REPUBLIC OF MOZAMBIQUE

COUNCIL OF MINISTERS

National Strategic HIV and AIDS Response Plan
2010 – 2014

«The National Strategic HIV / AIDS Response Plan, 2010-2014, is a Government document outlining policies and strategies for the combating of this epidemic, and which prioritizes the reinforcement of prevention, in all areas. In the same way, it seeks to emphasize action directed at the family, women, children, adolescents and the youth. It places equal emphasis on action against stigmatization and marginalization, so as to enable us all to wage this battle safely and confidently."

Extract of speech given by His Excellency, the President of the Republic Armando Emílio Guebuza, on 1 December 2009

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Abbreviations

AAAG	Anti-AIDS Activists Group
AIDS	Acquired Human Immunodeficiency Syndrome
AJA	Annual Joint Assessment
AMRE	African Medical and Research Foundation
ANC	Antenatal Consultation
APRAP	Action Plan for the Reduction of Absolute Poverty
ARRS	Assessment and Rapid Response Study
ARV	Anti-Retroviral Treatment
ASAP	AIDS Strategy and Action Plan
ATS	Health Counseling and Testing
BMI	Body Mass Index
BSS	Behavior Surveillance Survey
CBC	Communication for Behavior Change
CBOs	Community Based Organizations
CCR	Consultation of Child at Risk
CCT	Community based Counseling and Testing
CDC	Center for Disease Control
CHW	Community health worker
CIET	Community Information, Empowerment and Transparency
CNCS	*Conselho Nacional de Combate ao HIV e SIDA* - the National AIDS Council
CSBC	Communication for Social and Behavior Change
CSOs	Civil Society Organizations
CSP	Concurrent Sexual Partners
CT	Counseling and Testing
CVM	*Cruz Vermelha de Moçambique* - the Mozambican Red Cross
CVTC	Centre for Voluntary Testing and Counseling
DANIDA	Danish Agency for International Cooperation
DHS	Demographical and Health Survey
DNAM	*Direcção Nacional de Assistência Médica* - the National Directorate for Medical Assistance
DPS	*Direcção Provincial de Saúde* - the Provincial Health Directorate
DRH	*Direcção de Recursos Humanos* - the Human Resource Directorate
ECOSIDA	*Empresários Contra o SIDA* - Businesses Against AIDS
EP1	Primary School (Grade 1 to Grade 5)
FBOs	Faith Based Organizations
FDC	*Fundação para o Desenvolvimento da Comunidade* - the Foundation for Community Development
FHI	Family Health International
FM	*Fórum Mulher* - Women´s Forum
GAMET	Global AIDS M&E Team
GDP	Gross Domestic Product
GHAP	Global HIV & AIDS Program
GTZ	German Agency for Technical Cooperation
HBC	Home-Based Care
HDI	Human Development Index
HHs	Households
HIV	Human Immunodeficiency Virus

HPICT	Health Provider Initiated Counseling and Testing
HRH	Human Resources in Health
HU	Health Unit
IAAAD	Integrated Approach to Adolescents and Adult Diseases
IAID	Integrated Attention to Infant Diseases
ICS	*Instituto de Comunicação Social* - the Institute for Social Communication
IEC	Information, Education and Communication
IG	Insufficient Growth
INE	*Instituto Nacional de Estatística* - the National Statistics Institute
In-NFS	Nutrition and Food Insecurity
INS	*Instituto Nacional de Saúde* - the National Health Institute
INSIDA	*Inquérito Nacional de Vigilância, Comportamento e Informação* - the National Survey on Surveillance, Behavior and Information
ITP	Incubators and Technological Parks
JLICA	Joint Study Initiative on Children and HIV and AIDS
KAP	Knowledge, Attitudes and Practices
KAPB	Knowledge, Attitudes, Practices and Behavior,
KMMC	Knowledge and Multimedia Management Center
LB	Live Births
LBW	Low Birth Weight
M	Men
M&E	Monitoring & Evaluation
MATRAM	Movement for Access to Treatment in Mozambique
MC	Male Circumcision
MCH	Maputo Central Hospital
MCH	Maternal and Child Health
MCT	*Ministério da Ciência e Tecnologia* - the Ministry of Science and Technology
MDGs	Millennium Development Goals
MEC	*Ministério da Educação e Cultur*a - the Ministry of Education and Culture
MEGAS	*Medição de Gastos em SIDA* - AIDS Expenditure Assessment
MICS	*Inquérito de Indicadores Múltiplos de Grupos* - Research on Multiple Group Indicators
MINAG	*Ministério da Agricultura* - Ministry of Agriculture
MISAU	*Ministério da Saúde* - Ministry of Health
MJD	*Ministério da Juventude e Desportos* - Ministry of Youth and Sports
MMAS	*Ministério da Mulher e da Acção Social* - Ministry of Women and Social Action
MONASO	Mozambican Network of Organizations Against AIDS
MOT	Modes of Transmission
MP	Multiple Partners
MSM	Men that have sex with men
NASA	Assessment of Expenditure for the Combatting of AIDS, at National Level
NFS	Nutritional and Food Security
NFSS	Nutrition and Food Security Strategy
NGOs	Non Governmental Organizations
NHS	National Health System
OI	Opportunistic Infections
OMES	*Organização da Mulher Educadora do SIDA* - the Organization of Female AIDS Educators
OVCs	Orphans and Vulnerable Children
PEDD	*Planos Estratégicos de Desenvolvimento dos Distritos* - Strategic Plans for District Development

PEN I	*Plano Estratégico Nacional de Combate às DTS/HIV/SIDA 2000-2002* - National Strategic Plan for the Combating of STDs/HIV/AIDS 2000-2002
PENOVC	National Strategic Plan on Support for Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PESOD	*Planos Económico-Social e Orçamento Distrital* - District Socio-Economic Plans and Budget
PHC	Primary Health Care
PICT	Patient Initiated Counseling and Testing
PLWHA	People Living with HIV and AIDS
PLWHIV	People Living With HIV
PMTTSF	Technical Support Facility – Southern Africa
PNCITS/SIDA	*Programa Nacional de Controlo das Infecções de Transmissão Sexual e SIDA* – National Program for the Control of Sexually Transmitted Infections and AIDS
PNCT	*Programa Nacional de Controlo da Tuberculose* - National Program for Tuberculosis Control
PNDRHS	*Plano Nacional de Desenvolvimento dos Recursos Humanos da Saúde* - National Plan for the Development of Human Resources in Health
PNTL	*Programa Nacional de Luta contra a Tuberculose e a Lepra* - National Program for the Fight Against Tuberculosis and Leprosy
PP	Positive Prevention
PRC	Population Research Center
PROMETRA	Promotion of Traditional Medicines
PSI	Population Services International
PTC	Preventive Treatment with Cotrimoxazol
PTI	Preventive Treatment with Isoniazide
PVT	Prevention of Vertical Transmission
RENSIDA	National Network of Associations of People Living with HIV and AIDS
RVE	*Relatório de Vigilância Epidemiológica* - Report on Epidemiological Surveillance
SAAJ	*Serviços Amigos do Adolescente e Jovem* - Friends of Adolescents and Youth Services
SADC	Southern Africa Development Community
SAP	Strategy for the Acceleration of Prevention
SDSMAS	*Serviço Distrital de Saúde, Mulher e Acção Social* - District Services for Health, Women and Social Action
SETSAN	*Secretariado Técnico de Segurança Alimentar e Nutricional* - Technical Secretariat on Nutritional and Food Security
SSP	Sector Strategic Plan
SSR	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SW	Sex Workers
SWAP	Sector Wide Approach
TB	Tuberculosis
TMP	Traditional Medical Practitioners
TROCAIRE	Irish Charity Working for a Just World
UEM	University of Eduardo Mondlane
UNAIDS	United Nations AIDS Program
UNAIDS	United Nations Joint Program on HIV & AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population

UNGASS	Declaration of Commitment on HIV and AIDS at the Special Session of the Assembly of the United Nations on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
W	Women
WFP	World Food Program
WHO	World Health Organization

PEN III DRAFTING PROCESS

This National Strategic Plan was drafted in a participative manner, aimed at achieving the broadest possible consensus. The first step in this exercise was the drafting of Terms of Reference and a methodological approach, which the Executive Secretariat of the CNCS submitted to the CNCS Directorate for approval, in October 2008. With the endorsement of the Directorate, this was followed by consultations with national and international partners at various meetings, which culminated in the drafting of a document intended to orientate the process, entitled "***Concept Document for NSP III***". This document received comments from several sectors and organizational segments playing a role in AIDS-response actions in Mozambique.

So as to ensure the transparency and participative nature of the process, a steering committee was established, drawing together representatives from the public sector, civil society, the private sector, and bilateral and multilateral international partners, under the leadership of the Executive Secretariat of the CNCS. The committee was given technical and organizational responsibilities and had a permanent secretariat to document and drive the exercise.

The engaging of national consultants - whose responsibility was to collect documents and opinions on HIV/AIDS in the country, analyze these, and transform them into a strategic text - followed the establishment of the above-mentioned steering committee. This committee facilitated the interpretation of scenarios and expectations for the process, and acted as an intermediary in several consultations with thematic work groups[1] established at central and provincial levels, including meetings with the Multisectoral Group made up of HIV and AIDS focal points from different government bodies, representatives of civil society organizations, and the private sector.

In light of the results-based and evidence-sustained orientation which provides a methodological basis for this Strategic Plan, consultants and the members of the steering committee participated in training on the Results Based Approach. This training was facilitated by an accredited body providing technical assistance in the region – the Technical Support Facility.

The documenting and data collection processes, and the consideration of the contributions of various stakeholders, were driven in two ways: firstly, by responding to guidelines for questions previously prepared by consultants, which orientated the process of producing brief reports, especially at State-sector level. Secondly, by meeting with specific groups representing various interest groups and in particular civil society (which submitted its points of view by way of a manifesto) and the private sector.

In addition to weekly consultative meetings for the discussion of critical aspects of the PEN III drafting process, held by consultants and committee members, the first draft of the document received the consideration and technical and strategic guidance from the Vice-President of the CNCS, and Minister of Health. Consultations at the provincial level took place in two stages. The first, initial phase, was aimed at obtaining opinions on critical issues, priorities, challenges and criticisms of the national response.

[1] Monitoring and Evaluation, Research, Institutional Development, Gender, Prevention, Mitigation, Communication, Treatment and Care Groups, *inter alia*

The second phase, conducted after the preparation of a first draft, was intended for the critical analysis of the document, and for obtaining suggestions regarding issues deserving incorporation and prioritization, in light of the objectives guiding the development of a document intended to be strategic and applicable to all during the period of its validity.

The search for other opinions on technical and qualitative aspects of the document included the use of an internationally specialized service – ASAP[2], through contacts provided by UNAIDS and the World Bank, after ASAP editors had made their recommendations.

A more up-to-date version, incorporating the above-mentioned comments and discussions, was circulated for final comment after it had been reviewed by task groups, members of the committee, and the Executive Secretariat of the CNCS. Subsequently, the document was submitted, for consideration, to the Directorate of the CNCS, which, in an extraordinary session, recommended it for approval by the Council of Ministers of the Government of Mozambique, an act which took place in March 2010.

This document reflects a broad consensus, at several levels, on strategic approaches which will guide the response to HIV and AIDS in the 2010 to 2014 period. Its philosophy endorses a results-based approach, orientated by principles such as those of human rights, multisectoralism, systems strengthening, the economy of resources, and respect for socio-cultural dynamics which influence the behavior of Mozambican citizens.

During the session in which it was approved, the Council of Ministers of Mozambique instructed the National AIDS Council to dynamize the production of the operational plans through which to implement the main strategic thrusts of the document, through actions which can be put into effect in time and space, taking in consideration the national capacity for such purpose, available financial resources and the entire chain of interactions between actors, in the context of the synergies necessary for the successful carrying out of envisaged implementation plans.

[2] The Aids Strategy and Action Plan (ASAP), a specialized service for technical assistance with the development of strategic and operational plans, supported by partners, including UNAIDS and the World Bank

Executive Summary

Mozambique is currently experiencing a severe HIV epidemic. At present, 15% of pregnant women between 15 and 49 years of age live with the virus which causes AIDS. In geographical, socio-demographic and socio-economic terms, the epidemic is heterogeneous: women, residents of cities, and people living in the southern and central regions are those most affected by HIV and AIDS. The main transmission mode continues to be heterosexual in nearly 90% of adult cases. The main factors driving the epidemic are the following: multiple and concurrent sexual partners, low levels of condom use, a high level of mobility and migration, associated with increased vulnerability, the practice of sexual relations between individuals from different generations, transactional sex, gender inequality and sexual violence and low levels of male circumcision.

Since the year 2000, and with the intention of controlling the expansion of HIV, which threatens to undermine economic gains, Mozambique has been orientating its response on the basis of a nationally-applicable Strategic Plan. Two previous Strategic Plans (National Strategic Plan I - 2000-2002 and National Strategic Plan II – 2005-2009), the Strategic Plan for the Health Sector (National Strategic Health Plan 2004), the Strategy for the Acceleration of Prevention (2008), the National Strategy for Responding to HIV and AIDS in the Civil Service (2009) and the initiative, by the President of the Republic, on reflection for a multisectoral response to HIV and AIDS, which stresses the use of a contextually relevant approach to communication, have created guiding bases for the national response.

As a result of the implementation of these strategic directive platforms, there was a marked increase in prevention, advocacy, care, and treatment and mitigation activities from 2005 to 2009, including the implementation of communication initiatives which were more sensitive to contextual diversity, using multiple communication methods. Despite the efforts made, HIV and AIDS continue to have a devastating effect on all aspects of social and economic life, on a national and regional scale.

The main objective of this Strategic Plan is to contribute to the reduction of the number of new HIV infections in Mozambique, to promote the improvement of the quality of life of persons living with HIV and AIDS, and to reduce the impact of AIDS on national development efforts. So as to ensure the success of these interventions, the family is called upon to play a central role in all dimensions of the response.

The essence of the Plan is the reaffirmation of the guiding principles of respect for human rights, the multisectoral nature of the response, orientation according to proven results, the economy of resources, systems strengthening, respect for the socio-cultural context and the "mozambicanization" of the message, and the use of legally established mechanisms and structures, in the context of the decentralization of interventions.

These directive principles, which must guide the implementation of strategic action, are grouped into four main concepts, which, in addition to the generally applicable concepts of multisectoral response management and the strengthening of systems for the provision of services in various sectors, including communities, make up the PEN III. Communication for development plays a fundamental role

in all parts of this plan. The established strategic components, and the intended respective results, of PEN III are:

1. **Reduction of risk and vulnerability** — Implementation of collaborative actions for the reduction of risk and vulnerability results in an increase in the number of men and women, vulnerable to HIV and AIDS whose human and social rights are respected.

2. **Prevention** — Increased implementation of collaborative prevention actions results in a reduction in the incidence of new HIV infections in Mozambique by 25% in the next 5 years. As such, the prevalence of HIV in pregnant women aged 15-24, years will reduce, from 11.3% in 2007, to 8.5 % in 2014.

3. **Care and Treatment** — Increased implementation of collaborative care and treatment actions contributes to the relative reduction of death from AIDS by 5% in the next 5 years, in comparison with what would have happened without the additional interventions proposed in this plan. As such, in accordance with the projections of the *Spectrum* mathematical model, nearly 23000 deaths due to AIDS will be avoided in 2014.

4. **Mitigation of consequences** — Increased implementation of collaborative actions for the mitigation of the consequences of AIDS contributes to the reduction of the proportion of affected households, communities and OVCs affected by the impact of AIDS.

So as to ensure that the strategic actions defined in the four main components are implemented effectively, it is imperative to establish a solid foundation for management of the response and to focus on systems strengthening. From this perspective, the following supporting areas have been defined:

a) Multisectoral coordination – For effective coordination, the role of the CNCS as a leader and coordinator must be strengthened, by way of clarity of policy and organization at all levels of the response – national, provincial and district – which will allow a convergence of efforts in one direction, and under one command. The realignment of this body, so as for it to be dedicated exclusively to the coordination and facilitation of the current response, is an opportunity which will, on the one hand, permit the role it plays to unite the efforts of each involved party, and on the other, will help to provide the means, information, policies and human and technological resources, where these are necessary to make planned interventions viable.

While respecting and valuing the usual platforms for coordination and liaison with various partners - the principle of the Three Ones (One Coordinating body, One National Strategic Plan and One Monitoring and Evaluation Plan) - and various forums for interaction, the coordinating body must capitalize the search for realistic commitments from funding and implementing partners, both national and international, and establish platforms for accountability, for all parties involved in the response.

b) Monitoring and Evaluation – The PEN III follows a results-based management approach for the national response. Using this approach, the M&E system must guarantee that all established indicators

(for implementation, or for results and impact) are measured. This presupposes the obtaining of baselines, continuity of follow-up on progress, and the conducting of evaluations, in a complementary spirit, avoiding duplication. Routine information systems will need to be reinforced, so as to meet the growing demand for quality data. As such, a budgeted, multisectoral Monitoring and Evaluation Plan for the period 2010 - 2014 should accompany the PEN III.

c) Operational Research – Research constitutes an important component to inform the decision-making process and orientate planning and management based on evidence. Research is the best mechanism by which to search for solutions which are most appropriate for the epidemic profile (trends, groups, driving factors) and to revise, evaluate and improve the response to HIV and AIDS. The strategic focus for the research component will need to be centered on the revision, updating and implementation of the priorities of the national research agenda, drafted in 2008.

d) Communication - In the cross-cutting area of communication, the approach should be centered on the planning of communication programs which prioritize integrated approaches to communication actions, geared to the behavioral results intended to be achieved. The "mozambicanization" of messages, capitalizing on linguistic diversity, a culture of oral tradition, community, and inter-personal communication, combined with the use of the mass media, should be a priority.

e) Resource mobilization - Within the framework of this strategy, the achievement of universal access to sustainable HIV and AIDS services is imperative, and must be coupled with the development of fiscal resource planning scenarios for the medium and long term. This exercise is of great importance for the improvement of a process that is informed, and directed at resource mobilization, with the international community complementing the national efforts assumed by the government and the civil society, for the purpose of sustainability.

f) Systems strengthening – One of the key determinants for achieving objectives and targets is systems strengthening, which includes guaranteeing a supply of qualified and motivated personnel, the existence of infrastructure, and appropriate support mechanisms. Understood in its broadest sense, investment in systems strengthening must be made in all sectors and key institutions involved in the national response to HIV and AIDS, which interventions have a multiplying effect in terms of outreach and coverage of services. The strengthening of systems should be rooted in the expansion and improvement of physical health infrastructure at various levels, the recruitment, training, allocation and retention of qualified staff, in various sectors, the improvement of the logistical and distribution system for medicines and inputs (as appropriate in each sector), and a search for a more fluid approach to the funding of the system, which implies the mobilization of resources, and their allocation and distribution, at all levels of the response to the epidemic.

PEN III should be translated into budgeted operational plans, along with the respective plans for Monitoring and Evaluation. Key sectors, with clearly defined target groups, and with capacity to provide services with broad coverage, must receive more attention, most notably the sectors of health, education, youth and sports, women and social action, internal affairs, defense, labor, agriculture and justice. The civil service, in its capacity as the largest employer, must also develop an operational plan.

The CNCS (Executive Secretariat and its representatives) is also called upon to develop an operational plan for management of the response. Other sectors should integrate actions for the AIDS-response in their mandates. Civil society players, congregated into district, provincial and national coordinating platforms, are encouraged to develop broad and realistic operating and intervention plans, which recognize the challenges of sustainability. As soon as pledges are made, all national and international stakeholders must be held accountable to the Directive Council of the CNCS, irrespective of the source of funding.

I. Context

The Mozambican population is estimated to consist of around 20,226,296 inhabitants, of whom 52 % are women {1}. The majority (70.2 %) live in rural areas and have agriculture as their main source of subsistence. In accordance with the United Nations Development Program, the Human Development Index (HDI), measured in 2007, indicates that Mozambique is among the poorest countries in the world. More than a third of the population lives on less than a dollar a day. According to 2007 census data, life expectancy at birth is estimated to be 47,1 years for men and 51,8 years for women, with birth and mortality rates of 42.2 and 16 per 1,000 inhabitants, respectively, and an infant mortality rate of 118 per 1,000 LBs {2}.

The adult population (15-49 years) constitutes 29.4% of the total population, and there are nearly 3 million women of reproductive age, constituting 29.8% of the total female population. Adolescents and young people (10-24 years) constitute 19.4 % of the total population of the country.

The political stability and rapid economic growth from which Mozambique has benefited, has resulted in the reduction of the proportion of people living below the poverty line, from 69 to 54 per cent, from 1997 to 2003 {3}. Notable progress has also been made towards the achievement of the Millennium Development Goals, access to primary education being noteworthy[3]. In spite of the progress made, the low capacity of government institutions, the growing impact of HIV and AIDS and ongoing food insecurity constitute important challenges for the future.

