacted] e. USPSC OVC and Community Care Officer, 100%, Aug 2004 - Mar 2005, [redacted] f. FSN Implementation Specialist for Community Development, 100%, Jul 2004 - Mar 2005, [redacted] g. USPSC BCC and M&E Officer, 100%, Aug 2004 - Mar 2005, [redacted] h. FSN Communications and Risk Reduction Specialist, 100%, Sep 2004 - Mar 2005, [redacted] i. FSN Administrative Assistant, 100%, Oct 2004 - Mar 2005, [redacted] *Note: The total estimated cost for these staff from July 2004 through March 2005 is [redacted], but the difference of [redacted]s available from FY03 CSH-HIV funds already obligated by USAID Mozambique for HIV/AIDS program management support. Some of the FY04 costs for positions c, d, f, and j above are covered by prior-year HIV/AIDS funds already committed to these contracts, thus PEPFAR funding is requested for only a portion of the year. Two current local-hire PSC positions (one full-, one half-time, shown in parentheses in 4.1.2 below) end in Aug 2004. If b and h can be recruited locally rather than internationally, then the substantial savings on support costs will be shifted to additional program activities, not to additional staff. The lead role in PEPFAR reporting for the Mozambique Mission will be performed by b above.*	(Track 2) [redacted] (plus [redacted] from prior-year CSH-HIV)

Shared USAID Mission management costs for program operations support, incl. financial management and administrative management support, office rental and related costs, pro-rated shares of other technical and support services, strategy and design support, M&E and budget oversight, etc.:

a. Local-hire USPSC Maintenance Supervisor, 25%, Apr 2004 - Mar 2005,
b. FSN Handymen, 25%, Apr 2004 - Mar 2005,
c. Local-hire USPSC Mission Economist, 25%, Apr 2004 - Mar 2005,
d. Office space, 9%, Apr 2004 - Mar 2005,
e. Air charter contract for site visits and support, 15%, Apr 2004 - Mar 2005,
f. Summer interns and summer hires, 20%, May -Sep 2004,
g. Translation services, 20%, Apr 2004 - Mar 2005,
h. FSN Financial Analyst, 75%, Apr 2004 - Mar 2005,
i. Local-hire USPSC Project Development Officer, 40%, Apr 2004 - Mar 2005,
j. Local-hire USPSC Mission M&E Advisor and Evaluation Officer, 12%, Apr 2004 - Mar 2005,
k. Project design support, 25%, Apr 2004 - Mar 2005,
l. Mission communications strategy, 25%, Apr 2004 - Mar 2005,

Note: The total estimated FY04 cost for these items is [redacted] *but the difference of* [redacted] *is available from FY03 CSH-HIV funds already obligated by USAID Mozambique for these costs.*

(Track 2) [redacted]

(plus [redacted] prior-year CSH-HIV)

Total

(Base 04) [redacted]

(S/GAC)) [redacted]

(Total Track 2) [redacted]

5.1.2 U.S. Agency Management and Program Staff, Existing and New, By Category

	# Existing U.S. direct-hire	# New U.S. direct-hire for PEPFAR	# Existing FSN	# New FSN for PEPFAR	# Existing Interna-tional PSC	# New Interna-tional PSC for PEPFAR	# Other Existing staff	# Other New staff for PEPFAR	Total # Staff

Number of Program Staff	0	1	2	3	2	2	(1.5)	0	10
Number of Manage-ment Staff	0	0	0	1	0	0	0	1.02	2.02
Total Number of Staff	0	1	2	4	2	2	(1.5)	1.02	12.02

Table 5.2 U.S. Agency Management and Staffing – Department of Health and Human Services (HHS)

5.2.1 U.S. Agency Management Items and Activities	Budget	
	Adm/Mgt	Program
Personnel • Existing USDH: Country Director, Deputy Director, Senior Surveillance and IT Advisor • Existing FSN: Laboratory Technical Advisor, HBC Technical Advisor, VCT Technical Advisor, VCT Program Assistant, STI Program Assistant, Office Manager, Financial Analyst, Administrative Assistant, IT Assistant, Purchasing Assistant, 2 Voucher Examiners, Executive Secretary, 3 Secretaries, 3 Drivers • New FSN for PEPFAR: 2 Program Analysts, LAN Administrator • Existing International PSC: Senior PMTCT Technical Advisor, Senior M&E Technical Advisor, Senior Prevention Program Advisor, Senior Training Technical Advisor • New International PSC for PEPFAR: Senior Technical Advisor for Care and Treatment (to become USDH position in future)		
Travel		
Technical assistance, CDC Atlanta		
Transportation		
Communications and Rents		
Printing		
Contractual Services		
Supplies		
Equipment		
ICASS charges due to additional activities		
Total		