HIV and AIDS constitute the most serious risk for the development of the country, threatening to reverse the gains achieved in the last few years, from the point of view of social and economic development. So as to address this situation, the Government of Mozambique has ratified various regional and international declarations and conventions which aim to reduce the number of new HIV infections and the impact of AIDS in the country. Of the global and regional instruments ratified by Mozambique, the Declaration of Commitment on HIV / AIDS by a Special Session of the United Nations General Assembly (UNGASS) (2001) and the Millennium Development Goals (2001), are noteworthy.

On a regional level the Government of Mozambique has signed, *inter alia*, 1) the Abuja Declaration (2001), through which African Heads of State declared HIV to be an emergency and committed themselves to working to rectify the situation. In 2003, 2) the Maseru Declaration affirmed a high level of political commitment regarding HIV and AIDS, as well as priority areas and urgent action needed, including the prevention of HIV. In 2005, 3) the Maputo Declaration, which underlines the need to accelerate the prevention of HIV, and adopted the Gaborone Declaration on Universal Access to Prevention, Treatment, Care and Support. It is also important to refer, in this list of documents, to the Declaration of the African Decade (1999-2009), a document which appeals for a more inclusive HIV and AIDS response approach, as a way of minimizing the negative effects of this pandemic on women and men, and in particular in individuals with sensory, motor and physical deficiencies.

[3] Net enrollment rate in the first 5 years of primary school (EP1) increased from 106,5 % (around 95,1 % for girls) in 2002, to 147,3 % (around 104,3% for girls) in 2008

International and regional commitments have been incorporated into the National Policies and Plans which are directly or indirectly connected to HIV and AIDS response, of which the following are noteworthy: the two previous Strategic HIV and AIDS Response Plans (PEN I 2000-2002 and PEN II – 2005-2009), the Strategic STI and HIV / AIDS Response Plan for the Health Sector (PEN Health, 2004), the National Plan for the Development of Human Resources for the Health Sector - 2008-2015; the National Plan of Action for Orphans and Vulnerable Children - 2006-2010, the Strategy for the Acceleration of Prevention (2008), the National HIV and AIDS Response Strategy for the Civil Service (2009), the National Gender Policy and its Implementation Strategy, in addition to the Sectoral HIV and AIDS Response Plans for the Sectors of Education and Culture (I 2002-2005 and the II 2006-2011), Agriculture (2007), Youth and Sports, Internal Affairs, and others.

The Presidential Initiative to Combat HIV and AIDS (2006), led by His Excellency the President of the Republic, Armando Emílio Guebuza, galvanized response efforts at the national level, through deep reflection on the social and economic impact of HIV and AIDS, and the mobilization and involvement of representatives from Mozambican society.

Equally notable is the involvement and contribution of civil society, and of the private sector, in combined AIDS epidemic response efforts, on all levels.

In spite of progress recorded in the expansion of prevention, treatment and mitigation services, additional efforts are necessary to improve the impact of the national response to HIV and AIDS. The current spread of the epidemic, mainly among women, and its ominous impact, points to a gap between formal intentions and the efficient implementation of HIV and AIDS response plans and strategies in practice, as a result of several factors, including aspects of functional coordination, the capacity of institutional structures, and the alignment of priorities with the main driving factors of the epidemic, with emphasis on gender inequality. It is in this context that the directives of this Strategic HIV and AIDS Response Plan (PEN III – 2010-2014) must be framed with the main focus being on a more systematic alignment of evidence gathered during the last few decades, with strategic actions to be implemented, in order to respond effectively to the challenges posed by the epidemic.

Epidemiological Profile of the Country

II.1. Epidemic Trends

In Mozambique, epidemiological surveillance research regarding pregnant women is still the only measure of the incidence of HIV[4]. In countries in which the main form of HIV transmission is through heterosexual means, as in Mozambique, HIV prevalence trends amongst users of Antenatal Consultations (ANC), between the ages of 15 and 24 years, can be used to estimate incidence trends, although they are not the same as absolute numbers of incidence {4, 5}[5].

The prevalence of HIV in ANC users between the ages of 15 and 24 reached a peak of 15.6 % in 2004, after figures were recorded which varied between 12.2 %, in the year 2000, and 13.1 %, in 2002. Data from the 2007 Epidemiological Surveillance Round reveals a decrease, to 11.3 % – see Figure 1. This demonstrates that at the national level, the incidence of HIV is decreasing, but that it still continues to be one of the highest in the world. Data from the same round (2007) relating to ANC users aged from 15 to 49, revealed a national prevalence of 16%.[6] Regional variation was 9% in the north, 18% in the center, and 21% in the south. Preliminary data from the 2009 Epidemiological Surveillance Round demonstrates that the national estimated prevalence of HIV in adults, is 15 %. Regional prevalence figures are the same as for 2007 {6}.

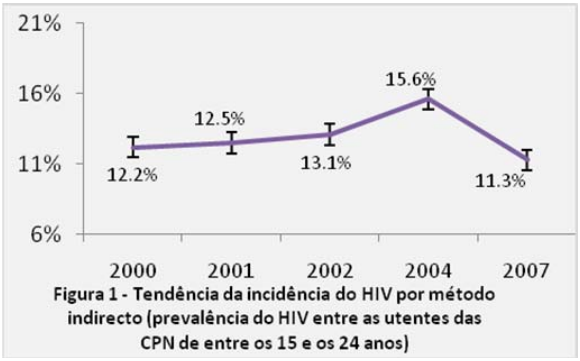


Figure 1 - HIV incidence trend, by the indirect method (HIV prevalence amongst ANC users of between 15 and 24 years of age) Source: {7}

The analysis of HIV prevalence data in ANC users between 15 and 24 years of age suggests a heterogeneous pattern of contraction and growth of the epidemic in the country {8}. The triangulation exercise for AIDS epidemic data {8} identified three geographical areas in which the prevalence of HIV has lessened or stabilized since 2002, or has remained low. The areas of presumably relatively low incidence were the northern region, and Tete and Manica Provinces, in the center of the country. In contrast, there were areas in which the prevalence of HIV amongst young users of ANC had increased over the years, or remained high. The areas of presumably high incidence were Maputo City, and the Province of Gaza, parts of Zambézia / the Beira Corridor, and other places, such as Quelimane, Pemba and Mabote {8, 9}. "*There are great regional variations in seroprevalence, in terms of the magnitude of the disease and trends over time, and unique behavioral, cultural and geographic characteristics which influence local epidemic trends.*" {8, page 13}.

[4] At the time of completion of NSP III, the analysis of data from AIDS Indicator Research - the NSSBI - which will provide more comprehensive information, was ongoing.

[5] Since the majority of adolescents and the youth may have become sexually active very recently, prevalence in this age group represents an occurrence of recent infections.

[6] Preliminary data from the 2009 epidemiological surveillance round reveals that the nationally estimated HIV prevalence in adults is 15%. As this is an estimate, In statistical terms, this rate may be between 14% and 17% - the plausible limits. For the southern region, the estimated rate is 21% (17% - 25%); for the central region, it is 18% (14%- 21%), and for the north, prevalence is relatively very low, at 9% (7% and 11%). {6}

II.2. Magnitude of the epidemic in the general population

The Demographic Impact of AIDS for 2008 {10} estimates that, in 2009, nearly 1.6 million people are living with HIV (55.5 % of which are women, and 9.2 % of which are children younger than 15 years), and that the number of seropositive pregnant women is 149,000. {9}. Each day, approximately 440 Mozambicans are infected with HIV. It is estimated that 96,000 deaths will take place due to AIDS in 2009, which corresponds to 22 % of all of the deaths in the country (33,000 men, 42,000 women above the age of 15, and 21,000 in children) {10}. Approximately 510,000 children younger than 18 years are orphaned each year due to AIDS, and 425,000 people above the age of 15,[7] and 48,000 children (younger than 15 years),[8] need ARV treatment. The implication of this increase contributes to the reduction of life expectancy at birth, and this in turn contributes to the reduction of the Human Development Index (HDI) {11}. According to UNDP reports, growing gains in the HDI (of 0.402, 0.414 and 0.428, in each of 2002, 2003 and 2004) have been lost since 2005 (HDI = 0.384), essentially at the expense of the heavy burden of AIDS {11}. Despite the absence of national evidence on the burden of HIV and AIDS for the elderly population, data from other African countries reveals a worrying picture, if we take into account the example of Kenya where, in 2007, HIV prevalence among the elderly (50-54 years) was 8% {12}.

II.3. Magnitude of the epidemic in certain segments of the population at high risk of exposure to HIV and AIDS

There are certain segments of the population which are at high risk of exposure to HIV, resulting from socio-economic, cultural or behavioral factors {13} - for example, sex workers, refugees, migrants, military personnel, prisoners, intravenous drug users, men who have sex with men, and women, particularly in communities where there is pronounced gender inequality. Prevalence data for high risk populations in the country is very limited. The Assessment and Rapid Response Study (ARRS) provided preliminary data on the prevalence of HIV in 2008 {14}. The prevalence of HIV was 48 % (N-63) in commercial sex workers of both sexes who used counseling and testing services, and 43 % (N-43) amongst drug-users who used counseling and testing services {14}. There is also some data on HIV prevalence amongst blood donors in military service (35 % in 1997; 33.3 % in 1998; 48.7 % in 1999) {15}, blood donors 15.3 % (1997-1999 {) 15} and prisoners (29 % in men and 32 % in women) {16}[9]. In spite of limitations in terms of samples, this information may suggest a greater magnitude of the epidemic in high risk populations. However, there is an urgent need to investigate and systematize more representative evidence, so as to confirm this weighting, and so as to define specific actions directed at these groups.

[7] Estimate based on the criteria of starting ARV treatment if CD4 <200 cells/mm3, for adults. If the new criterion were to be applied (CD4 < 250 cells /mm3), many more people would need treatment.

[8] Estimate based on 2006 WHO criteria. If new 2008 WHO recommendations were to be applied (all infected children <1 year of age eligible for ARVs), the number would be higher

[9] The next Behavior Surveillance Survey (BSS) will provide data on the HIV prevalence and behavior of female sex workers, long distance truck drivers, miners who have been working on South African mines for at least one year, and men who have sex with men (MSM)

II.4. Main sources of new infections

The heterosexual transmission of HIV is still responsible for the majority of new HIV infections in adults. The mathematical model for Estimates of HIV Incidence, used in 2008 {9, 10}, allowed the estimation of the relative weight of new infections in each exposure group.

The established models predict that individuals who say that they have had a single sexual partner in the last 12 months will contribute to between 42 and 47 % of new infections in Mozambique each year (2008). This result is partially owing to the fact that this group is very large (around 4.3 - 5.1 million people). New HIV infections appear in serodiscordant couples (in which one of the two is HIV-Positive, and the other HIV-Negative) and in the absence of condom use, when relationships are stable.

Multiple partner behavior relates to two exposure groups: those who have multiple partners, and their stable, monogamous, partners, who are inadvertently part of a sexual network. This multiple partner behavior is considered to be responsible for nearly 24-29% of all new infections {9}. New infections in sex workers (SWs) contribute to around 2% of the incidence of the total annual incidence, and new infections of the clients of SWs, to around 7%. The regular partners of clients of sex workers became part of the sexual network, and nearly 10% of all infections occurred in these regular partners, in 2008. This fact means that sex workers (SWs, their clients, and their partners) were responsible for 19% of new infections in 2008.

The contribution to new infections by men who have sex with men (MSM) constitutes 5% of the total incidence. The contribution to the incidence of HIV by intravenous drug-users was estimated to be 3%, but this estimate is uncertain due to limited data. Injection equipment may be responsible for 2% of the total annual incidence, and blood transfusions, in spite of a low incidence of less than (1%), contribute to this increase. {9, p. 11}. Mother to child transmission accounts for 2.2% of children under 5 years of age who are infected with HIV {10}.

II.5. Main factors driving the epidemic

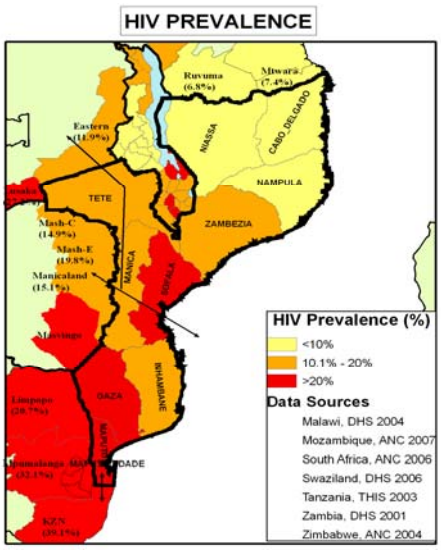
Several primary and secondary studies were undertaken, so as to try to understand the epidemiological pattern, and especially so as to identify factors associated with increased risk, of which the following are noteworthy: the Mozambican HIV data triangulation exercise {8}, which synthesizes data on epidemiological patterns at national and local level; the analysis of the coverage and intensity of preventive efforts, and the study on modes of transmission {9}, which analyzed the epidemic, and provided a policy response and synthesis, which led to recommendations regarding the improvement of the HIV prevention response. A combined analysis of sources indicates that the main factors driving the epidemic are associated with the following factors:

a) Concurrent sexual partners: In Mozambique, several studies and reports have been aimed at multiple, and sometimes concurrent, partners (having two or more sexual partners, simultaneously). The reported frequency of multiple partners (MP) varies from report to report, *depending on the time period used, but ranged from 2 to 26%, in the case of sexually active women, and from 17 to 55%, in the case of sexually active men*. According to the results of a study undertaken twice, at national level, on knowledge, attitudes and practices (KAP), it is suggested that the frequency of multiple partners in sexually active adults decreased from 32% in 2002 to 23% in 2007 (CIET study). PSI data from 1996,

2001 and 2004 supports this pattern of decrease, and suggests that the biggest reduction in CSPs took place amongst the unmarried, and amongst people living in the northern region of the country. Known extramarital relations, one form of having multiple partners, is more frequent in husbands with economic power and in the case of young women, with higher education, living in urban areas {9}.

b) Low incidence of condom use: *In spite of an increase in the availability of condoms over the years, their use is still too low to significantly reduce transmission*. The consistent use of condoms is higher in non-regular partners than in regular partners. Indicators of unprotected sexual acts are highest among young people. Self-assessment of the risk of HIV is weak, and the low perception of the risk is related to failure to use a condom. {9} The low level of female condom availability places women at a greater disadvantage in the search for protected sexual relations.

c) Mobility and migration: The highest prevalence of HIV in pregnant women was found in high mobility corridors, namely, Lichinga-Pemba, the Nacala Corridor, Quelimane-Milange, the Beira Corridor, Chokwe-Chicualacuala, Chokwe-Xai-Xai-Maputo and the Maputo Corridor. However, in general, the levels of HIV prevalence in the various regions of Mozambique reflect the levels of the epidemic in neighboring countries. Multiple partners, associated with long and short term migration, are an important driving factor. Structural factors contribute to weak commercial networks and capital systems. The commercial transport corridors in the region facilitate the spread of HIV {8**}.** Figure 2 – Trans-border influence on the geographical heterogeneity of the HIV epidemic in Mozambique



d) Sexual relations between people of different generations, and transactional relations: Both have a strong socio-economic and cultural base in Mozambique and in the southern region of Africa, and create risk contexts. Transactional sex means the transfer of money, presents or favors, for sex. The report entitled "Milking the Cow" {17} affirms that young people in the center of Maputo have transactional sex with lovers who are in most cases much older, and that the practice of commercial sex without the use of a condom is also common. According to the 2003 DHS {18}, 3.1% of young people between the ages of 15 and 19 years had extramarital sexual intercourse in the previous 12 months with a man 10 or more years older than them. In South Africa, studies have been done which demonstrate that the bigger the disparity in age, the less likely is the probability of safe sex {9}.

e) Low levels of male circumcision: In regard to cultural and religious habits and the practice of male circumcision, despite high levels of risky behavior, the prevalence of HIV in pregnant women remains lower in areas with a high rate of circumcision (See Figure 3) {8}. In three provinces in the northern region - Cabo Delgado, Nampula and Niassa - as well as in the province of Inhambane in the south of the country, according to the 2003 DHS {19}, the proportion of people who have undergone circumcision is greater than three in every four men, and in these four provinces, rates of seroprevalence are also lower. On the other hand, the provinces of Gaza, Manica, Sofala, Tete and Zambézia have low levels of circumcision (<50 %) and all have recorded high rates of HIV

seroprevalence. This observation corroborates international evidence supporting the claim that men who have undergone circumcision have a lower risk of contracting HIV than men who have not undergone circumcision {20-23}.

III. Analysis of the 2005 - 2009 National Response to HIV and AIDS

During the 2005-2009 five year period, Mozambique implemented the second National Strategic HIV and AIDS Response Plan (NSP II), with renewed emphasis on a multisectoral approach. Since 2005, the NSP II has been guiding the integration of HIV and AIDS into national instruments and management policies, demonstrating the commitment of the Government to adopting a comprehensive approach to the HIV and AIDS epidemic {3}. Although the NSP II has not been evaluated in its entirety, the partial evaluations carried out during the last two years point to the following summary of results:

III.1. Coordination of Response

Between 2005 and 2009, the Directive Council of the CNCS - the highest coordinating body for the multisectoral response to HIV and AIDS in Mozambique - was involved in the coordination and driving forward of HIV- and AIDS-response actions, and particularly in the direct coordination of task groups, such as the Prevention Reference Group, which produced tangible results, of which the launching of the Strategy for the Acceleration of Prevention is noteworthy.

In the course of implementing the PEN II, the coordinating body had the opportunity to collect information on experiences and challenges at various levels - district, provincial and central, adopting participative methods of interaction with civil society institutions, and strengthening private-public partnerships in response to HIV and AIDS at the workplace. The functioning of institutional mechanisms for coordination, whereby various actors have a forum through which to put forward their contributions, had greater leverage at the central level, demonstrating a need to boost action at the provincial and district levels. In addition, coordination still needs greater harmonization, and the capitalization of synergies, so as to respond in a more effective manner to the current pattern of the epidemic.

Of the main recorded challenges to coordination, the most noteworthy are: the need to intensify the connection and coordination between central, provincial and district levels, in the planning processes; the need to secure an effective integration of HIV- and AIDS-related activities, in institutional plans; the need to adopt mechanisms for the strengthening and establishment of sustainable interaction with local partners, especially those which can add value to the work carried out at provincial level; the demand for improved management and the sharing of information at all levels; improving the architecture and operationalization of financial management, improving budgetary forecast mechanisms, and appropriate funding for the strategic and operational HIV and AIDS response plans.

In general, during the PEN II period, limitations on the availability of human resources, aggravated by high personnel turnover, resulted in unequal performances by CNCS and its partners, with some notable achievements, but also with others which were unsatisfactory. Being aware of these challenges, CNCS and its partners developed a process, during 2009, for the functional analysis and realignment of the functions and responsibilities of this body, which should result in a framework for action which will

place greater emphasis on coordination, institutional development, communication and monitoring and evaluation {24}.

III.2. Prevention

The main prevention-related interventions were directed at the reduction of sexual transmission; the reduction of hospital-based transmission; counseling and testing; the promotion of initiatives targeted at young people and adolescents; increasing the level of HIV-related knowledge, and the reduction of mother to child transmission of HIV.

An assessment of the profile of HIV prevention programs implemented in the context of the PEN II is supplied in the report on means of transmission {9}. This report analyzed 3,282 implemented activities. As concerns areas of focus, it noted that only a third of the activities focused on communication for social change, and the change of risky behavior (CSBC) and that 22% of activities were directed at work places. Activities related to mobilization and prevention for young people in schools accounted for 11%, of which 9% of activities were aimed at young people who were out of school. Programs which included PLWHIV and special and vulnerable populations constituted nearly 6% and 5% of the volume of activities respectively. Counseling and testing activities (CT) accounted for around 2%. {9}.

Programs directed at young people emphasized initiatives in and out of schools, and implemented a multisectoral approach. Preventive action aimed at school-going youth essentially consisted of communication for behavior change, on the basis of IEC activities (86%, including peer education and training of activists), and the same thing was done for non-school-going young people (80 %) {9}. The prevention programs targeted at children and young people, which also implemented a multisectoral approach, with emphasis on interpersonal communication and peer education, were aimed at children and young people between 10 and 24 years; provided information on reproductive sexual health, in and out of schools, in 70% of the country's districts, and had reached 40% of young Mozambicans by 2008. Children and adolescents aged from 12 to 15 years were reached through sensitization initiatives aimed at prevention in EP1, in all provinces, through the programs implemented by the MEC and its partners.

In the context of PEN II, the implementation of the program for the prevention of vertical transmission (PVT), initiated in 2002, was continued. The program was marked by an expansion of services and a positive increase in access to its services. Around 950 pregnant women were reached in 2006, 3,647 in 2007, and 6,388 by December of 2008. From the time of commencement of the program, the number of health posts offering PMTCT services expanded quickly, from 8 health units in 2002, to 386 in 2006 and 744 in December of 2008. The implementation of new policy approaches and the integration of services facilitated the service expansion process, and the introduction of more effective therapeutic regimes contributed to the reduction of mother to newborn HIV transmission. In 2008, the national coverage of PMTCT during ANCs was 32% (46,848 pregnant women with HIV treated with ARV prophylaxis), with variations at regional level (65% in the south, 20% in the center, 20% in the north) {9}.

In spite of this progress, access to PMTCT services for pregnant women is still insufficient in Mozambique. Several factors contribute to this fact - in particular, limitations on human resources, both as regards quantity and quality, for the provision of services; more attention being focused on HIV

positive women, without interventions for seronegative and serodiscordant couples, with potential for improving prevention; the low level of involvement of men; high levels of stigmatization and discrimination, which limit the possibility of pregnant women using existing services for the treatment and prevention of vertical transmission; the loss of opportunities to follow up on exposed women and children, due to stigmatization and discrimination, combined with insufficient human resources to actively search for users who abandon the services, and a low level of involvement by families and communities.

At program level, efforts were made to re-size interventions in the area of the prevention. In 2008 a Strategy for Acceleration of Prevention of Infection by HIV was developed. {25}. This strategy appeared as a response to the need to control and reduce the incidence of HIV in the country, with greater urgency, and in a sustained manner, with emphasis on 8 priority action areas: STIs; condoms; high risk groups; early detection and treatment of STIs; PMTCT; access to treatment and biosafety; and male circumcision, in addition to generally applicable areas, with emphasis on communication, M&E and the coordination of the response.

While the component of prevention has constituted one of the principal pillars of the response to HIV and AIDS in Mozambique, its actions have not yet accomplished the predefined objectives. The fact that there are very few programs for the prevention of HIV which are evidence-based, or have a particular focus on specific and well-defined population groups; the occasional nature of, and the lack of an ongoing and institutionalized approach to, the implementation of prevention actions; very little emphasis being given to the main vulnerable / risk groups and to behavioral patterns which feed the epidemic; a reduced degree of family and community involvement, and above all, the low level of commitment on the part of leaders and influential individuals at the local level; the insufficient appropriation of educational community structures, including the family, which are most able to influence individual behavior; and limited human resources, associated with stigma and discrimination, which weaken the ATS strategy (2), all contribute to this scenario.

Limited progress in the area of prevention demonstrated the need for a strategic resizing of this component in the PEN III, on the basis of initiatives showing evidence of efficiency. Limitations experienced during the period of the PEN II demonstrated that preventive activities should: be directed at the main vulnerable/risk groups, and at behavioral norms which are feeding the epidemic; pay intense attention to young people and adolescents; focus on families, and cover more children and couples; strengthen community involvement; consider structural aspects responsible for the increase of the vulnerability of women and girls to HIV infection, and stimulate the participation of men in preventive activities and services, since they constitute key actors in the process of deciding when and where to seek health care.

III.3. Advocacy Action

2006 was notable for renewed political commitment to the multisectoral approach to HIV and AIDS. The Presidential HIV and AIDS Response Initiative, led by the President of the Republic during the first half of 2006, was a clear expression of political involvement at the highest level. In the context of this initiative, members of the government at central, provincial, district, and community levels, and representatives of civil society, and of religious and youth organizations, inter alia, were involved in the debate, and renewed their involvement in national efforts against AIDS.

This event gave rise to other advocacy initiatives, such as the Youth Conference on HIV; the CSO conference on HIV and AIDS; and the establishment of a high level Reference Group for HIV Prevention, led by the Minister of Health, who was responsible for coordinating and intensifying prevention efforts, on the basis of evidence. The establishment of task forces in the context of HIV and AIDS has also played an important role in advocacy and the technical direction of specific intervention areas.

As regards advocacy, the involvement of Provincial Governors, Administrators and local leaders in the HIV / AIDS response, through the consolidation and spread of strategic HIV and AIDS programs, and the inclusion of HIV- and AIDS-related aspects in strategic documents, should also be mentioned. These initiatives were secured by the sensitive distribution of integrated support materials with specific content on how to transmit information which could create awareness in communities, so as to bring about their involvement and proactive action. Mention must also be made of the training of 250 focus groups from the planning sectors, aimed at the inclusion of HIV and AIDS in normal cycles of sectoral planning, and the involvement of 150 companies in the preparation and implementation of policies on HIV and AIDS in the work place.

Civil society was also involved in advocacy activities, and contributed new initiatives and mechanisms for social mobilization, for example, the Movement for Access to Treatment in Mozambique (MATRAM), and there has been growing involvement of organizations in defense of women´s rights in the HIV response.

These advocacy initiatives, and the strengthening of the legal context, carried out in the context of the PEN II, include the ongoing dissemination of Law 5/2000 of 5 February, against discrimination against PLWHA in the work place; the approval of the Law on the defense of human rights, and the struggle against stigmatization and discrimination against people living with HIV and AIDS, in 2009.

III.4. Treatment

The main interventions in the area of treatment were directed at intensifying counseling and testing (CT), as a key means of access; the monitoring of the health status of HIV positive patients, and the provision of treatment for opportunistic infections, or of ARV treatment in eligible patients; the control of TB / HIV co-infection; psychosocial support, and the provision of home based care (HBC).

Counseling and testing is a basic component of the response to HIV/AIDS, since it is an entry point for care, treatment and psychosocial support, as well as for behavior change. Thanks to the new approach to Counseling and Testing in Health (CTH), which combines counseling and testing initiated by clinical providers (HPICT), CT initiated by the patient (PICT – via the CVTC) and that provided at the level of the community (CCT), the number of beneficiaries has increased significantly, by nearly 5 times, from

2003 to 2008. Recent information regarding the "proportion of women from 15 to 49 years of age that were counseled and tested at antenatal consultations" points to an increase of only 3% (DHS, 2003) {19}, to 45.7% (MICS, 2008) {2}. From routine data, it can be deduced that most of the users who are attended CTH are women (60 %), and that 23 % (80.554/344.906) of all those tested in 2008 were HIV-positive {26}.

The administration of ARVs is relatively new in Mozambique. Following the strategic turn embodied in the PEN II, 2003/2004 marked the start of the ARV treatment program in the public sector. From this time on, the country has recorded tremendous progress in the expansion of service provision {27}. This rapid expansion was also facilitated by a policy change adopted in the middle of 2006, when medical technicians were widely trained and authorized to administer ARV treatment, thus allowing for geographical expansion to all districts in the country in the 1st term of 2007 {28}. From 2003 to 2007, the number of Health Units providing ARVs increased remarkably, but from then on, the network recorded practically no expansion, with a variation from 211 in 2007 to 216 in 2009. The number of people benefiting from anti-retroviral treatment increased significantly, from less than 7,000, in 2004, to over 170,000, in 2009.

In spite of outstanding efforts to expand ARV services, the difference between accomplishment (that planned for the population) and coverage (the estimated population needing ARVs) was unsatisfactory. The proportion of eligible patients older than 15 years benefiting from ARVs rose from 2% in 2003 to only 32% in 2009, which means that around 2/3rds of eligible individuals still do not benefit from this service. Pediatric ARVs are an even more recent victory.

In 2006, the MISAU developed a detailed plan for the increase of pediatric treatment, including the development and updating of tools, such as a manual on the treatment of children with HIV and AIDS, and specific training modules on pediatric ARV treatment for clinical staff who are not doctors (medical technicians). This allowed for an increase in coverage for children below 15 years (from 5% in 2005 to 23% in 2009). As reported by the MISAU, the expansion of the number of locations administering ARVs was reduced, so as to maintain quality, due to logistical constraints linked to weak existing infrastructure, a scarcity of qualified personnel, a scattered population, difficulties of access and the consequent limitation of regular supervision of pre-ARV services and ARV treatment {28}.

Other progress achieved is linked to the increase of positive synergies and collaboration between TB and HIV programs, which contributed to the reduction of the proportion of HIV-infected individuals who develop TB. The National Program for TB Control (PNCT) recognizes the importance of expanding and integrating TB and HIV services, and progress in the implementation of these activities is being made. {29,30}. Data from AJA VIII, on the Health Sector, indicated that the improvement of this coordination permitted the maintenance of levels of HIV-testing in tuberculosis patients, and to improve the system of referring TB/HIV patients, for ARV treatment. In 2008, the prevalence of TB/HIV-positive co-infection shows a growing tendency, corresponding to 60.1%, in comparison with the 2007 year, in which there was a recorded prevalence of 47.3% {29}. The PNCT has been showing considerable growth in the implementation of collaborative TB/HIV activities. The TB program trained all of its personnel in voluntary counseling and testing (in 2008, 79% of TB patients were tested for HIV). Of these tested patients, 92% and 30% began Preventive Treatment with cotrimoxazol (PTC) and ARVs respectively. However, only 0.9% (3039) of PLWHA who were registered with the ARV treatment

program services were tested for TB, and only 676 began preventive treatment with isoniazide (PTI) {29, 31}.

Home Based Care provided by volunteers and health activists to patients with AIDS and their relatives grew considerably, rising from 17,790 beneficiaries in 2004 to 99,122 in 2008. Equally, the number of Health Units with connections to programs providing Home Based Care rose from 79 in 2004 to 200 in 2008.

III.5. Mitigation of Consequences

The mitigation of the effects of HIV and AIDS consists of the promotion and implementation of measures (structural and non-structural) directed at reducing the socio-economic and environmental (negative) consequences of HIV and AIDS on individuals, households, communities and institutions. In the context of the implementation of the PEN II, mitigation action undertaken was aimed at (i) improving food security and nutrition; (ii) reinforcing the income generating capacity of families; and (iii) guaranteeing the educational and vocational support of orphans and vulnerable children, adolescents and youth.

Support for PLWHA, OVCs and their families, as the main groups targeted by mitigation action, was ensured by the involvement of civil society organizations, especially faith-based organizations, and associations led by women, and associations of PLWHA, which concentrated on action directed at the reduction of vulnerability, and in particular on the provision of basic hygiene care, and nutritional, moral and psychosocial support. This support also included economic empowerment activities for target groups, by building technical and vocational knowledge, and other life skill capacities. By the end of 2007, more than 12,000 PLWHA and more than 360,000 OVCs had been reached. Nearly 1,200 volunteers were trained, countrywide, to provide home based care support to AIDS patients {32}.

The implementation of the National Strategic Plan for the Support of Orphans and Vulnerable Children (PENOVC) {33} represented an important landmark in directing service providers towards perceiving the need for the implementation of basic services for OVCs. The MMAS, in partnership with other government and civil society actors, has invested in the establishment of coordination mechanisms, such as the Technical Group for OVCs, and Multisectoral Groups for OVCs, functioning in some of the provinces.

A lack of systematic data on the achievements on the mitigation component limits the production of an analysis which does justice to the hundreds of interventions carried out in this context. With regards to constraints to this component, the following aspects are noteworthy: the lack of systematized support mechanisms for people most affected by the impact of HIV and AIDS; a low level of consideration, in the operating framework, of the increased vulnerability of women and the elderly, in their capacities as the main providers of assistance to members of households affected by AIDS, and who bear the burden of the impact of HIV and AIDS in the family; limited human resources, which hinders the expansion of associated services in terms of both quantity and quality; and a shortage of integrated programs which address the issue of food and nutritional insecurity associated with HIV and AIDS.

III.6. Monitoring and Evaluation (M&E)

So as to put the principle of the "Three Ones", advocated in the PEN II, into effect – including one system for the M&E of the national response - the CNCS is coordinating the implementation of the respective M&E plan, together with the provincial delegations of the AIDS Council, civil society and the public and private sectors, and also amongst implementing and coordinating partners. The National Monitoring and Evaluation Structure (2005-2009) identified a set of 27 indicators, which included indicators agreed upon for the Monitoring and Evaluation of the UNGASS declaration. It also defined the sources of data for indicators and other relevant information, the systems that need to be put in place to ensure the flow, storage, analysis, dissemination and correct use of data, and the role of each stakeholder.

However, the process of harmonizing and integrating information produced by different stakeholders has proven to be a big challenge. Nevertheless, certain achievements are noteworthy, including several workshops conducted on M&E harmonization, most notably the workshop on the delineation of measures for the strengthening of the M&E system , flow and management of data run by the Global Fund for the health sector during 2007; the consultative workshop on the analysis of the status of M&E in the national response organized by the CNCS in May 2009, and workshops organized in the context of the preparation of the strategy for the acceleration of HIV and AIDS prevention, carried out in 2008/2009.

During PEN II, it was widely recognized that the alignment of M&E interventions must start with the CNCS and its partners playing a more active role , so as to ensure that all key stakeholders report regularly, according to the set directives. Furthermore, the involvement of all of the decentralized structures is seen as key for the documentation of the response – an essential factor to demonstrate the efforts undertaken .

III.7. Research

Research was a fundamental pillar of the implementation of the PEN II, and was aimed at increasing the level of scientific knowledge on HIV and AIDS and its consequences, and thereby, at obtaining knowledge of good practice, so as to better respond to the epidemic. Some progress was recorded in this component, of which the following may be highlighted: the mapping of research on HIV and AIDS during the 1987-2007 period, a diagnosis of HIV and AIDS research needs, the establishment of an HIV and AIDS research database, the establishment of the Knowledge Management Center in Beira, the participative formulation of a research agenda for HIV and AIDS, and its institutionalization, through the National HIV/AIDS Investigation Program the implementation of which is coordinated by the Ministry of Science and Technology {34, 35}.

During the period of validity of the PEN II, several studies on the prevalence of HIV, STIs, high risk behavior and driving factors of the epidemic were carried out of which the following should be highlighted: the AIDS Expenditure Assessment - *Mediçao de Gastos em SIDA* - MEGAS (2004/2006) {36}, Research on Multiple Group Indicators - MICS (2008) {2), the demographic impact of HIV and AIDS (2008) {10}, two rounds of HIV surveillance in sentinel posts (2007 and 2009) {6,7,37}, a 5-year impact evaluation of the Global Fund {38} a triangulation study on data from several secondary sources (2007/2008) {8}, an analysis of modes of HIV transmission, and prevention response (2009) {9}, biennial UNGASS reports {39} and the commencement of National Research on Prevalence, Behavioral

Risks and the Impact of Information on HIV and AIDS in Mozambique – INSIDA, among others. These studies and reports allowed the recording of the pattern and impact of HIV and AIDS at national and local level, and the evaluation of the degree of coverage and intensity of the results of HIV and AIDS prevention and response efforts.

In spite of the progress made, knowledge regarding HIV and AIDS in all of the dimensions indicated by the PEN II is still not available. This is because of the fact that the conditions in which such knowledge was produced have not always followed the lines of the established HIV and AIDS Research Program. There are still important data gaps, on issues such as accurate national prevalence rates and rates of incidence in specific populations, data on factors driving the epidemic, data on the most vulnerable populations, and data on what works, and on which programs are effective. The lack of this data has limited the existence of evidence-based plans and evaluation. Additionally, there is insufficient coordination of HIV research activities in the country, which results in the proliferation of unharmonized research, and which leads to its duplication. When research has been done, the dissemination of results has not been done effectively, and even when results have been disseminated, there has not been sufficient capacity to use these results in the planning and adjustment of existing programs.

In general, the response in the area of research has shown that there is still a need to better understand the epidemic, so as to plan the response thereto, and to best redirect strategic interventions. This can be done by engaging in more advocacy for the recognition of the importance of research, so as to be able to respond effectively; through the provision of institutional capacity building in research methodologies and in the use of results, while at the same time improving the dissemination of results and the coordination of activities aimed at the research of HIV and AIDS in the country.

III.8. Communication for social change

In 2005, the CNCS developed a *National Communication Strategy* {40}, so as to respond to the challenges posed by the fragmentation of communication activities and so as to orientate communication action, in accordance with the priority areas of the PEN II. The implementation of this strategy commenced in 2006, through the preparation, implementation and monitoring of provincial action plans.

Some of the main communication initiatives which were implemented during the PEN II include the Presidential HIV and AIDS Response Initiative, and prevention programs directed at specific groups, such as children and young people, such as the *Window of Hope*. In addition, civil society, the private sector and international agencies developed and implemented communication interventions which used an approach which integrated different media (radio, drama, TV and mobile units). At the same time, audiovisual materials were printed, produced and distributed, increasingly in local languages; partnerships were developed with community radio stations, so as to stimulate community dialogue; investment was made in peer educators, including young people, truck drivers, military personnel, and sex workers, inter alia, and social marketing was undertaken as the main strategy for incentivizing the use of condoms.

Although there has been some progress in the implementation of communication for the promotion of social change, this component has not contributed, to the desired extent, to the improvement of the HIV

and AIDS response. What contributed to this scenario was the fact that communication was not prioritized in the different institutions undertaking HIV and AIDS response interventions. This situation resulted in insufficient investment in the recruitment and capacity building of human resources for the research, design, implementation, monitoring and evaluation of communication interventions. Communication activities mainly made use of the mass media, and there was hardly any community mobilization, and these activities needed greater institutional commitment and participation as well as a high level of investment in terms of time, funds and human resources.

In general, progress in the area of communication, during the PEN II, has demonstrated and taught that the theoretical presuppositions and guiding principles set out therein are still relevant and may be capitalized on in the implementation of the PEN III. Its implementation must be guided by the ever more urgent need to adapt interventions and messages to the social and cultural contexts in which individuals find themselves; to ensure the ever-increasing involvement of families and communities in the design and dissemination of messages; to consolidate positive models and concrete examples, on the part of leadership, and to provide evidence of the impact of work done in the area of communication, so as to inform the response to HIV and AIDS in the country.

IV. Strategic Vision and Main Guiding Principles of PEN III, 2010 – 2014

Through this National Strategic HIV and AIDS Response Plan, 2010-2014, the Government of Mozambique renews its commitment to promoting an effective response to HIV and AIDS, on a national and regional scale, by striving to comply with ratified global and regional commitments.

Taking into account the experiences and knowledge which has been accumulated by the country during 20 years of responding to HIV and AIDS, the Government of Mozambique reiterates the need to capitalize on these inputs, so as to guide the adoption of those strategic measures which are most appropriate for the epidemiological profile of the country and the region, the structure of available services, and the socio-cultural characteristics and behavior of the Mozambican people.

This Strategic Plan is a guiding document for the dynamization, harmonization and coordination of HIV and AIDS response interventions in the country. The strategic orientation of this response is centered on interventions which combine an emergency and a development approach. The emergency perspective is centered on acting at a grassroots level, by identifying action through which to confront factors which aggravate vulnerability to the infection, which facilitate the propagation of the virus. In this emergency context, it is crucial to identify population groups considered to be high risk, and the phenomena which surround them. The development perspective confronts HIV and AIDS from a long term, sustainable and integrated perspective, in programs and sectoral plans at public, private sector and civil society level, so as to consolidate its generally applicable character, and so as to guarantee the sustainability of interventions in the long term.

As a result of the consideration of strategic orientations, the Plan is in harmony with the results-based vision of the pillars of the 2025 Agenda {41} - human capital and economic development - since the evidence demonstrates, notoriously, that HIV and AIDS continues to be one of the structural challenges currently faced, and to be faced in the following years, by Mozambique. The response to HIV and AIDS is one of the essential aspects of efforts undertaken to improve the quality of life and well-being of Mozambicans. The response to HIV and AIDS is victorious, and only makes sense, when its results have repercussions for the global challenges of the country, the reduction of poverty and the promotion of socio-economic development. The PEN III presents a strategic vision which is informed by the analysis of trends in the evolution of the epidemic, and by evidence generated in the context of the implementation of the previous strategies.

The PEN III is built on the foundation laid by the two previous plans. Its main strategic components include the traditional thematic areas of prevention, treatment and care and mitigation of impact, and a new component is incorporated - the reduction of vulnerability to and risk of HIV infection. This is supported by lessons learned from the history of the response itself, which indicates that in spite of the investment made in containing levels of incidence, and in ensuring a better quality of life for people living with HIV, the epidemic continues to have a critical impact at individual, family and community level.

In the component of **reduction of risk and vulnerability**, the impact result is to see a reduction in the degree of risk and vulnerability of the Mozambican population to HIV, particularly for those populations considered to be most vulnerable. Interventions are centered in the general environment

of risk and vulnerability to infection by HIV at individual behavioral level, at structural level, and at socio-cultural and community level. The aim of these interventions is to confront and limit the precarious social conditions which facilitate the establishment of a favorable environment for the increase of risk and vulnerability to HIV. Intervention aims to limit the aggravation of vulnerability because of gender inequalities and because of cultural, educational, demographic, legal, economic and political factors.