Total	Base 04 Track 1.5	Base 04 Track 2	S/GAC Track 2	Total FY04

5.2.2 U.S. Agency Management and Program Staff, Existing and New, By Category

	# Existing U.S. direct-hire	# New U.S. direct-hire for PEPFAR	# Existing FSN	# New FSN for PEPFAR	# Existing Interna-tional PSC	# New Interna-tional PSC for PEPFAR	# Other Existing staff	# Other New staff for PEPFAR	Total # Staff
Number of Program Staff	1	0	15	3	4	1	0	0	24
Number of Manage-ment Staff	2	0	4	0	0	0	0	0	6
Total Number of Staff	3	0	19	3	4	1	0	0	30

Note: TA needs have been identified and budgeted for under the respective program components, linked to specific interventions and activities where external assistance will be required (e.g. Laboratory, PMTCT, VCT, etc..

Table 5.3 U.S. Agency Management and Staffing - U.S, Department of Defense (DOD) (subject to further review and approval by the Office of the Secretary of Defense)

5.3.1 U.S. Agency Management Items and Activities	Budget
None	
Total	

5.3.2 U.S. Agency Management and Program Staff, Existing and New, By Category

FY 2009	# Existing U.S. direct-hire	# New U.S. direct-hire for PEPFAR	# Existing FSN	# New FSN for PEPFAR	# Existing International PSC	# New International PSC for PEPFAR	# Other Existing staff	# Other New staff for PEPFAR	Total # Staff
Number of Program Staff									
Number of Manage-ment Staff									
Total Number of Staff									

Table 5.4 U.S. Agency Management and Staffing - Department of State (DOS)

5.4.1 U.S. Agency Management Items and Activities	Budget
AEFM/EFM HIV/AIDS Assistant to the Ambassador (FP-7): Coordinates Ambassador's participation in and oversight of PEPFAR activities; prepares remarks and correspondence; [ ] compensation plus one-time [ ] for office furniture/equipment	[ ]
Total	(S/GAC under Track 2) [ ]

5.4.2 U.S. Agency Management and Program Staff: Existing and New, By Category

	# Existing U.S. direct-hire	# New U.S. direct-hire for PEPFAR	# Existing FSN	# New FSN for PEPFAR	# Existing International PSC	# New International PSC for PEPFAR	# Other Existing staff	# Other New staff for PEPFAR	Total # Staff
Number of Program Staff	0	0	0	0	0	0	0	1 (AEFM)	1
Number of Management Staff	0	0	0	0	0	0	0	0	0
Total Number of Staff	0	0	0	0	0	0	0	1	1

Table 5.5 U.S. Agency Management and Staffing – Peace Corps

5.5.1 U.S. Agency Management Items and Activities	Budget
Local-hire project assistant, July 2004 - March 2005	
Local-hire driver, July-March	
Two workstations - computers and furniture	
Total	(S/GAC under Track 2)

5.5.2 U.S. Agency Management and Program Staff, Existing and New, By Category

	# Existing U.S. direct-hire	# New U.S. direct-hire for PEPFAR	# Existing FSN	# New FSN for PEPFAR	# Existing International PSC	# New International PSC for PEPFAR	# Other Existing staff (Peace Corps Volunteers)	# Other New staff for PEPFAR (Peace Corps Volunteers	Total # Staff (incl Peace Corps Volunteers
Number of Program Staff	0	0	0	0	0	0	7***	15	22
Number of Management Staff	1.2*	0	2.5**	2	0	0	0	0	5.7
Total Number of Staff	1.2*	0	2.5**	2	0	0	7***	15	27.7

** One full-time and 10% each of two other positions; ** 10% of total 25 FSN staff; ***10% of 71 education volunteers who incorporate HIV/AIDS into English and biology lessons and work with after-school and community HIV/AIDS activities*

Table 6. Budget for the President's Emergency Plan for AIDS Relief

Program Area	FY04 USAID			FY04 HHS			FY04 DOD*		FY04 Other (State and Peace Corps	TOTAL
	Base Budget	PMTCT Budget**	S/GAC Request	Base Budget	PMTCT Budget	S/GAC Request	Base Budget	S/GAC Request	S/GAC Request	
PMTCT										
Abstinence / Faithfulness										
Blood Safety										
Safe Medical Injections										
Other Prevention										
VCT										
HIV clinical care (non-ART)										
Palliative Care										
OVC										
ART (non-PMTCT Plus)										
PMTCT Plus										
Strategic Info										
Cross Cutting Activities										
Lab Support										
Management & Staffing										
TOTAL										

* Subject to further review and approval by the Office of the Secretary of Defense

*** USAID PMTCT activities for FY04 were requested, approved, and awarded under Track 1.5, before mid-March guidance that FY04 PMTCT allocations could only be counted by HHS/CDC and only under Track 2. If these cannot be attributed to FY04 PMTCT, they should shift to the S/GAC column.*