The **prevention** component *continues to be an area of central focus and is supported by evidence highlighted in the Strategy for the Acceleration of Prevention*. Here, investment is aimed at the reduction of the prevalence of HIV in 15 to 24-year-old pregnant women, from 11.3% recorded in 2007 to 8.5% in 2014"[10]. Priority action areas are prevention of HIV in high risk populations, particularly in girls; promotion of the consistent use of condoms, including female condoms; promotion of social and behavior change, prevention of vertical transmission, ensuring biosafety and availability of male circumcision services. These prevention strategies are supported by a change component of a social and individual nature, galvanized by the broad involvement of the family and communities.

In the **treatment and care** component, the expected impact results are related to the reduction of mortality from AIDS, by 5%,[11] in the year 2014, in relation to expected rates, without an increase in access to treatment envisaged in this plan {10}, and the improvement of the quality of life of people living with HIV and AIDS. The strategic interventions brought together in the Treatment and Care component are centered around five areas of services provision, which are mutually interconnected, and include the intensification of Counseling and Testing in Health as a way of reaching out to more Mozambicans, in order for them to know their status and seek timely and appropriate services and health care, and to adopt safe behaviors; the provision of continuous care services, both for HIV positive patients not yet eligible for ARVs as well as for those who are already on ARVs; the improvement of the TB tracking system for HIV-positive patients, and vice-versa; as well as the guaranteeing of psychosocial support (including for health workers who are confronted with the drama of HIV and AIDS in the health units on a daily basis); and nutritional support an d home based care for eligible patients, with broad involvement of the family and the community.

In the **mitigation of consequences** component, the expected impact result is to have reduced the magnitude of the impact of HIV and AIDS, hunger and poverty among households, communities and among Orphans and Vulnerable Children, giving priority to the involvement of local leaders and other persons of influence in the society, so as to accelerate a more effective community and familial response. In terms of strategic areas, the mitigation of the effects of HIV and AIDS is centered on the reduction of the consequences of HIV and AIDS on PLWHA, households, Orphans and Vulnerable Children, communities and institutions, through initiatives which aim at providing basic care and support to Orphans and Vulnerable Children; ensuring nutritional and food security; reinforcing the income generation capacity of families; protecting the rights of PLWHA and promoting social cohesion, giving special attention to differences in the needs of men and women.

10 This reduction corresponds to 25% and is based on mathematical projections (Spectrum).

11 This 5% reduction implies that around 23.000 deaths due to AIDS would be avoided in comparison to what would happen without additional interventions proposed in NSP III by 2014. However, this result must be interpreted with caution since they are based on mathematical projections (Spectrum)

With a focus on the achievement of the overriding objective of reducing the number of new HIV and AIDS infections in Mozambique, promoting the improvement of the quality of life of people living with HIV and AIDS, and reducing the impact of AIDS on national development efforts, and consequently contributing to the elevation of the country's socio-economic development indicators, the following **Guiding Principles** are reaffirmed:

1. Respect for Universal Human Rights

Respect for human rights is fundamental to the achievement of results by strategies connected to sensitive matters, such as sexuality. Respect and advocacy for individual human rights, and particularly for those of PLWHA, marginalized populations, high risk populations, women, people with disabilities, and the elderly, are essential for the guaranteeing of an active search for services and information on the primary and secondary prevention of HIV and AIDS in individuals, families and communities, allowing treatment to be effectively equal to that provided for other chronic diseases, not being entangled in preconceived ideas and taboos, in light of the form in which it is acquired. This principle includes the recognition of the right to free participation and involvement of all people and population groups in the HIV and AIDS response, including the promotion of positive action, with a view to involving population groups which are generally excluded from HIV and AIDS response investment.

2. Multisectoralism

At present, HIV and AIDS constitutes one of the greatest problems for development, and a serious threat to the progress and gains achieved in several economic, social and political arenas, demanding treatment and attention, without discrimination, in all sectors of government, and in society in general. In effect, the association of HIV and AIDS to poverty is becoming increasingly apparent, as it aggravates individual vulnerability, and so also poverty. It is an epidemic that evolves from behaviors which can be prevented, which brings with it the challenge of strategic attention to prevention being multisectoral. In the context of the principle of multisectoralism, the effective coordination of the efforts of all actors involved in the response to HIV and AIDS must be seen as key to the complementary nature and success of interventions. The question of an integrated response and of the coordination of efforts demands articulation between the actors and institutions involved in the response to HIV and AIDS, institutionalized in clear mechanisms and procedures for the coordination and funding of the response, so as to ensure a fluid implementation process for the priorities defined in this Strategy.

3. Results-Orientated, and Evidence Based

This principle implies the need for any proposal to be based on evidence, and the obligation to document, assess and use best practices in the strategy's various areas of implementation. In terms of this principle, the combination of a strategic orientation, supported by evidence, and a results-based approach, should be at the vanguard of the response to AIDS, and should include consideration of the different aspects and priorities of different provinces and regions.

4. Economy of Resources

As HIV and AIDS is a structural development issue which demands constant and long term attention, and recognizing that at present the response to HIV and AIDS is largely ensured by the financial contribution of international partners, the search for the guaranteed sustainability of the response to the epidemic demands that the Government undertake the funding of the response, on an ever-increasing basis, using domestic funds. Adherence to the principles of economic austerity, the minimization of expenses and the maximization of benefits demands that the choice of the areas of incidence of the response be based on criteria, so as to allow the principle of the economy of resources to be fully implemented.

5. Systems strengthening

This strategic plan assumes that systems strengthening is one of the preconditions for the achievement of the objectives and targets set by it. Understood in the broadest sense, systems include all of the institutional and community structures for service provision at the central, provincial, district and community levels. Endowing systems with appropriate infrastructure, qualified human resources, instruments and procedures, logistical and financial support, information systems and leadership, is crucial for an effective and sustained implementation of the response to HIV and AIDS and to global challenges for development.

6. Communication and "Mozambicanization" of the Message

In the context of the principle of communication and Mozambicanization of the message, it is reaffirmed that the Mozambican response to HIV and AIDS can only be more effective if it meets the need for the implementation of communication strategies which are attentive to the characteristics of the epidemic, and to the social and cultural contexts in which Mozambican populations live. The content of communication approaches in the response to HIV and AIDS must be structured, systematized, attentive to gender dynamics, and implemented in ongoing manner, through dialogue, making use of the multiple means and communication channels available at national, community, familial and interpersonal levels. The direction which the messages should take, and their thematic content, must strive towards community participation, capitalize on the involvement of leadership at all levels, be inspired by the ethics, culture, languages and learning embedded in the cultural contexts which characterize the broad diversity of Mozambique, while at the same time being directed towards safe behaviors and attitudes, jointly directed against the HIV and AIDS epidemic.

7. Decentralization of the Response

In the context of this principle, attention is given to the importance of the district as the starting point for all of the processes of involving sectors, communities and families in the response to HIV and AIDS. The operational planning and implementation of action in response to HIV and AIDS must capitalize on existing synergies at district level, so as to respond to the challenges and specific needs of the communities living in specific districts. Partnerships between the public and private sectors and civil society organizations must find operational bases for expression at district level, as part of a strategy of greater closeness to, and interaction with, Mozambican families and communities needing services.

IV.1. Reduction of Risk and Vulnerability Component

Precarious economic and social conditions are determining factors for the establishment of an environment favorable to the increase of risk and of vulnerability to HIV {43}. To be vulnerable in this context means to have little or no control over the risk of contracting the infection or, for those already infected or affected by HIV, means to have little or no access to appropriate care and support. Vulnerability is the final result of the interaction of many factors, whether personal (including biological) or social, and can be aggravated by a variety of cultural, education, demographic, legal, economic and political factors {44}.

A risk factor is defined as an aspect of individual behavior, a way of life, or exposure, based on epidemiological evidence which is associated with transmission or contracting the infection {13}. The driving forces of the epidemic are related to the environment, structural factors and social contexts, such as poverty, gender inequalities and the violation of human rights, which are not all easily measurable, despite contributing to the increase of the vulnerability of individuals to HIV {13}.

The analysis of key driving factors of the epidemic and of priority interventions is focused on three inter-related levels:

- Individual and couple, which includes biological, demographic and behavioral factors which may influence the risk of the individual contracting HIV;
- Community, which includes those determinants of HIV transmission which are outside of the direct influence of the individual or couple;
- Structural, which includes aspects directly influenced by policies and by National Strategic AIDS Response Plans

IV.1.1. Individual Behavioral Risk and Vulnerability Factors

Behaviors which place individuals at high risk of HIV infection include unprotected heterosexual and homosexual relations and the injection of drugs using shared equipment {13}. In addition, there is a risk of vertical transmission, from HIV-positive pregnant mothers to their children.

A study of a small sample, carried out in the province of Sofala, addressed the issue of individual perception of risk: most men have some perception of their personal risk of contracting HIV, while more than half of women do not. Women and men aged between 20 and 39 years feel more vulnerable than those over 40. The biggest rate of perception of risk is found in the 30 - 34 year age group. Men determine their vulnerability on the basis of their number of partners, and on taking measures to have safe sex or not, while women evaluate their risk of infection both on the basis of their sexual behavior and on the basis of their evaluation of the behavior of their partners {45}.

IV.1.2. Community Risk and Vulnerability Factors

At community level there are several socio-cultural factors which influence risk and vulnerability to infection by HIV in various ways, in particular, for women: the way in which society conceives of feminine and masculine identity and sexuality, the social status of a woman, stigma and discrimination (in spite of Law 12/2009), unequal access to health services, poverty and social exclusion and the

guarantee of basic human rights. The analysis of socio-cultural factors suggests that cultural beliefs and practices support and maintain gender inequalities, relegate women and girls to a secondary social status, and increase the vulnerability of women to infection. In addition, gender relations based on unequal power relationships, as well as marriage dynamics, favor men in decisions relating to economic needs. In these conditions, domestic violence is common.

Traditionally, in the context of marriage, and outside of it, women are expected to be passive towards their partners, there is little communication and negotiation between couples regarding sex, which is mandatory, and women not being allowed to discuss possible infidelity with their partners. There are frequent cases of young girls being forced to enter into premature marriages with older men, sometimes in polygamous contexts, which also represents a risk factor. Widows and orphans, in particular when their inheritance rights are withdrawn from them, are left without land and without shelter, being more vulnerable to risky practices, situations of abuse and sexual violence. Very often old women continue to be the only people to care for orphaned children. There are other socio-cultural factors relating to sex and sexuality which contribute to the risk of infection, such as sexual purification rituals for widows, treatment by witchdoctors, involving unprotected sex, and the use of vaginal products to dry the vagina and provide greater friction during the sexual act, which increases the risk of infection to HIV {46}, besides being practices which are considered to be incompatible with condom use {47}.

Strategies for the reduction of risk and vulnerability to HIV must be multisectoral, taking into account the context, community cultures and their needs, using an approach focused on the understanding and strengthening of the gender component in a manner which is sensitive to the different needs of men and women, and which promotes equality, rights of citizens to non-discrimination, and social inclusion.

IV.1.3. Structural Risk and Vulnerability Factors

Poverty and social development

Young people constitute a considerable part of the population most exposed to the risk of infection, the highest rate of prevalence of HIV being in the age group between 20 and 24 years (18.3 %). About half of young Mozambicans are sexually active before reaching 16 years of age. Women in Mozambique constitute nearly 52% of the total population, 72.2% of which live in rural areas, with extremely low human development indicators (such as an illiteracy rate of around 68 %).

Reflecting the inequality in gender relationships in Mozambique, a woman is frequently constrained from having access to resources and opportunities, and her economic dependence favors domestic violence and increases vulnerability and the risk of infection to HIV. The available data estimates that 380,000 women may be involved in sex work, with early commencement of this activity (17.8 years), and there are cases of 10 year old girls being involved.

During the 2005-2009 Government Program, the reduction of levels of absolute poverty, through the promotion of rapid, sustainable and widespread economic growth, centered in the rural areas, constituted one of the priority actions of the Government. The woman was placed at the center of attention, with a view to securing for her equal opportunities and rights, and to increasing her level of

education {3}. The objective of reducing levels of poverty in the country presupposes the directing of basic services to the most vulnerable populations, composed of households with elderly people, disabled people, chronically sick people and Orphans and Vulnerable children. The promotion of income generation initiatives is one of the strategies that must be included in the country's policies, with the aim of reducing poverty, on the one hand, and the socio-economic impact of HIV/AIDS, on the other {49}.

Food insecurity

Food insecurity has contributed to the risk and vulnerability of individuals, especially children and adolescents, in particular those of the female sex. Food insecurity may result from the incapacity of individuals and households (HHs) to produce food in sufficient quantity, or from their incapacity to buy food. Approximately half of household expenses are spent on purchasing food. As such, any fluctuation in the factors affecting the economic level of a HH (such as poverty and price rises) has an even greater impact on the capacity of families to access food. Since access to food is a priority for any HH or individual, the lack of it and the search for means of survival implies risky behavior, such as involvement in transactional sex; an increase in intergenerational sex, resulting in the inconsistent use of condoms {50}; and high levels of mobility and migration, which favor involvement in multiple sexual networks {51}. Some efforts have been done to include activities which would increase agricultural production and income generation for vulnerable people, but coverage is still limited.

Mobility and migrant labor

Throughout the history of Mozambique, the phenomenon of migrant labor has been an important economic factor, with relevance in the context of regional integration at the SADC level. The emigrant, in most cases a man, normally has no means with which to take his family with him, and, as such, he is driven to create other relationships in places where he travels or works. Meanwhile, and for similar reasons, the wife of an emigrant also has a tendency to develop new relations. The consequences of this situation affect the stability of the family and influence the increase of vulnerability to HIV. In addition, the most important economic corridors between Mozambique and neighboring countries are also commercial sex areas. This data reinforces the need for initiatives directed at girls and women.

Human rights and legal aspects

An approach to HIV based on human rights advocates the empowerment of people, so that they are able to know and claim their rights to protection, thereby reducing social asymmetries at individual, family and community level. The Declaration of Commitment of the Annual General Meeting of the United Nations on HIV and AIDS recognizes human rights as being an essential element of the global response. In our country, the creation of legal instruments for the protection of the rights of vulnerable people reached an important point, in 2009, with the promulgation of the Law on the Defense of Rights and the Combatting of Stigmatization and Discrimination against affected individuals[12], making it broader than Law 5/2002, which is directed only at the defense of employees. However, the challenge of strengthening systems, in order for laws to be effectively applied, must be taken into account.

12 Prepared by the Parliamentary Commission on Social, Gender and Environmental Affairs

Discrimination and stigma

Another set of factors which influence vulnerability to HIV-infection is the issue of marginalization and stigmatization of high risk populations. Populations which are at high risk of infection, include men and women in prison; street children; sex workers, their clients and partners; users of intravenous drugs and their partners; partners of people who live with HIV (PLHIV) and men who have sex with men {39}.

Some of these population groups have difficulties in accessing health care, including HIV prevention, which could be directed towards responding to their specific needs, generally because of denial and stigma. Linked to the issue of marginalization is the behavior of the community in general, and that of health workers, which inhibits individuals from accessing health services, particularly when they come from stigmatized groups. Nearly 61% of women aged from 15-49 interviewed during MICS said that they wanted to keep their serostatus secret, for fear of discrimination. Legal barriers can also hamper access by these groups. HIV and AIDS stigma means that people living with HIV are rarely considered to be priority users of basic services. Since stigma and discrimination are multisectoral, programs must operate at several levels (individual, family, community, organizational, institutional, government and legal) and must make use of a range of approaches, through which all of the population groups needing services can be involved {43}.

Gender disparity

Gender disparity is one of the main challenges, and a critical barrier, to the access and use of care and treatment services, in contexts with socio-cultural norms which reduce the power of women to negotiate safe sex. Recent research indicates that 55% of men and 52% women do not recognize the right of women to refuse sex with their husbands or boyfriends {9}. The low level of access of girls to education and basic information on health care aggravates their vulnerability. Girls drop out of school for fear and/or as a result of the acts of violence and sexual abuse which take place in schools, as well as because of premature marriage and pregnancy. Sexual abuse is not addressed in the context of the violation of the human rights of women, but that of the interruption of expectations, connected to the social role attributed to a woman in gender relationships {52}.

Access to services

In Mozambique, access to public services has been improving, in spite of significant disparities which remain among social groups based on income levels, among different regions, and between rural and urban areas. The results of research on poverty and vulnerability in Mozambique suggest improvements in access to public services, particularly in health and education {53}. Geographical and gender disparities in access to health care and to ARVs are relatively well-documented. Nevertheless, it remains necessary to document access to other services; for example; support for mass media in the community and psychological support for women, so as to improve their accessibility.

From this perspective, access to information, in order to allow all individuals to enjoy their rights and to be protected, and using different languages for different age groups, continues to be a great challenge. The main sources of information for most people are the community, religious authorities and members of the government, and also individuals in the family context, neighbors and friends.

These methods are appropriate, considering the level of illiteracy in the rural environment {53}. In particular, community radio must be considered to be an important vehicle for mass communication.

Strategic Priorities

At the individual level - Behavioral: to promote the informed, active, free, inclusive and significant participation of those affected by HIV in the design, implementation, monitoring and evaluation of HIV and AIDS programs; to formulate and disseminate operational research on stigma and discrimination; to formulate and disseminate research on perceptions of individual behavioral risks, among high risk and vulnerable populations; and to reduce the marginalization and social stigmatization of vulnerable and high risk populations, guaranteeing access to health services.

At socio-cultural community level: to reduce ritual sexual purification practices for widows, and to strengthen sensitization campaigns against risky cultural practices; to promote positive intergenerational cultural dynamics of gender equity, through peer education for men and women, capitalizing on the involvement of community leadership; to develop educational action which promotes greater communication between partners, the negotiation of safe sex and the reduction of risky sexual practices; to promote social action programs with the participation of the family, civil society, religious institutions and community leaders; to guide community leadership on the application of law against domestic violence; to promote knowledge, sensitivity and tolerance regarding HIV in schools; to provide guidance to communities regarding preventive aspects, using cultural approaches; and to involve traditional doctors, traditional midwives, traditional chiefs responsible for circumcisions in the community, and women's and youth organizations in programs of prevention which are culturally acceptable and safe.

At structural level: to promote income generating activities for young people, women and the elderly; to support interventions in the informal and private sector, as a way of reducing the vulnerability of employees; to increase and promote activities which improve the food security of individuals and the most vulnerable HHs; to promote and support initiatives from civil society and groups of women, so as to reduce structural vulnerability; to apply broader criteria for the determination of poverty, as appropriate to the particular situation of PLWHA and their families; to promote the participation of gender focus points in the planning, implementation and monitoring of activities related to HIV in the different sectors; to undertake capacity building for health workers providing services to high risk and vulnerable populations; to promote debates amongst men on male responsibility and on behavior change for men; to secure access to education, and opportunities for children, young people and women to complete their education; to increase social services, where children, young people and women can be encouraged to seek assistance and to abandon violent relationships (in the case of women); to monitor the implementation of legal instruments which guide the prevention and mitigation of the impact of HIV/AIDS at the workplace, to draft legal instruments providing protection against premature marriages and the sexual abuse of minors; and to support the implementation of policies on HIV/AIDS, as a response to Law 5/2002 of 5 February.

IV.1.4 Results Matrix – Reduction of Risk and Vulnerability

Impact of the Component	**Increasing the number of men and women, vulnerable to HIV and AIDS, who enjoy their human and social rights[13]**	
Area	Results	Output
1. General environment of risk and vulnerability HIV infection	1.1.Reduction in factors of vulnerability at the individual-behavioral level	1.1.1. Increase in the number of 10-14 year old pupils who developed skills which allow them to identify, overcome and cope better with situations of risk or contexts of exposure
		1.1.2. Increase, in the cases of stigma and discrimination, of the number of such cases which are documented and integrated into positive legal or community responses
		1.1.3. Increase in the number of studies on the "stigma index" {54}, on people living with HIV
		1.1.4. Increase in the number of men involved in the reduction of the behavioral vulnerability of women
		1.1.5. Increase in the number of reports on implemented operational research on stigma and discrimination
		1.1.6. Increase in the number of reports on operational research on risk perception among vulnerable and high risk populations
	1.2. Reduction in factors of vulnerability at the socio-cultural level	1.2.1. Increase of the number of traditional medicine practitioners, traditional midwives, and community and religious leaders who are trained in, and who implement, approaches to STIs, HIV and AIDS
		1.2.2. Increase in peer education action, for men and women of all ages and community leaders, in communities which promote positive cultural gender dynamics and gender equity
		1.2.3. Increase in the number of leaders who receive training and apply the law against violence
		1.2.4. Increase in the number of schools and teachers who receive training on knowledge, sensitivity and tolerance with regards to HIV
		1.2.5. Increase in the number of HHs with members exposed to formal and informal training programs
		1.2.7. Equal access created to resources and services among vulnerable and non-vulnerable individuals
		1.2.8. Reduction in the number of cases of violence reported to the police and community authorities
		1.2.9. Increase in the number of resolved cases of violation of rights
		1.2.10. A communication channel for the reporting of violations of rights created and publicized
		1.2.11. Introduction and implementation of a culturally acceptable penal code, which prohibits the purification of widows through sexual means
		1.2.12. A penal code introduced and implemented which prohibits publication regarding people who treat STIs, HIV and AIDS, without proof, through any means of communication

13 So as to quantify the result of the impact there is a need for basic studies which will allow the gathering of comparable statistical data, demonstrating progress at showing the progress, at school level, in the perception of risk, gender equity, protection against sexual violence, access to health services and the reduction of the stigmatization of persons living with HIV and AIDS.

Impact of the Component	**Increasing the number of men and women, vulnerable to HIV and AIDS, who enjoy their human and social rights[13]**	
Area	Results	Output
		1.2.13. Increase in the number of widows who make use of legal reforms which recognize their rights to property and inheritance
		1.2.14. Studies on domestic violence carried out, distributed and implemented, as a contribution to the informing of action aimed at the reduction of risk and of vulnerability to HIV
		1.2.15. Studies carried out on the rights of women and children, and of people living with HIV, as part of the effort to record evidence
	1.3. Reduction in factors of vulnerability at the structural level	1.3.1. Increase in the intervention capacity of the private and informal sectors
		1.3.2. Increase in the number of employed women, and of those with sources of income
		1.3.3. Increase in the number of companies implementing policies on HIV and AIDS, and reducing vulnerability for workers
		1.3.4. Reduction in the number of workers who are discriminated against and stigmatized, at risk of losing their job
		1.3.5. Increase in the number of young people, women and elderly who are affected, and who do not benefit from micro-credit or forms of social transfer
		1.3.6. Increase in the expansion of the primary school network for boys and girls, and of schools which offer professional education
		1.3.7. Increase of the migrant and mobile population using health services in border areas and outside of their residential areas
		1.3.8. Increase in the availability of social services, in order to cater for children, young people and women in cases of sexual violence
		1.3.9. Increase in the number of gender focus points in activities connected with HIV in the different sectors
		1.3.10. Application of laws on inheritance so as to benefit and protect, in particular, women who become widows and orphaned children

IV.2. Prevention Component

In this component the interventions respond to the main challenges identified in the analysis of HIV-prevention initiatives implemented during the period of the PEN II, and are based on orientations which form part of the Strategy for the Acceleration of Prevention (SAP), which establishes mechanisms for the progressive but sustained reduction of the incidence (in other words, the number of new infections) of HIV, and guides actions for the response for the next 10 years {25}. In the prevention component, priority action areas include counseling and testing in health; promotion of the consistent use of condoms; promotion of action aimed at changing the sexual behavior of high risk groups; early detection and treatment of sexually transmitted infections (STIs); male circumcision; the prevention of vertical transmission (PMTCT); access to treatment and extension of lives; and biosafety.

IV.2.1. Counseling and Testing in Health (CTH)

Counseling and Testing (CT) is a fundamental component of the prevention of HIV and AIDS, since it is an entry point for care, treatment and psychosocial support, and constitutes a base for the diagnosis of the main chronic diseases, including HIV and AIDS, and as such, allows for the better guidance of an individual towards healthy living, behavior change and access to treatment, care and support {25}.

Challenges

The basic principles which guide Counseling and Testing (Informed Consent, Counseling and Confidentiality) are not understood by the population, nor by most health workers, which affects the quality of services offered, as well as the seeking of such services by citizens; equally, there is a low level of HIV testing, as a result of superstition, ambiguity, shame, hesitation for fear of the result, and misinformation. However, in some communities there is a feeling that testing should be compulsory, taking into account the emergency situation and generalized epidemic in which the country finds itself. Meanwhile, there is a lack of clarity regarding the system for referring individuals tested in the community to the public health network. The existence of a multifaceted counselor profile - counselors being trained by different organizations - both in terms of duration and non-uniform content, as well as in regard to their admission criteria, and a lack of qualified human resources for the provision of health sector services in general, whether in terms of sufficient quantity, or desirable quality, associated with the absence of non-medical counselors integrated into the National Health System, constitute the main constraints hampering the adequate provision and reach of CTH services.

Strategic priorities

Priorities should be directed at promoting the quality and expansion of Counseling and Testing services in the clinical context, in Counseling and Testing in Health Units (UATS) and in the community, integrating counseling and testing into the routine activities of health workers, expanding community counseling and testing and promoting communication centered on social mobilization towards being tested, seeking subsequent services and adhering to treatment. An inclusion strategy for non-medical counselors must be incorporated into the framework of the National Health Service, as must be the current National Communication Strategy for HIV/AIDS, and mass communication campaigns, with the aim of promoting counseling and testing services and knowledge of serological status. No less important is the introduction of a National Testing Quality Control System, integrated into the quality control of laboratory activities of the National Health System, as well as the adjustment of groups of

activists and message bearers to target groups, in other words, creating community groups of activists composed of adult men and women, pregnant women and elders, so as to make the information more credible.

The integration of the issue of stigma and fear associated with HIV, even amongst health workers, and the establishment of user confidence in CTH services, is essential. Several ATSC must be encouraged, including mobile brigades in rural and urban areas and door-to-door campaigns by activists.

The standardization of Counseling and Testing procedures, especially at community level, in terms of the training curricula and the qualification of service providers (lay counselors), and the standardization of supervision, monitoring and coordination mechanisms of CT initiatives, is fundamental. The strengthening of doctor-initiated CT strategies during consultations (with special attention to consultations involving children at risk, and those who are healthy) and pediatric wards, the improvement of the referral system, and the ensuring of logistical support and quality control in testing, to respond to the expected growing demand for tests, must be ensured.

IV.2.2. Condoms

Consistent use of condoms during sexual relations is an essential element in the reduction of new infections, especially in young people, and in contexts in which multiple and concurrent sexual partners are one of the driving factors of the epidemic. The use of condoms in the last sexual encounter, is one of the indicators of behavior change, to the practice of safe sex.

Challenges

In spite of the increase in the distribution of male condoms, there are weaknesses in systems of management and distribution, especially in rural areas. Meanwhile, there is still no evidence indicating that distributed condoms have contributed to the significant reduction of the rate of new infections. The sale of condoms has been identified as a factor diminishing access to them. In spite of this, available data show that the consistent use of condoms is higher in non-regular partners, and that unprotected sexual acts are constant among young people. Self assessment of the risk of HIV is weak, and the low perception of risk is related to the non-use of condoms {9}. In Mozambique, patterns of weak or no condom use have been documented, and are related to issues of discordance in couples, cultural and religious barriers and unequal relationships between men and women, whether they are young, or adult. {9}, 63. In addition, the experience of PEN II implementation revealed a low level of dissemination and access to female condoms {47}.

Strategic priorities

In order to respond to these challenges, the strategy entails the improvement of logistical and management capacity in the distribution of condoms at all levels, especially in the rural areas, through better coordination between stakeholders (the public and private sectors, and civil society), including the free distribution of male and female condoms; the increase, among sexually active men and women, serodiscordant couples involved in multiple and concurrent networks, adolescent partners, young people, adults and the elderly, of the proportion of those consistently using male and female condoms, through communication activities aimed at behavior change, and the undertaking of social marketing to

promote acceptance; producing appropriate communication materials for the Mozambican context, to be used in and for families, and involving community leaders, including TMPs, traditional midwives and initiation rites counselors, in their dissemination. The promotion of the use of condoms must be accompanied by educational communication initiatives, through which men and women may come to understand that a condom is protective, and must be used in a responsible manner, and with mutual respect. Development corridors must prioritize the reaching of groups of highly mobile people. It is necessary to facilitate the existence of grassroots evidence on the use of female condoms, through research opportunities aimed at identifying and understanding the conditions under which it would be desirable for women to use female condoms, as well as at investigating alternative prevention means, over which women would have exclusive decision-making power.

IV.2.3. HIV Prevention in High Risk Groups

WHO defines high risk populations as being those groups of people who are frequently involved in and / or adopt behaviors that lead to the transmission or acquisition of a disease (in this case, HIV). These behaviors include unprotected sex (particularly anal sex), sex with multiple partners, and the use of the same cutting objects and intravenous equipment. These populations include men who have sex with men, sex workers and their clients, users of intravenous drugs, and prisoners, and the migrant and displaced population {66}. Mozambique has no evidence on the profile of these populations, and it is hoped that the National Research on AIDS (INSIDA), which is underway, will provide data on these groups, as regards the prevalence of HIV, the size of the groups and their level of exposure to risk. The Technical Working Group on People at High Risk of Contracting HIV (MARPs), when prioritizing populations at high risk of contracting HIV to be included in Behavior Surveillance Surveys (BSS) {67}, must also include women older than 15 years involved in transactional sex, long-distance drivers; and miners and their wives / partners.

Challenges

Interventions in these populations are limited by the lack of a national strategic platform directed at them; by weak alignment between prevention activities and the population categories at high risk; the areas and populations with high mobility are known but there are few prevention activities that offer services adapted to HIV for these populations; few resources are applied to activities for these populations (less than 1% of the total prevention expenditure from 2004 to 2006) {9}; the existence of once-off interventions, without continued and institutionalized vision, and with a low level of involvement by government institutions; a lack of clear definition of populations at risk, up until now, which led to the fact that most specific interventions were concentrated on sex workers and their clients, sidelining other important high risk groups; limited access to information and to health services; difficulties in referring individuals to counseling, testing and health and social assistance {39}.

Strategic Priorities

So as to respond to these challenges, there is a need to improve coordination between institutions responsible for high risk groups, when designing and harmonizing instruments (policies, strategies) facilitating interventions for these groups. Women, children and adolescents, members of the armed and security forces, health workers, teachers, prisoners, athletes competing at a high level, miners, sailors and sex workers, are those who must be prioritized by the Government for immediate

interventions; so as to focus greater attention on HIV-prevention activities specifically related to high risk populations. Response interventions must promote an increase in the desire to know one's serostatus, train TMPs to motivate their patients to take HIV tests and to ensure more preventive practices at work, promote the adoption of patterns of consistent condom use, and reduce the risk of HIV transmission, in serodiscordant couples; improve the coordination of institutions responsible for high risk groups; develop communication and health promotion programs and strategies, including strategies for the prevention of STIs and HIV; in coordination with neighboring countries, establish coordinated control, follow-up and protection mechanisms for high risk populations at a regional level, and formulate standardized monitoring and evaluation instruments for each group, so as to allow future action to be based on evidence, as well as to allow for the comparison of results from different geographical areas. In the case of interventions directed at highly mobile people and migrants, activities should take their specific characteristics into account, as regards their type of activities and periods of high mobility, in which interventions must be more intense if they are to secure the desired impact. Nevertheless, in order to facilitate better intervention in these groups, an estimate of the numbers of these populations, or research on how to obtain this data, is necessary, so as to better define intervention targets and to prepare plans of action.

IV.2.4. Early Detection and Treatment of Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) are kept secret, since they are contracted through sexual relations, and since they are culturally considered as being embarrassing to deal with. People often prefer to suffer in silence, rather than to seek medical care. However, if left without treatment, STIs can cause serious health problems, including constant pain, infertility, problems during pregnancy, abortions, cancer and death. STIs can also have damaging effects on babies and small children, through mother to child transmission. Although many people are not aware of these types of illnesses, they are common types of infection, which very often do not manifest externally.

Challenges

Confronting situations or behaviors which result in a delay in seeking treatment by patients with STIs, due to ignorance and / or disregard of the signs, symptoms and consequences of these infections, constitutes a challenge to be overcome. At the same time, the lack of respect and confidentiality on the part of some health workers, allied to the fact that traditional medical practitioners perpetuate cultural beliefs regarding the transfer of STIs for spiritual reasons, must be addressed urgently. Equally, due to cultural issues, many women have problems approaching their partners, being afraid of reprisals and aggression as a result of their weak negotiating capacity, which gives rise to the challenge of facing of this reality through interventions which involve sustained community solutions in the culture which is characteristic of each place. Another issue of no less importance is associated to the deficient connections between different services in health units, with consequent deficiencies in the recording, notification, monitoring and evaluation of activities for this component.

Strategic Priorities

So as to respond to the challenges created by opportunistic infections, it will be essential to raise the level of community awareness of the importance of the early detection and treatment of STIs, including contacts, by integrating communication activities for STIs in the communication strategies for HIV;

expand and systematize activities undertaken together with traditional medical practitioners and traditional birth attendants and develop a monitoring system for these activities; improve coordination, at all levels, among the MISAU, the MEC and the MJD, so as to increase the early detection and treatment of STIs in young people and adolescents; give priority to high risk groups in the provision of these services, and improve the recording, notification, monitoring and evaluation systems for STIs, including contacts.

IV.2.5. Male Circumcision (MC)

In spite of limited information on the contribution of male circumcision to the rate of prevalence in the country, it has a protective effect against HIV infection, mainly for men {8, 9}. Some studies suggest that MC can reduce the probability of infection by 60%. It can secure indirect long-term protection for woman by reducing the risk of a heterosexual man becoming infected. At the same time, it also provides protection against other sexually transmittable diseases. Although it is recognized that circumcision has an effect on the prevention of HIV, it must be integrated with other prevention strategies, so as to maximize preventive benefits {20}.

Challenges

In accordance with data obtained during the drafting of the Accelerated Strategy for the Prevention of Infection, the practice of MC varies throughout the country. In addition to this factor, some aspects were identified which weaken its practice, such as poor collaboration among health workers and the people in charge of performing circumcisions in the communities; the way circumcision is done during initiation rites (with the use of non-sterilized materials); the high costs charged by the health units, and the insufficiency of qualified HR in the health sector {25}. As a last challenge there is a need to make men and communities in general understand that male circumcision is a protective factor which must be adopted in a responsible manner, so as to avoid contributing to the exacerbation of masculinity stereotypes which drive men to think that they are less prone to infection.

Strategic Priorities

To respond to these challenges, it is necessary to reinforce the NHS (especially with qualified personnel) so that it can respond to the potential increase in demand; to improve the conditions of its current practice, at practice locations, guaranteeing asepsis; to facilitate the practice of health centre based male circumcision, defining a plan of implementation and priority target group; and to train community leaders and those responsible for initiation rites, on the issue of HIV prevention. Although it is recognized that circumcision has an effect on the prevention of HIV, it must be integrated with other prevention strategies, such as effective communication and the use of condoms, so as to maximize the level of protection against infection, and in similar interventions which minimize the risk of a woman being subjected to coercive sex, and not being able to negotiate safe sex. At the same time, as recommended by the Strategy for the Acceleration of Prevention, it is necessary to improve the viability of this strategy, and the real contribution which it can make to the response to HIV and AIDS in the country, as an additional element of prevention efforts against HIV and STIs.

IV.2.6. Prevention of Vertical Transmission

The prevention of the transmission of HIV from mother to child continues to be a thematic priority area in the prevention component. PMTCT was one of the areas of intervention which expanded quickly during the implementation of the PEN II.

Challenges

Although there is recognition of the rapid expansion of the prevention of vertical transmission (PMTCT) in the last few years, the main challenges are connected to the fact that children continue to benefit less, due to a low level of awareness in families and companions; the current insufficient access to ARVs for eligible pregnant women at ANCs; insufficient use of maternity hospitals, which would facilitate contact with women; insufficient coverage of PMTCT services; incomplete coverage of ARVs for children and poor follow-up of exposed children; the inconsistent adoption of safe breast-feeding practices; fragile inclusion of the family, male partners and other key decision makers in the family; insufficient control of the quality of data in the area of monitoring, and a low level of standardization of indicators; very little practice of operational research development and program evaluation in Maternal and Infant Health {39}.

Strategic priorities

The strategic focus in this area is aimed at securing an appropriate and holistic provision of quality PMTCT services for all women of reproductive age, and for their children, as well as their follow-up at family and community level, so as to reinforce adherence. This objective will be achieved by designing and implementing community interventions aimed at improving the perception of the importance of PMTCT for the health of the mother and the child, and the impact of the survival of the mother on the family's well-being, mainly in the education of children, and by facilitating the integration of PMTCT/ARV/IMAI topics into the pre-service training curriculum for basic MCH nurses, so as to increase quality access; reinforcing the link between the NHS, families and the community by being aware of and discussing social and cultural practices, including the systematic link to the National Health Service, with actions tending towards the 'empowerment' of women, such as groups of mothers as a way of reducing the feminization of HIV and improving the PMTCT; initiating ARV treatment in eligible children for the treatment of seropositive mothers; to reinforce the integration of PMTCT with SSR components such as family planning and post-natal consultation; reinforcing counseling for safer maternal breast feeding, especially during the post-natal period; defining ways in which men, mothers-in-law and elders of repute, traditional practitioners and PMTs can be involved, as well as improving coordination between several health unit sections, so as to increase access to PMTCT for pregnant women and the regular follow-up of exposed children in CCR consultations; revitalizing the processes of regular supervision for training purposes, including the updating of supervision instruments, and the definition of activities and guiding standards for supervision. Food and nutritional support for women in PMTCT and children must deserve special attention, because they contribute to the program effort towards adherence.

IV.2.7. Biosafety

Unchecked blood and its derivative products, the use of contaminated cutting materials and the absence of basic precautions constitute sources of HIV-infection in Mozambique. Only 36% of blood

banks perform qualitative checking of blood. Besides incidents involving contaminated injection material, exposure to physical body fluids, insufficient protection equipment and non-compliance with basic precautions constitute exposure risk factors at the work place {65}.

Challenges

The analysis of progress achieved during the PEN II noted that there is still a need to ensure the safety of blood which is transfused in health units at district level through the availability of reagents, improvement of infrastructure, availability of centralized systems for sterilization in provincial, general and district hospitals, and of individual protection equipment. In addition, there is a need to tackle the insufficiency of kits for testing, collection and conservation of blood and its by-products; a low level of implementation of rules on Post-Exposure Prophylaxis and poor notification and follow-up of the incidences of exposure to HIV, as well as the lack of capacity of Laboratory Technicians to counsel blood donors who are detected as being HIV positive {25}. It was equally noted that there is a lack of availability of blood banks in all of the health units; that many emergency blood transfusions take place outside of the blood banks and that sometimes health units without blood banks perform blood transfusions without testing {39}.

Strategic priorities

Strategic action aimed at facing up to the constraints is directed at the regular supply of individual protective equipment to health units and the increase of the capacity and quality of infrastructure and equipment for testing, collection and conservation of blood and its by-products; ensuring centralized sterilization systems in the provincial, general and district hospitals; expanding the implementation of PEP in health units, and improving PEP notification and follow-up; notifying blood donors of any identified infection, and facilitating opportunities for blood donors to access pre- and post-test counseling, care and treatment. Additionally, priorities must include the training of those performing circumcisions and TMPs, as regards asepsis, to improve information and education in families and the community, for protection against the use of cutting objects on the body for decorative purposes, or for treatment.

IV.2.8. Prevention of HIV at the workplace

HIV and AIDS is a threat to the productive sector of the economy of the country. In both the public and private sectors, occupational vulnerability linked to factors such as professional mobility, sexual harassment, occupational risk, resulting from a lack of safety conditions, and risky behaviors, expose the worker to HIV {64}. Highly mobile civil servants, drivers, uniformed populations, migrant workers (especially miners), and health workers are prone to HIV infection because of the specificity of their profession and the vulnerability which it can bring {65}.

Challenges

The response to HIV in the work place is still not consolidated. In the public sector, it started with the PEN I and was enhanced by the PEN II, but even now, not all sectors integrate HIV and AIDS into their cycles of periodic planning {64}. In the private sector, the response started during the PEN II, and although the number of companies with HIV programs at the workplace has increased, the process of approving and applying HIV and AIDS Policies still remains a challenge, since some managers are afraid

that the cost of interventions to be undertaken by companies (especially small and medium enterprises), might limit its capacity to generate profits {64}.

Strategic priorities

Priorities are aligned with the choices made in the Public Sector HIV and AIDS Response Strategy for 2009-2014 and in the EcoSIDA Strategic Plan for 2005-2010. For the reduction of infections, both documents give priority to prevention outreach programs and the control of the risk of HIV-infection resulting from professional activities; programs aimed at behavior change, with greater focus on the reduction of concurrent partners; the promotion of counseling and testing activities; the improvement of logistical capacity and the distribution of condoms at the workplace, especially for workers with higher professional mobility, and a greater involvement of infected workers in the implementation of prevention actions.

IV.2.9. Communication for social and behavior change

Although the importance of communication for the efficiency of the response is recognized, its contribution is still not at the desired level. An assessment done in 2004 on the installed capacity for communication for HIV and AIDS in the Country, noted that most interventions were fragmented, the objectives and target group were not clearly defined, and that the level of coordination was insufficient. So as to respond to the high level of fragmentation of communication activities, a National Strategy for Communication was designed in 2005, based on a participative methodology, and was implemented in 2006. {9, 56}

Challenges

The main challenges in the area of communication relate to the fact that interventions and messages are very much centered on the individual, while his / her behavior is determined by a chain of values and standards of life in society. In addition, the involvement of the recipient of the message, of families, communities and people of repute, such as TMPs, and of community leaders and initiation rites counselors, has not reached the desired level, which translates into a low level of suitability of messages {57-60}. In parallel, there is lack of evidence on the impact of the work done in the area of communication in the country {56}. Regarding the content of communication, there is still insufficient connection between preventive messages and cultural and social concepts which predominate in families and communities (with divergent understanding of the possible causes and types of transmission or diseases); educational messages regarding biological transmission are disseminated without these messages being linked to notions of social contamination (violation of taboos), which are often confused with AIDS symptoms, which delays testing, prevention and treatment, and the non-consolidation of use, in preventive messages, of language which is culturally and contextually acceptable to families, for talking about sex, blood or death {61, 62}.

Strategic priorities

In terms of approach, priorities must be directed at combining different communication methods (interpersonal, mass media and social mobilization); at promoting communication which involves, in an active and participative manner, traditional authorities, TMPs, matrons and counselors / those

responsible for female and male initiation rites; at involving PLWHA in communication activities; and at stimulating a balanced investment in mass communication and in localized, participative communication. In terms of content, communication must address the patterns which are driving the HIV epidemic in Mozambique; considering, in an integrated manner, the individual, family and social dimensions of behavior change, and social standards; creating favorable environments which promote frank and open family dialogue on HIV and AIDS between men and women, between generations and between different cultural stakeholders; implementing initiatives genuinely produced by communities; involving political, community and religious leaders as positive role models, in campaigns; stimulating studies on gender dynamics in communication approaches for prevention; strengthening multimedia mobile units; promoting the ongoing monitoring of communication interventions and the evaluation of the impact of these initiatives, so as to produce evidence of success, and to stimulate investment in the expansion of best practices.

IV.2.10 Results Matrix – Prevention

Impact of the Component	**Reduced prevalence of HIV in 15 to 24 year old pregnant women by 25%, from 11.3% in 2007 to 8.5% in 2014**

Area	Results	Output
1. Counseling and Testing in Health	1.1 Increased proportion of women and men who know their HIV status	1.1.1. Increase the number of women and men counseled and tested in each of the types CTH, PICT, HPICT and CCT
		1.1.2. Increases the proportion of Health Units which have space for PICT activities and psychosocial support
2. Condoms	2.1. Increased rates of consistent use of female and male condoms	2.1.1. Increase in the % of men and % of women older than 15 years of age who report the use of condoms (male and female) in their last sexual encounter with non-regular partners
		2.1.2. Increase in the % of young people younger than 15 years who report the use of condoms in their first sexual encounter
		2.1.3. Increase in availability of female condoms
		2.1.4. Technical and logistical capacity created to respond to the growing demand for condoms, including the demand for female condoms by women's organizations and by women
3. High Risk Groups	3.1. Increase in the proportion of sex workers who consistently use condoms	3.1.1. Specific prevention programs available to sex workers and their clients
	3.2. Increase in the number of sex worker clients who consistently use condoms	3.2.1. Sex workers' clients covered by programs on individual behavior change, through peer educators
		3.2.2. Sex workers covered by communication skills programs for safe sex negotiation
	3.3. Increase in high risk populations who know their status	3.3.1. Increase in the % of men and % of women older than 15 years who have already undergone an HIV test and know their status, particularly among populations at high risk (sex workers, men who have sex with men, truck drivers, miners, seasonal and other workers)
		3.3.2. High risk populations undergo testing, receive results and know their results (disaggregated by sex and risk groups)
		3.3.3. Increase in the % of patients who undergo HIV tests, who have been referred by traditional medical practitioners
	3.4. Increase of the proportion of men who use condoms during sexual relations with another man	3.4.1. Men who have sex with men are covered by programs on prevention, adapted to their needs
		3.4.2. A baseline study carried out on the functioning of sexual networks involving men who have sex with men, and a follow-up study after 5 years
4. Early detection and treatment of	4.1. Improvement in the recording and notification of STIs	4.1.1. Improved coordination at all levels between MISAU, MINED and MJD, in order to increase the early detection and treatment of STIs in young people and adolescents

Impact of the Component	**Reduced prevalence of HIV in 15 to 24 year old pregnant women by 25%, from 11.3% in 2007 to 8.5% in 2014**

Area	Results	Output
STIs		4.1.2. Improved recording, notification and evaluation of STIs, including contacts
	4.2. Intensification of community awareness sessions on the early detection and treatment of STIs	4.2.1. Integration of communication activities related to STIs, in the HIV Communication Strategy
		4.2.2. Expansion and systematization of activities undertaken jointly with traditional medical practitioners and traditional midwives
		4.2.3. Increase in services, and service availability, for the diagnosis and treatment of STIs, for High Risk Groups
5. Male circumcision	5.1. Increased rates of male circumcision	5.1.1. Improved conditions of hygiene and HIV prevention in areas where circumcision is practiced as part of initiation rites in communities
		5.1.2. Increase in the number of men and women who opt for male circumcision for their children
		5.1.3. Increase in the proportion of men older than 15 years who are circumcised
	5.2. Increased number of newborns circumcised by health professionals	5.2.1. Health Units are able to carry out safe male circumcision
		5.2.3. Increase in the number of trained health workers carrying out circumcision in accordance with good practice standards
	5.3. Circumcised men keep on using condoms during sexual encounters	5.3.1. Increase in the proportion of men covered by communication programs, in the context of male circumcision
6. Prevention of vertical transmission	6.1. Reduced incidence of HIV in children younger than 2 years	4.1.1. All HUs with MCH services offering PMTCT
		4.1.2. Increase in the proportion of women counseled and tested for HIV during prenatal consultations
		4.1.3. Increase in the proportion of HIV-positive pregnant women who receive ARV prophylaxis, and of those eligible for treatment who receive ARVs
		4.1.4. Increase in sexually active HIV-positive women consistently using contraceptives
		4.1.5. Increase in the number of children from HIV-positive mothers with access to early diagnosis and / or testing for HIV, from 9-18 months
		4.1.6. Increase in the number of children born from positive mothers who receive prophylaxis with cotrimoxazole in their first 4-6 weeks of life
		4.1.7 Increase in the number of women who benefit from ARVs after delivery
	4.2. Increase in women adopting safe breast-feeding practices	4.2.1. Families and communities exposed to counseling and support programs for the improvement of nutrition and feeding for newborns

Impact of the Component	**Reduced prevalence of HIV in 15 to 24 year old pregnant women by 25%, from 11.3% in 2007 to 8.5% in 2014**

Area	Results	Output
	4.3. Increase in women adopting safe breast-feeding practices	4.3.1 Increase in the % of malnourished women in PMTCT who receive food and nutritional aid
		4.3.2 Increase of the % of exposed children who receive food and nutritional aid during the first 2 years
7. Biosafety	6.1. Reduced HIV transmission in health units through physical fluids and contaminated medical equipment	6.1.1. Increased number of health units with blood banks
		6.1.2. Health workers take basic precautions and use individual protective equipment
		6.1.3 HUs equipped with individual protective equipment and auto-claves for the sterilization of surgical and medical equipment
		6.1.4 Increase in the number of HUs implementing PEP in the HU
8. Prevention of HIV in the work place	5.1. Public institutions and private enterprises integrate HIV in their annual business plans and implement a coordinated response to HIV	5.1.1. Increase in the proportion of civil service and private sector workers using quality HIV prevention services, through HIV and AIDS programs in the work place
		5.1.2. Increase in the number of small and medium enterprises implementing complete HIV and AIDS programs in the work place, using their own resources.
9. Communication	9.1. Reduced proportion of girls and boys adopting risky sexual behaviors	9.1.1. Reduction in the proportion of young people aged 15-24 years who have had sexual intercourse with a man 10 or more years older
		9.1.2. Reduction of the proportion of boys and girls commencing sexual activity before the age of 15
	9.2. Reduced proportion of men and women involved with Multiple Partners	9.2. Reduced proportion of men and women involved with Multiple Partners
		9.2.3. Active participation of HIV-positive people in communication activities for behavior change

IV.3. Treatment and Care Component

The strategic interventions brought together in the Treatment and Care Component are centered around five areas of service provision which are mutually interconnected, including: the provision of care continuity services for HIV-positive patients not eligible for ARVs, as well as for those who start ARVs, so as to ensure that they abide by the prescribed measures; improvement of TB tracking in patients who are HIV-positive, and vice-versa, and the creation of prophylactic treatment measures for risk exposure cases, as well as ensuring nutritional, psychosocial and home based care support for eligible patients who need such support.

IV.3.1. Pre-ARV and ARV Treatment Follow-up

One of the determining factors for the quality of ARV treatment is the need for patient follow-up, before starting ARV treatment. Pre-ARV services include, inter alia, tracking for Opportunistic Infections (OI), prophylaxis and treatment of OI, determination of CD4 levels, nutritional education, preparation for ARV treatment and preventive action so as to avoid re-infection or the propagation of HIV, and counseling and psychosocial support.

The ARV expansion strategy in place in Mozambique is fundamentally directed at the decentralization of services to peripheral areas, and the integration of various HIV and AIDS components in the area of prevention, as well as the provision of assistance to HIV and AIDS patients. This measure contributes to the reduction of stigma and in parallel promotes a reorganization of services and the maximization of human, physical and material resources, which in its turn, creates space for a global improvement in the performance of the Health System {28}.

Challenges

The pre-ARV and ARV treatment programs face serious operational challenges, from improvement of the quality of treatment, to the continuous expansion of the services offered. Other socio-economic and structural factors influence nutritional parameters, which most of the time are not tracked, which affects the quality of the ARV treatment. Entry into the ARV program in an advanced stage of the disease has contributed to high early mortality and the appearance of resistance to antiretroviral drugs.

The WHO has launched new standards for pediatric ARV treatment, which have been adopted by the MISAU, and which imply that their health system should be adjusted, in light of the dilemma involving the current state of conditions in the network of infrastructure, materials, and qualified personnel, and the need for expansion to difficult access areas in the country. The same challenges are applicable to ARV treatment in adults, since there are currently new standards, which were authorized in 2009. The challenge is how to expand the provision of quality ARVs for children and adults, taking into account the changes in available technical personnel, the need for ensuring the appropriate training of health providers regarding an integrated approach to infant diseases (IAID), and for adolescents and adults (IAAAD), the transfer of management responsibility to technical personnel with lower academic levels, and the extension of service hours.

As an integral part of the priorities recommended by the WHO, the tracking of nutritional status for all PLWHAs as well as the ensuring of the consumption of macro- and micro-nutrients, are notable, since the coexistence of HIV and malnutrition quickly aggravates the patient's situation. As such, one of the challenges will be to ensure tracking, counseling and nutritional support for PLWHA eligible for ARV treatment[14].

Over time, given the chronic nature of AIDS, an increase in the number of people receiving treatment will be inevitable and along with it the number of complicated cases to be managed at these levels will continue to increase due to abandonment, weak adherence and side effects, and / or due to therapeutic failure – which may create space for more failure. In addition, it is recognized that the success and quick recovery of PLWHA depends on the provision of adequate nutritional support. Meanwhile, the level of coordination between civil society organizations and government authorities able to contribute to this last component, is still very weak.

Strategic priorities

Without sacrificing the quality of treatment and care, intensifying the process of transferring the handling of ARV tasks to technical personnel with lower academic level, is one way to expand treatment and care beyond the district, along with the inclusion of the handling of CTH and ARV treatment in pre-professional training, and in on the job training for all targeted technical personnel. The management of ARV treatment in the context of an integrated approach to pediatric diseases (IAID), and for adolescents and adults (IAAAD) must be reinforced.

So as to continue to guarantee the implementation of an integrated pediatric package, which includes strong psychosocial support for the child, the provision of support to parents and supporting people, and above all, the creation of awareness regarding adherence to ARV treatment and care. In the cases where this is not possible, the minimum pediatric package {69} must be used as a basis, and expanded into health centers. The identification of the HIV positive child must be extended beyond the mother herself and must include other caregivers, such as elderly people.

The strengthening of coordination between health providers and civil society in the promotion of adherence to treatment, in divulging the importance and advantages of pre-ARV and ARV treatment services, in jointly assessing service quality, and in the active search for non-compliant PLWHA receiving ARV or OI treatment, should be guaranteed. The search system must especially include patients defaulting on appointments for OI/pre-ARV treatment and for ARV treatment. Equally important are support visits to patients who are at risk of poor adherence, detected during counseling or other medical consultations. These strategies must involve the PLWHA, so that they can create social change at individual and social level. Since many patients seek traditional medical services, it has become important to obtain an understanding of the mechanisms for referring patients between traditional and conventional medicine.

[14] A study undertaken in 33 districts involving 922 people on ARVs, found that 25% had a Body Mass Index (BMI)below normal (less than 18,5 kg/m^2) and 2/3 of the interviewed were in state of vulnerability and food insecurity {68}

There is equally a need for continued capacity building for health personnel in the understanding and application of tracking parameters for PLWHA with malnutrition. Nutritional counseling, food and nutritional support for eligible people, and the monitoring of its impact and cost-effectiveness, are vital for quality treatment. Integral sensitization programs for PLWHA on good food habits, based on accessible products, must be an integral part of the counseling and psychosocial support action.

IV.3.2. HIV-Tuberculosis Co-Infection

Tuberculosis (TB) constitutes a serious problem for public health in Mozambique, and its association with the HIV and AIDS epidemic is one of the biggest challenges in the fight against this disease. In regions where the scourge of TB/HIV is more frequent (the center, and the south), TB is seen as being caused by the non-observance of traditional rules, which forces many people to first seek treatment from traditional medical practitioners, a fact which can contribute to a delay in receiving health services, and an increase in the spread of cases {70}.

Challenges

The main challenge for the health system is the timely diagnosis of TB in all patients with HIV, and of HIV in all patients with TB, and the consequent immediate and appropriate handling of TB/HIV co-infection cases. At the moment, the TB Program lacks extensive integration into the general health services and as in the case of HIV, the mechanisms for its effective integration need to be better defined. The intensification of the diagnosis of TB cases, the provision of PTI and measures for the control of TB infection, by the HIV program, continue to be very weak and need to be boosted.

The high incidence of TB in HIV-positive people, which complicates the treatment of these cases, in addition to the advent of more cases of multi-drug-resistant TB increases the complexity of prophylactic efforts and of existing treatment. Recently several clinical providers have been recording an increase in the scourge of TB/HIV, which poses the challenge of ensuring the regular tracking of this target group. Last but not least, there is a low level of involvement by traditional medicine practitioners in TB tracking and referral activities.

Strategic Priorities

Just as HIV services have been integrated into the basic PHC structure, so the TB services should take similar steps. Collaboration between the TB and HIV programs must be strengthened at all levels. At the same time while investment is being made into increasing the systematic TB tracking mechanisms in all HIV positive patients, and TPC strategies are being enhanced, the HIV program must intensify TB tracking and establish PTI strategy on a larger scale.

There is a need to establish a "one stop" approach for patients undergoing TB and ARV treatment[15], and to give priority to TB/HIV patients who receive treatment in the TB ward. The development of community interventions and those extensive to the family must be stimulated, with the aim of securing the improvement of the capacity to search for cases in residences, and to identify non-

15 A mechanism through which TB/HIV patients on treatment are attended to in the same place and by the same health worker, so as to allow for a better synchronization of treatment and so as to timeously make adjustments for interactions and side effects, and intimate monitoring

adhering patients.

Equally, it is imperative to sensitize health providers, as a high risk group, to the need to take regular TB and HIV tests, as a mechanism for early tracking. Capacity building for traditional doctors on diagnosis, sensitization, for the early sending of patients with TB to Health Units, and their involvement in the drug administration strategy under direct community observation, which will contribute to the promotion of patient adherence to treatment, is all urgent.

IV.3.3. Home Based Care and Support

As of now, home based care[16] and support services have not been provided systematically, especially in response to efforts based on opportunity and needs. The need for home based care is vast, and evolves quickly over time. With the considerable expansion of ARV treatment, home-based care providers will need to increase support initiatives for the prevention of and counseling on HIV and AIDS, adherence to medication, and a reference system, besides providing mere palliative care and psychosocial support, and psycho-spiritual visits.

The policy of the Ministry of Health entails that home based care must be offered as part of continuity of care, in order to improve the quality and extent of the life of the people with chronic diseases, through community initiatives. The essential home based care services defined in Mozambique {73} include: clinical care (adherence to treatment, reference to Health Units, evaluation and possible handling of OIs, nutritional evaluation and clinical follow-up); the provision of preventive and promotional services; psychological care; spiritual care, and the provision of social services, including legal, social and food support.

Challenges

The role of an organized community has a significant impact on the success of care offered to patients with chronic illnesses, including by their families {74}. Nevertheless the challenge relates to the establishment of standard mechanisms for the transfer of this knowledge from official institutions (the Ministry of Health, the Ministry for Women and Coordination of Social Action, and coordination and implementation partners) to communities. In addition to this challenge, the following challenges are also noteworthy: (i) a lack of qualified focal persons throughout the DPS and SDSMAS; (ii) lack of implementation of directives on how key stakeholders must act, how to interact with public services, up to what level of care may be offered in the community, and how to conduct referrals to the public network; (iii) in Mozambique, several organizations have been involved in the provision of care in the context of HIV and AIDS and other chronic diseases, a fact that contributes to difficulties in the coordination and harmonization of their activities; (iv) weak supervision and monitoring of NGOs and their activists involved in home based care; (v) heavy dependence by national and international partners on the provision of home based care by civil society organizations, without clear sustainability mechanisms; and (vi) the low involvement of men in voluntary unpaid work.

Strategic Priorities

Taking into account the complexity of home based care and support, the government, partners and civil

16 Care is hereby defined as a service provided at the home of a PLWHA or those of persons with other chronic diseases and their families {71, 72}

society should concentrate their actions on the following aspects: (i) Developing and executing home based care policies that define rules and areas of action for NGOs and CBOs, prioritizing those places which the public health network does not cover; (ii) Establishing mechanisms for accrediting NGOs and CBOs promoting home based care; (iii) In line with home based care policies, preparing a capacity building curriculum for NGOs and CBOs on home based care, where standards of competence and proficiency are set for activists or volunteers providing care in the community; (iv) Guaranteeing that the already existing training manuals are used by all stakeholders; (v) Providing the DPS and SDSMAS with qualified home based carers and support, which will be key to normalizing and monitoring the process of home based care and support undertaken by the organized community; (vi) guaranteeing the greater involvement of men in activities connected and associated with home based care, setting up dialogue in order to promote the analysis of social and gender roles; (vii) Encouraging NGO and CBO partners to undertake capacity building activities in families with chronically ill patients, so as to establish income generation mechanisms; (viii) implementing referral mechanisms for various services, which are appropriate for the patient and / or family (such as health, social services, food support and nutritional programs, assistance and access to legal services, positive prevention programs, family planning programs and others); (ix) undertaking capacity building in NGOs and CBOs, relating to the transfer of skills to members of families with chronically ill patients, as a way to ensure that they undertake nursing care, and attend to hygiene, positive living, food / nutrition, emotional support, the prevention of infections, and referral and connection to the health network. Capacity building action to be undertaken by civil society organizations must also include awareness strategies, so as to increase adherence to treatment, for individuals on ARVs; (x) Defining, standardizing and providing kits for home based care, including protective equipment for HIV and AIDS assistance providers; and (xi) conducting operational investigations which help to better document the benefits of HBC.

IV.3.4. Results Matrix – Treatment and Care

Impact of the component	Mortality by AIDS reduced by 5%[17] in 2014, as compared to what would have happened without the additional interventions proposed in this plan{10}

Area	Result	Output
1. Pre-ARV follow-up and treatment of OI	1.2. More PLWHAs benefit from follow-up in the health services, before starting ARV treatment	1.1.1. Increase in the number of HIV+ patients followed in the HUs
		1.1.2. Increase in the proportion of HIV + women and men not on ARVs who are followed in the health services, who have received treatment with cotrimoxazol.
2. ARV Treatment	2.1. Increase of HIV + children and adults on ARVs	2.1.1. Increase in the proportion of eligible children who start and adhere to combined anti-retroviral drug therapy
		2.1.2. Increase in the proportion of eligible adults who receive combined anti-retroviral drug therapy
		2.1.3. Increase in the number of HUs which offer ARV treatment
		2.1.4. Increase in the proportion of HUs with active quality control systems
	2.2. Increase in adherence to treatment	2.2.1. Increase in the proportion patients on ARVs that have had an adherence evaluation in the last 12 months
	2.3. Increase in the number of malnourished patients who improve their nutritional status	2.3.1. Increase in the number of patients (adults and children) who start ARV treatment, who have had their nutritional status assessed (from 2010)
		3.3.2. Increase in the proportion of HIV + children, women and men on ARVs with malnutrition, who receive food and nutritional support
3. HIV-Tuberculosis Co-Infection	3.1. Increased successful treatment of PLWHAs with concurrent tuberculosis infection	3.1.1. Increase in the proportion of women and men with TB counseled and tested for HIV
		3.1.2. Increase in the proportion of HIV + patients who underwent a TB check during their last consultation
		3.1.3. Increase in the proportion of HIV + individuals who benefit from prophylaxis with isoniazide
		3.1.4 Increase in the proportion of TB / HIV patients who commence ARV and tuberculostatic treatment
4. Home based care and support	4.1. Increased number of individuals benefitting from home based care and support through own community initiatives	4.1.1. Increase in the number of HIV+ women and men (including children) receiving HBC

[17] This 5% reduction implies that nearly 23.000 deaths due to AIDS will be avoided, in comparison with what would happen without the additional interventions proposed in PEN III. However, this result must be interpreted with caution since it is based on mathematical projections (Spectrum).

IV.4. Impact Mitigation Component

In the context of the implementation of PEN III, the mitigation of the effects of AIDS is directed at the reduction of consequences for PLWHA, Households (HHs), Orphans and Vulnerable Children (OVCs), communities and institutions, through initiatives that aim at guaranteeing basic support for Orphans and Vulnerable children (education and life skills, health, food, financial and psychosocial support); guaranteeing food and nutritional security and reinforcing the income-generating capacity of families; securing protection of the rights of PLWHA and of other vulnerable groups, such as women, the elderly and disabled people infected and affected by HIV and AIDS; and building bases for evidence on mitigation, so as to inform the development process for policies and programs.

IV.4.1. Orphans and Vulnerable Children

In caring for orphaned children, the Government has prioritized social and family integration for those who are abandoned. The National Strategic Plan on Support for Orphans and Vulnerable Children (PENOVC) {33} identifies 13 categories[18] of vulnerability, any one of which would be sufficient to consider a child vulnerable. The MMAS will fulfill its role of defining and coordinating the implementation of policies for OVCs in a broader context, in coordination with other social sectors, whereas the CNCS, through the PEN III, will concentrate on OVCs in a limited sense: orphaned children, infected and affected by HIV and AIDS.

Mozambique recognizes the need for providing support and assistance to OVCs, via basic services[19], and has formulated the PENOVC (2006-2010) {33) which defines a set of strategies and priority action, coordinated by the MMAS, aiming at offering a multisectoral response to OVCs in the context of HIV and AIDS. The objectives of PENOVC include (i) the creation of a protective environment, conducive to the reduction of the impact of HIV and AIDS on OVCs and (ii) the strengthening of the capacity of families and communities to find local solutions for the protection and care of OVCs. The Demographic Impact Data on HIV and AIDS {10} highlights the existence in the Country of 453,000 orphaned children, due to AIDS, in 2009. The coverage of assistance to OVCs, despite its growth, benefited only 28 % of the children who were in need of support during 2008{75}.

On the death of sick guardians as the result of AIDS, children begin to assume greater family responsibilities, roles that were traditionally played by extended family networks. In addition to children, grandparents are often forced to deal with the problems of their grandchildren. In this context, OVCs leave school because they have to help with domestic and agricultural work, girls being the first victims. Many orphans are subjected to being forced to work in exploitative situations, to being stigmatized, subject to violence, abuse and negligence, or forced to live on the streets. Limited psychosocial support, abuse by adoptive families and neighbors, and difficulties in accessing basic

18 The 13 categories of vulnerability are as follows: those affected or infected by HIV; those in households headed by children, women, youth or the elderly; in HHs where adults are chronically ill; street children; children in institutions (ex: orphanages and prisons); children in conflict with the law (eg: children wanted by the justice system for crimes); disabled people; victims of violence; victims of sexual abuse and exploitation; victims of trafficking; victims of the worst forms of work; children married before they reach the legal age; refugees and the displaced {33}

19 NSPOVC divided basic services into 6 categories: education, health, financial, nutritional, psychosocial and legal support

services all require direct intervention by government institutions and their partners, so as to reinforce the capacity of families and communities, with the aim of ensuring due care and protection for OVCs.

Challenges

Although countries with greater prevalence have strategies of support for OVCs, national programs are few and only cater for a minority of these children {43}. The challenge in Mozambique is to increasingly provide support, via basic services, to the nearly 80% of OVCs (82% in the urban area and 76% in the rural area) who still do not receive any type of support.

Of late, the establishment and strengthening of grassroots community organizations has been encouraged, for the provision of home based care and support to vulnerable families, recognizing the role of the elderly, and implementing action {76} to help the elderly with the provision of care to PLWHA and children. Meanwhile, poverty significantly limits the capacity of the families to confront the effects of HIV and AIDS {77}, and especially to protect children.

Strategic priorities for the support and protection of OVCs

With the aim of reversing the suffering of OVCs, it is urgently necessary to ensure that they access all of the necessary support, through effective integration in family and community networks stimulating the adoption of children and active community participation, so as to ensure long term sustainability. From this perspective, the role of women and the elderly in the provision of care to OVCs, must be recognized, and the process of child adoption speeded up. Strategic actions to be implemented aim at guaranteeing access to basic services, including food and nutrition; formal education and life skills; health; psychosocial and financial services and legal protection. Whenever possible, the active participation of children in the design of programs, and in the definition of targets, types of implementation and their evaluation, is essential.

IV.4.2. Nutritional and Food Security

The interaction between Nutritional and Food Security (NFS) and HIV and AIDS is obvious, and its strategic integration constitutes a key element in the response to HIV and AIDS.

Chronic malnutrition reduces productive capacity by 2-3% of GNP each year. The report (2004-2009) on the situation of Food Insecurity (InSAN) in Mozambique highlights the fact that the number of people affected by InSAN increased from 202,000 to 801,654 during the respective period. In spite of the efforts by the Government and its partners, data still indicates a worrying situation, in which climatic adversities play a significant role. The 2005 peak, for example, was essentially due to the occurrence of a severe drought {81}. According to MICS 2008, the percentage of children with chronic malnutrition is 44 % {2}. It is important to note that this data is generalized, and does not refer exclusively to PLWHA. The data on nutrition for the years from 2006 to 2008 shows that the rate of Low Birth Weight (LBW) increased slightly (10,1 in 2006, 10,2 in 2007 and 10,4 in 2008), and remains above the 7% limit considered to be acceptable. Rates of insufficient growth, in contrast, reduced significantly (5,4% in 2006, 4.3% in 2007 and 3.6% in 2008). The nutritional situation is still more critical when it concerns PLWHAs, their dependants and OVCs.

To try to respond to the adversities imposed by InSAN, the Government has created a Specific Executive Secretariat (SETSAN)[20], and has approved the Strategy on Nutritional and Food Security (ESAN) {81}. One of its objectives, in relation to InSAN, is to minimize the negative impact of HIV/AIDS on the productive system, food security and the life of people and communities.

Challenges

There is greater recognition of the importance of food and nutrition in the context of HIV/AIDS. Nevertheless, there are still some challenges for implementation, which include: (i) Limited clarity on concepts of nutritional interventions; (ii) a low level of empowerment in women – the main target of the epidemic - for wealth-production purposes, (iii) problems of fund disbursement, in order to support affected families in income generation; (iv) the existence of a multiplicity of short term food and nutritional support programs, which do not include long and medium term interventions, and are highly dependent on external help; and (v) a low level of coordination and M&E of various ongoing interventions.

Strategic priorities in the area of food security and nutrition

To intensify communication, so as to sensitize civil society organizations, including associations and networks of PLWHAs, so that they concentrate their efforts on the generation of income and on promoting the production and availability of food, raising nutritional standards and employing a broad-based approach which addresses the three-fold threat of poverty, food insecurity and HIV and AIDS. The Ministry of Agriculture and other sectors of production must boost joint efforts to coordinate food production. Action will need to be centered on (i) supporting agricultural and non-agricultural activities; (ii) promoting policies for social protection, so as to provide food, financial and nutritional assistance (iii) improving the formulation and implementation of policies for the agricultural sector.

IV.4.3. Legal Aspects

Legal instruments need to provide support and protection to vulnerable people, so that they can better face the effects of HIV and AIDS. In the context of property and inheritance rights, injustices are suffered, mostly by widowed women and OVCs, which range from social and economic exclusion, to exploitation and the expropriation of their resources. The creation of legal instruments reached an important landmark when Law 12/2009, on the Defense of Rights and the Combating of Stigmatization and Discrimination against PLWHA {82}, was promulgated[21].

Strategic legal priorities

The dissemination and appropriate enforcement of laws of this nature will contribute to the reduction of the vulnerability of PLWHA, women and OVCs, guaranteeing their rights of access to resources and services, and reducing stigmatization and discrimination. The promotion of the enforcement of laws of this nature, with greater dissemination in work places, health services, schools and communities, and

20 See Resolution 16/98 of 23rd December of Cabinet of Ministers

21 The following aspects are set out in Law 12/2009, inter alia : the non-compulsory character of HIV testing, equal rights for HIV and non-HIV children, the right to public services, heavy penalties for those who deliberately infect someone, all of which are fundamental aspects contained in this law.

the guaranteeing of the existence of communication channels which facilitate whistle blowing and the channeling of solutions, in cases where standards are not complied with, must be prioritized.

IV.4.4. Research in the area of mitigation

The low level of investigation and documentation in the area of impact mitigation {83}, and the scarce systematization of existing data limits knowledge of the results of programs implemented in the country, and reduces the possibility of taking appropriately substantiated decisions. Nothing has been recorded regarding the impact of the 1,543 sub-projects financed by the CNCS, which involved 11,302 households and 450 organizations, supporting 74,500 PLWHAs throughout the country, during 2008 {84}. Promotion of research, with the aim of enlarging national knowledge on best intervention practice, as regards impact mitigation, must be encouraged.

IV.4.6. Results Matrix – Impact Mitigation

Impact of the component	**Reduced proportion of households, communities and OVCs affected by the impact of AIDS[22]**

Area	Result	Product
1. OVCs (orphans infected and affected by HIV and AIDS)	1.1. Basic services secured for OVCs (education, health, financial support, food and nutritional support, psychosocial support)	1.1.1 Increase in the proportion of OVCs whose families received free basic child care support
		1.1.2. Increase in the number of OVCs adopted or taken into care by relatives
		1.1.3. Increase in the number of OVCs receiving psycho-social support
		1.1.4. Reduced rate of effective dependence[23] in OVCs families
	1.2. Increased proportion of OVCs that enrol in schools (primary, secondary, technical and professional) and graduate.	1.2.1. Increase in the proportion of OVCs graduating from life skills development initiatives
		1.2.2. Increase in the proportion of schools (primary and secondary level) that create life skills development initiatives
	1.3 Strengthened community actions in support of OVCs, with the involvement of local leaders and other influential people in the society (religious leaders, elders, AMETRAMO, and others)	1.3.1. Increase in the proportion of heads of households who have identified a guardian to take care of their children if they do not manage to take care of them
		1.3.2. Increase in the number of community organizations which have received support for assisting OVCs via basic services, by the type of support received: (i) food, (ii) financial resources, (iii) training on psychosocial support/vocational skills and (iv) others
		1.3.3. Increase in the number of organizations that implement community initiatives, and take care of OVCs, by type of support: (i) nutritional planning; (ii) skills training, (iii) psychosocial support and (iv) a referral system for health, educational support, and money
		1.3.4. Increase in the number of adoptive families, family networks and community support structures which include OVCs
		1.3.5. Increase in the financial, material capacity and psycho-social skills of people who take care of OVCs and PLWHA, with special attention to women and the elderly, as a way to provide better services
	1.4. Increased proportion of OVCs with secured legal rights	1.4.1. Reduced number of OVCs (0-17 years) that live without family care
		1.4.2. Increase in the number of children that have documentation which allows them to have access to basic services
		1.4.3. Increase in the number of registered OVCs
		1.4.4. Legal framework that allows access to inheritance for young children or those having immediate needs
2. Households (HHs) affected by HIV and AIDS vulnerable to Food and Nutritional	2.1. Reduced proportion of HHs affected by HIV and AIDS vulnerable to InSAN	2.1.1 Increase in the number of vulnerable HHs affected by HIV and AIDS involved in food production and income generating programs
		2.1.2. A reduction in the lack of food reserves by a period of at least 4 months a year in HHs affected by HIV and AIDS
		2.1.3. Increase in the number of HHs affected by HIV and AIDS with appropriate food

[22] This result should be measured through (i) a baseline study, so as to evaluate indexes (ii)the Millennium Development Goals and (iii) Monitoring of Food and Nutritional Status

[23] Rate of dependence: relation between productive and non-productive force (and by implication, the availability of manpower)

Impact of the component	**Reduced proportion of households, communities and OVCs affected by the impact of AIDS[22]**

Area	Result	Product
Insecurity (In-NFS)	2.2. Increased nutritional standards for people infected and affected by HIV and AIDS	2.2.1. Reduced rates of chronic malnutrition in members of HHs affected by HIV and AIDS
	2.3. More HHs affected by HIV and AIDS with improved health conditions	2.3.3. Reduced number of members with health problems associated with nutrition in HHs affected by HIV and AIDS
		2.3.4. Increase in the proportion of PLWHAs and their families with a right to a basic food basket for a period of at least 6 months, while connected to a sustainable micro-project for income generation and the promotion of food production
3. Response capacity of PLWHA and Households	3.1 Ensured legal rights of PLWHA, and of AF vulnerable to HIV and AIDS	3.1.1. Well-adjusted and publicized legal instruments created, which prohibit stigma and protect against acts of violence against people infected and affected by HIV and AIDS, especially the elderly, disabled people and women.
		3.1.2. Increase in the number of those infected and affected by HIV and AIDS, especially the elderly and disabled people, with access to judicial services when they need them
		3.1.3 Increase in the proportion of people infected and affected by HIV and AIDS, especially the elderly, women, disabled people, who are aware of and enjoy their rights
	3.2. Reduction of stigma and discrimination against PLWHA and AF affected by HIV and AIDS	3.2.1. Increase in the proportion of PLWHAs and HHs infected and affected by HIV which benefit from the actions implemented in order to mitigate the effect of HIV/AIDS, as stated in laws and regulations
		3.2.2. Increase in the proportion of people expressing receptive attitudes (non-discriminatory, and non-stigmatizing) in regard to infected persons, and HHs affected by HIV/AIDS
		3.2.3. Uniform identity card for those who are ill, so as to avoid distinction of PLWHA
	3.3. Men and women infected and affected by HIV and AIDS exposed to the same social, economic and political opportunities, at family, community and national level.	3.3.1. HIV/AIDS infected and affected men and women with equal access to resources and services as the non-vulnerable
		3.3.2. Increase in the number of resolved cases of violation of rights
		3.3.3. Communication channel created and disseminated for the reporting of violations of rights
4. Evidence in the area of mitigation	5.1. Improved database in the area of mitigation of HIV/AIDS effects	5.1.1. Increased research into the area of mitigation of HIV/AIDS effects
		5.1.2. Increase in the undertaking and publicizing of impact assessment studies on the interventions undertaken, and above all on the integration of results into the emergency and development program

g) PEN III Support Component

V.1. Coordination

Since the creation of the CNCS, the Government has adopted a multisectoral response approach to HIV and AIDS, which entails greater involvement of several sectors of the society, with the CNCS as the main coordinating body, as illustrated in the picture presented in annexure 1. The analysis of the nearly ten years of existence of the CNCS indicates that the role of this central body, to whom the function of coordination fell, ended up being diluted by its other functions, such as the management of grants for implementing bodies, which is common practice in coordinating bodies in the AIDS response throughout the world. This function, which is central to action directed at results, requires resizing, with a clear indication of the competences and attributes of the various stakeholders in the response.

In order to ensure the efficiency of coordination efforts, it is imperative to establish mandatory rules regarding the respecting and following of information flow systems; compliance with strategic priorities defined by the Government, and inclusivity and sole leadership, for all stakeholders in the response. The rhetoric of the Three Ones (One Coordinating Body, One National Strategic Plan and One Monitoring and Evaluation Plan) is not sufficient for this purpose - it must be materially translated and factually practiced. At the same time, it is recommendable that circuits for the coordination of the objectives and processes which the response to AIDS entails are established and maintained between the government and its partners, at all levels – national, provincial and district.

Equally, Partners' Forums, as well as the thematic technical groups coordinated at the level of the CNCS, are privileged places for dialogue and coordination, since technical representatives of several national and international partners participate. Consolidation of dialogue and coordination, including articulation between central, provincial and district levels, is fundamental to coordination which reinforces the principle of the Three Ones at national level. Interconnection between these groups and other similar groups, which deal with the treatment of HIV and AIDS at sector level, is necessary so as to reinforce the coordination efforts between the CNCS and several sectors. The search for a realistic commitment from international partners is fundamental, in this extent, so as to better extract benefits, for the reinforcing of the national response, from International Declarations used as a reference for development assistance (Paris Declaration (2005) {85).

Meanwhile, the recognition of the fact that the institutionalized national response is also implemented at provincial level, demands, on the one hand, the optimization of this system in the provinces, and a clear positioning of the coordinating function at the district level. In this area of territorial administration, it is recommended that the coordinating body explore Law 8/2003, which sets out the principles and standards of organization, competences and functioning of local State organs. To that end, while giving momentum to the role of the district in the planning of socio-economic and cultural development, this law allows for the local formulation of Strategic District Development Plans (PEDD) and District Socio-Economic Plans and Budgets (PESOD), in which HIV and AIDS is treated as an issue of relevance to all. As such, these available mechanisms, at district level, must be capitalized on, so as to enable the integration of HIV and AIDS and the coordination of the actions of multiple actors and sectors intervening in the response to HIV and AIDS at the provincial and district level.

The role of the CNCS, as leader and coordinator of the multisectoral response needs to be reinforced, through clear policies and organizational set-up at all levels of response – national, provincial and district, so that the convergence of efforts in one direction and under one command can be properly structured and improved. The above-mentioned clear policies and organizational set-up should be reflected in the strengthening and institutional development of the body, and in its extension to provincial and district levels. The current realignment of this body, so as to be wholly dedicated to the coordination and facilitation of the response, is an opportunity to be taken advantage of, from the first moments of existence of the PEN III. The exercise of this main function is incumbent, in the areas of coordination, monitoring and evaluation, and communication, on showing improvements in the following strategic interventions:

Strengthening of multisectoral mechanisms of coordination at all levels, so as to secure a coherent, objective and cost-efficient response, aligned to all of the strategic HIV and AIDS response directives and guidelines in the country; facilitation and harmonization with different sectors (state and non-state), and the alignment of its operational plans with the National Strategic HIV and AIDS Response Plan, on several levels; articulation with international partners, and the adjustment of agendas and platforms for technical cooperation and financial support in the area of HIV and AIDS, to the strategic priorities of the Government; investment in more integrated coordination systems, from design, to program implementation, at all levels; strengthening of communication systems with partners and response beneficiaries; recognition and use of communication as an important instrument of advocacy and management.

V.2. Monitoring and Evaluation

The NSP III has adopted a results-based management approach for the national response. Management based on results presupposes three basic aspects: measures based on results, implementation based on results, and planning based on results. Hence, the M&E system must reinforce this overriding principle.

It worth underlining the persistent challenges in the component of M&E, which include: (i) The fact that most of the implementation indicators (input, process and output) still do not have baselines, which hampers the monitoring process; (ii) Lack of data for the calculation of some indicators, especially those related to communication, high risk populations and community interventions, such as home based care, psycho-social support and community CTH; (iii) Reduced use of data, divided by sex, in spite of the relative increase in the volume of data; (iv) Weak support mechanisms for personnel in the health services, who are already overloaded with other public service duties, hence limiting the quality and quantity of epidemiological information and information on activities gathered in the HUs; (v) A low level of commitment by multiple actors involved in the national response to HIV and AIDS, as regards the gathering, sharing and processing of M&E data, which must feed the single national M&E system; (vi) Weak collaboration by national and international partners in regular reporting , in accordance with the required frequency, in addition to weak coordination activities in sectors, giving rise to a top-down approach and a duplication of efforts.

The strategic priorities in this component are: (i) the preparation of a budgeted Multisectoral Monitoring and Evaluation Plan for 2010-2014, which will contain indicators based on national and

international standards, which will allow for the quantification of the expected results of the PEN III; (ii) The mapping of data which feeds these indicators, from the baseline, and if necessary conducting baseline studies and gathering sufficient data; (iii) Coordinating with INE , so as to harmonize the research periods for the epidemiological and behavioral surveillance of populations (such as DHS, BSS, INSIDA), in order for this to serve as means of mid-term and final evaluation of PEN III; (iv) Structuring and harmonization of the functional chain of the monitoring component, allowing fluid intercommunication among stakeholders, so as to feed the single M&E system; (v) The promotion of training, follow-up and supervision, so as to ensure the objective evaluation of progress and constraints to the response, allowing the adoption of appropriate and timely corrective measures; (vi) The promotion of an intermediate evaluation, which allows for the updating and redirection of interventions; (vii) Definition of a mechanism which obliges all actors (coordinating and implementing) in the national response to provide programmatical and financial information on national response action; and (viii) Preparation of a plan aimed at strengthening HIV and AIDS data collection and reporting mechanisms, in all sectors, highlighting key sectors (health, education, women and social action, youth and sports, defense, interior, labor, civil service, justice and agriculture) and the network of civil society organizations, given their outreach potential for service provision.

V.3. Operational Research

Operational research constitutes an important component for the strengthening of the priority areas of this plan. It is a mechanism which informs the decision making process and guides the appropriate planning of response interventions. A systematic response to HIV and AIDS needs a systematic process of knowledge production and use, driven by a search for solutions most suitable for the epidemic profile. The strategic approach, for the research component, should be centered on promoting research and/or utilitarian action, which allows for an understanding of the different settings of the epidemic, and the improvement of interventions; research which demonstrates the impact of HIV and AIDS, documenting patterns, determinants and populations at risk, and response experiences, so that institutions can use these when developing programs.

In general, the implementation of PEN III should be based on evidence, and this evidence will be supplied by research. However, for this to take place, it is necessary that the cross-cutting nature of research as a tool for the planning and validation of interventions be recognized; that investment be made into the intensification of mechanisms which allow the sharing and use of knowledge; that networks be established through the MCT and the PNI Center for Management of Knowledge and Multimedia for the sharing of information and knowledge produced in the context of the implementation and operationalization of interventions directed at HIV and AIDS; to facilitate dialogue, through PEN III, for the promotion, dissemination and use of the knowledge obtained in the context of the national response, so as to provide a basis for interventions; to facilitate the allocation of resources for operational research, in the context of programs for behavior and social change, so as to understand what works and the results of behavior change; and to continue to promote the coordination, funding and enabling of research, through the National HIV and AIDS Research Program.

V.4. Approach to Communication

In a context of great ethno-linguistic diversity and multiple standards of epidemic behavior, communication should be structured, strategic and systematic, so as to produce effects which lead to

behavior change. So as to respond effectively to the above-mentioned behavioral factors or standards, different communication approaches (Advocacy, Community Mobilization, Interpersonal Communication, Mass Communication and the Promotion of Health Services) must converge into a shared vision of communication.

Effective communication must be based on presuppositions which explain how cultural and social standards determine human behavior, and how this can be affected by interpersonal and mass communication; formative research on target groups, so as to ensure the suitability of messages; using appropriate communication channels for specific objectives, and the participation of beneficiaries in the design, as well as in the pre-testing, ownership and use, of messages and communication materials, aligned to the strategic objectives defined for each one of the PEN III pillars, and in annual plans of activity which will need to be prepared subsequently.

In operational terms, the approach taken to communication should be centered on the observance of the following priorities and principles:

Strategic communicative action must be taken as an integral and generally applicable part of the PEN III and respective operational plans must be participatively developed with strict coordination between the CNCS and its partners, in light of the evidence and priorities identified for each period; the alignment of the strategic directions and directives conveyed by the Presidential Initiative, must be stimulated, with the main lines of action of the Communication Strategy being replicated on several levels, with special attention being paid to the mozambicanization of the message, and efforts should be catalyzed to activate appropriate mechanisms for the dissemination of messages based on the socio-cultural reality of each place of intervention, thus guaranteeing the mozambicanization of the messages.

Planned strategies should be orientated around messages directed at the construction of new social values and the adoption of safe behaviors; communication should be dynamized, using local languages and involving local figures, including PLWHA, by reconciling the use of different available linguistic instruments, for the correct placing of messages and the targeted public; the use of interpersonal communication and mass communication should be appropriately combined, in communication interventions; and the capacity of private sector institutions, civil society and community actors to conceive and implement programs of communication which are appropriate for their needs, should be reinforced.

V.5. Resource Mobilization

Political commitment should be expressed by way of the budgetary volume of the State Fund allocated to the AIDS response program, in a global manner. HIV and AIDS is a structural and development issue that demands ongoing, long term attention. Hence, the ensuring of the sustainability of the response to the epidemic requires the Government to reinforce the funding of the response, using domestic funds. This alternative should be reflected in the normal flow of resource endowments to sectors, so as to fund their HIV and AIDS response plans, as duly prioritized. In addition, so as to achieve universal access to sustainable HIV and AIDS services, there is a need, within the framework of the current strategy, for the development of scenarios regarding the predictability of resources in the medium and long terms

(fiscal scenarios). This exercise is of great importance for the improving of a directed and informed process for mobilizing resources, together with the international community.

The management of the response, at this level, also demands the disciplined planning and allocation of resources and their rational use, as well as follow-up and documentation, so as to guarantee the full provision of the services envisaged in the strategic orientations and areas of intervention contained in this plan.

As the Strategic Plan is an advocacy document, both for demonstration of the level of political concern and the philosophical orientation of countries in the response to HIV and AIDS, and for obtaining financial support for advocated actions, it is necessary that this document combine a cost forecast for strategic action and planned services, and that it contain a total annual and multiannual budget.

V.5.1. Response Funding

During the implementation of the PEN II, it has been demonstrated that there is a possibility of extending funding to civil society actors in less favored areas. However, the mechanisms and procedures used seem to be inappropriate, given the level of competences of grassroots managers, on the one hand, and, on the other, the rapidity of action, and emergency, which characterizes HIV and AIDS.

In order to have a response which stimulates grassroots actors, there is a need to re-examine the financial architecture of the funding of AIDS response activities, and to find a model which is better suited to the predominant reality of the country. Only through the use of funding models which stimulate all actors, both state and non-state, at local and district level, and which respond to the constraints faced by these players, in a fiduciary context, will the response be able to be extended to peripheral levels, with the objective of achieving the expected results of this strategy.

Financial planning, and its alignment with medium term fiscal scenarios, already institutionalized in the country, are instruments to be recommended so as to increase the credibility and security of funding for HIV and AIDS response activities set out in strategic and operational consensus documents. In this context, it is recommended that the inclusion and costing exercise for AIDS response activities in sectoral activity plans be commenced, thereby securing their generally applicable nature and long term sustainability.

V.6. Results Matrix – Support Components of PEN III

Results of the Impact	**NSP III implemented and set targets achieved by 2014**	
Area	**Results**	**Outputs**
1. Coordination	1.1. Involvement of leadership at the highest level in the response to HIV and AIDS	1.1.1. CNCS multisectoral representation extended
		1.1.2. Realignment process of CNCS/SE completed
	1.2. Multisectoral response to HIV and AIDS effectively coordinated	1.2.1. Functional multisectoral coordination forums at Central, Provincial and District level
		1.2.2. Communication channels among the different levels of response execution, both internally in the government, and between the government and civil society and partners, created and functional
		1.3.2. Greater coordination and functionality facilitated between the focal points and / or responsible technical personnel in the area of HIV and AIDS, gender and other cross cutting themes in the public, private and civil society sectors
	1.3. Reduced duplication of actors and operational gaps in terms of coverage of the interventions	1.3.1. Multisectoral coordination platform anchored at the CNCS/SE
		1.3.2. Principle of the Three Ones Observed
1. Monitoring and Evaluation	2.1. Results of the PEN III properly monitored and assessed	2.1.1. Periodic reports produced regularly
		2.1.2. Mid-term and final evaluation reports produced and shared in a timely manner
	2.2. Recommendations of the M&E systems integrated into sectoral plans	2.2.1. Regulating and facilitating instruments produced and disseminated for coordination and participation of actors in M&E activities
		2.2.2. Dissemination mechanisms established for M&E results
	2.3. Evidence used published, so as to orientate interventions through sectoral plans	2.3.1. Human resources benefitted from capacity building at public, private and civil society sector level, on matters of M&E
2. Operational research	3.1. Annual plans of several sectors implemented on the basis of evidence of the annual evolution of the response	3.1.1. Priority research topics Implemented and disseminated through the INE
	3.2. Increased number of institutions and organizations which plan on the basis of evidences	3.1.2. Established mechanisms for the dissemination of the results of research
	3.3. Profile and behavior of the epidemic and quality of the response to the epidemic, is known	3.3.1. Research action carried out and updated, aiming at the understanding of different epidemic settings, and so as to allow the improvement of interventions, in the context of an effective national response to HIV and AIDS;
3. Communication	4.1. Increased proportion of the general population and of groups at high risk which report changes in behavior	4.1.1. Implemented communication approaches which are sensitive to gender dynamics and to cultural specificities
	4.2. Favorable environment created for the materialization of the crosscutting character of the communication component in the response to HIV and AIDS in Mozambique	4.2.1. Reinforced capacity of the public, private sector and civil society institutions and community actors in conceiving and implementing comprehensive and holistic communication programs suited to their needs
4. Resource Mobilization	5.1. Increased financial sustainability in the response to HIV and AIDS	5.1.1. Increase in the budgetary endowments of the government for the multisectoral response to HIV and AIDS
	5.2. PEN III priorities implemented with appropriate financial support	5.2.1. Institutions, actors and implementers of the PEN III prioritize access to funds and resources
		5.2.2. Simplified funding mechanisms established for the functional response, and suitable for the reality of the country

VI. Systems Strengthening

This strategic plan assumes that one of the preconditions for achieving its objectives and targets, is the strengthening of systems. In a more integrated health context, this strategic plan should help to build and consolidate the idea of the institutional development of actors, improving their strength and consistency, so as to achieve a qualitative response to the challenges presented by AIDS. Particular attention is paid to the strengthening and development of the capacities of the different actors, from the public and private sectors, and civil society, in light of the multisectoral dimension of the response and, particularly, of the complementing and expansion, by other actors, of the actions launched by the Government. Such strengthening should also take place as regards processes of management, of the development of more simplified programmatical and financial management systems, of technological use and, above all, of the empowerment of human resources.

The analysis of the epidemiological profile of the country and of preceding HIV and AIDS response efforts, indicate that, given the current behavior of the epidemic in Mozambique, more people will need comprehensive and quality services in the areas of prevention, treatment, care and mitigation of the impact of HIV and AIDS. The success of the response capacity of the country, in the appropriate provision of these services, will necessarily require investment in the strengthening of multiple service provision systems and mechanisms in key supporting sectors, highlighting the Health, Civil Service, Education, Youth and Sports, Women and Social Action, Agriculture, and Defense and Internal Affairs sectors, as well as civil society organizations, and in the body which is itself responsible for the coordination of the response, the Executive Secretariat of the CNCS and its respective Provincial Bodies.

As regards the Health Sector, it is widely recognized that the current system is characterized by countless gaps. The structure of the national health system was established to deal primarily with patients with acute conditions (such as malaria, diarrhoea and pneumonia), which contrasts with the demands imposed by HIV and AIDS, which imply the follow-up, for a prolonged period of time, of patients, while new patients are being admitted. As a result, there is an urgent need for the formulation of a functional health service model for the handling of chronic diseases, both in terms of restructuring the current system, as well as in terms of expansion. Only then will the NHS be able to provide a response to chronic diseases, as in the case of HIV and AIDS.

The health system must be equipped and expanded, as regards its infrastructure, human resources, monitoring and evaluation systems, information systems and financial resources, in the context of the cumulative increase in the number of individuals who need ongoing attention. As regards health Infrastructure, in the last 5 years, the efforts of the government have been concentrated on the upgrading of already existing infrastructure to an acceptable level of quality and capacity, in addition to the building of new health units, especially in areas difficult to reach.

However, the reality shows that Mozambique still has weak coverage by the public health system, and that where services exist, the limitations are huge in terms of basic health infrastructure, such as laboratory capacity for carrying out the follow-up of patients in treatment and care (including hematology, biochemistry and CD4 testing), drugs, warehouses, etc. Priorities for the next 5-year

Government Plan include (i) Continuing with the expansion of the heath network and the rehabilitation of existing infrastructure; (ii) Increasing the laboratorial capacity, to the level at which patients receiving ARV treatment must be monitored and (iii) Strengthening the system for the management of medicine supply, logistics, storage and distribution; and (iv) Supplying hospital equipment (including surgical equipment).

Mozambique is considered to be one of the countries most severely affected by a crisis of human resources in health (HRH) with only 3.3 doctors and 23.9 nurses per 100,000 people. The lack of HRH has negatively impacted the current efforts to expand CTH, ARV and PMTCT services, particularly in rural areas. The HRH Development Plan {86} expresses the political commitment of the government to strategically increasing HRH, in order to contribute to the achievement of the Millennium Development Goals. (DMGs). The main response strategies to the challenges for the availability of human resources in health include the revitalization of APEs, the increase of numbers of technical personnel, such as laboratory technicians, medical technicians, pharmacy technicians, nurses and administrators, increasing pre-professional and on the job training, and the establishment of mechanisms for the retention and motivation of qualified professionals. PEN III funding and implementation partners are called on to contribute to this area.

The implementation of a multi-pronged response to HIV and AIDS also needs to focus on the strengthening of the capacity of several public and private sector institutions, and civil society organizations, including grassroots community organizations, as a way of securing greater availability in the country of installed capacity for the provision of several services necessary for an appropriate confrontation of the HIV and AIDS epidemic.

On the level of public and private sector institutions, paying particular attention to those which have greater capacity to reach out to other population groups and to more beneficiaries, such as the Civil Service, Education, Youth and Sports, Agriculture, Woman and Social Action, Defense, Internal Affairs, and Large and Medium Enterprises, investment must be strengthened , with a view to securing an appropriate and consistent integration of the HIV and AIDS component into sectoral plans and routine interventions, with special focus being placed on those thematic components whereby sectors add exponential value to the national AIDS response. The development of HIV and AIDS competences in human resources, and the strengthening of sectoral management capacities and the institutional management of specific components (in contrast to the exacerbated focus placed on the focal point) must be prioritized. Capacity for appropriately evaluating the needs of the sector, and for implementing comprehensive programs, capacity for guiding the development and implementation of appropriate communication strategies, and for executing consistent processes of monitoring and evaluation, and of the sharing and dissemination of results, must be prioritized, in investments directed at systems strengthening.

On the level of civil society as a whole, including associations of people living with HIV and AIDS and grassroots community organizations and religious institutions, organizational capacity, and programmatical and financial management systems and procedures must be reinforced, especially among national NGOs, while preserving their capacity for social mobilization and integration with

communities and families. For actors and civil society institutions, there is a need to reinforce advocacy capacity and the representation of the interests of their multiple target groups, as a way of widening the impact of their voice in different forums on approaches to the collective response to HIV and AIDS. The national, provincial and district platforms and networks of civil society organizations must be prioritized, as they are entry points for the process of the strengthening of the capacity of civil society actors and institutions.

The on-going CNCS realignment process must be completed quickly, including the provision of a human resource institutional development plan, as a way of ensuring the fulfillment of the expected coordination, communication, monitoring and evaluation mandate of this body, as a fundamental pre-requisite for the effective, multisectoral implementation and coordination of the national response to HIV and AIDS in Mozambique.

The undertaking of these strategic actions, aimed at strengthening systems, should allow for the increased implementation of the basic objectives of a multisectoral response to AIDS, whereby the government is dedicated to the creation and maintenance of an environment in which civil society, private enterprises and individual health professionals can act efficiently, effectively and with minimum bureaucratic complications, prioritizing interaction and centering on synergies between service providers and clients.

VI.1 Results Matrix – Reinforcing Services and Strengthening Systems

Results of the Impact	**NSP III implemented and expected targets achieved by 2014**	
Area	**Results**	**Output**
1. Reinforcing services and strengthening systems	1.1. Strengthened response structure and systems in the public and private sector and in communities	1.1.1. Resources mobilized internally and externally to support the construction/rehabilitation of service infra-structure
	1.2. Increased availability of human resources and technical competencies of actors and implementers, so as to effectively implement PEN III priorities	1.1.2. Increased number of people involved in the provision of HIV and AIDS response services in various sectors
		1.2.1. Established and implemented technical and institutional partnering mechanisms among national organizations and international agencies with sufficient capacity to assist with the institutional development of national actors.
	1.3. Widened provision and logistical capacity	1.3.1. Operational Manuals, procurement procedures, and the facilitating action guidelines of partners developed and made available at various levels

VII. Challenges for the Implementation of PEN III

When being implemented, a set of challenges will need to be addressed urgently, with the aim of catering to the efficient achievement of the purposes guiding this plan, and intended to achieve the targets set out in its matrix. So as to allow for the ongoing monitoring of the natural progress of action to be taken, so as to allow for the systematic implementation of this strategic Plan, the most prominent challenges to be faced are set out below.

VII.1. Strengthening of coordination (vertical and transversal)

The imperative strengthening of coordination among various stakeholders is an essential condition for avoiding the perpetuation of parallel or isolated action, not directed towards a shared vision of priorities and orientation, which may contribute to a dilution of efforts, and to the non-achievement of the expected impact. Coordination should flow horizontally, allowing for discussion on information flows and data on the response, the commitment of actors to the purposes and commitments which are achieved at a specific level of response, and the creation of a more transparent and inclusive action platform, favoring interdependence among the actors. Meanwhile, the globular assessment of response developments, and of the most widespread challenges to be addressed, demands articulated vertical coordination, which flows from the base (district level), through the intermediate level (provincial) up to the top (national), and vice-versa, with clear information, commands and data which constantly feed the exercise, cyclically, and in both directions. The fluidity of both vertical and horizontal coordination will allow for the filling of possible operational gaps, and the elimination of duplication of efforts and of resources. Therefore, the commitment and the strengthening of leadership at all levels is crucial for more efficient coordination, greater integration and the use of synergies among actors. Poor coordination may put the principles of rationalization and multisectoralism, at risk.

VII.2. More planned actions – fewer campaigns, and more ongoing, articulated and sustainable activities

The combat of HIV and AIDS is a long term activity. Its undertaking, although at some moments requiring the undertaking of campaigns and one-off actions, for the most part requires sequential planning, with ongoing and long-term activities directed at quantifiable results and visible impact. Equally, by adopting an integrated and multisectoral dimension response model, this characteristic constitutes an essential benchmark for securing sustainability.

VII.3. More effective use of scarce resources (human, material and financial)

The optimization of increasingly scarce resources is an imperative already formulated as a principle, which should be followed and put into effect, during the implementation of this plan. It implies an increase in financial planning capacity, and a more rational appropriation of resources to be used, allowing for a multiplication of results chains with less investment. The development of synergies and the greater integration of programs, and the sharing of data and resources, which can be used to achieve multiple objectives, are strategic options for the optimization of resources which must constantly be taken on board.

VII.4. Greater involvement of people living with HIV and AIDS

The response should provide collaboration opportunities to people living with HIV and AIDS. The greater involvement of this group should not only be in the provision of testimonies, but particularly in activism which allows society to begin facing HIV and AIDS without stigma and discrimination. Their active participation in advocacy, in prevention, in care and support and in the entire chain of mitigation of consequences for the family and society in general, as a factor encouraging intended change, should be stimulated at all levels.

VII.5. Greater involvement of grassroots community organizations

The decentralization of the response and the strengthening of grassroots structures for a response which is increasingly framed in the family and community circles, must be centered on greater mobilization and the involvement of grassroots community organizations. The sustaining of strategic directives formulated here, will be more consistent when the involvement of grassroots community organizations, formalized or not, takes on its role of providing continuity for the directives listed in this document, and spreading these out further, to families,

Implementation of the Response and Formulation of Operational Plans

The multisectoral approach commits all sectors to making their contribution to the struggle against AIDS. As a result thereof, the strategic directives contained in this plan require implementation through the formulation of sectoral operational plans. The monitoring of the implementation of sectoral plans should take place by way of structured reporting to the coordinating body, at time intervals which respect the planning cycles in use in the country. The sectoral plans must thus, for the purpose of articulated coordination, be made known to the members of the National AIDS Council, who will be responsible for verifying the degree of its implementation, thus ensuring reporting during the entire process of seeking measurable results. This verification must, in alignment with planning cycles and joint evaluations with partners, include the calling of a broad based meeting of the National AIDS Council, on an annual basis, for this purpose.

In addition to the operational plan of the CNCS which should set out activities for the coordination and facilitation of the implementation of this plan, sectors are called on to share responsibility for the implementation of the suggested strategies, in accordance with a hierarchy. That is justified by the fact that the burden of the HIV/AIDS epidemic varies from sector to sector, from the point of view of its impact on manpower, as well as on the demand for specialized services with which to confront it.

As such, the decisive criterion to be considered when determining the hierarchy of responsibilities for each sector, is the burden the epidemic places on that sector's mandate, and the pressure which it brings to bear on the human factor of sectors, as well as the demand placed on sectoral services to confront it, and the negative influence which it has on the provision of these and of other services by sectors. This criterion evidences a multisectoral setting of hierarchies, on two levels: the first, is the Health Sector, followed by the Sectors of Education, Youth and Sports, Women and Social Action, Defense, Internal Affairs, Agriculture, Labor, the Civil Service and Justice. The second brings together other sectors with responsibility for continuing to proceed with the integration of the struggle against AIDS into their sectoral plans, and for implementing programs of prevention and mitigation for their workers and for their main customers.

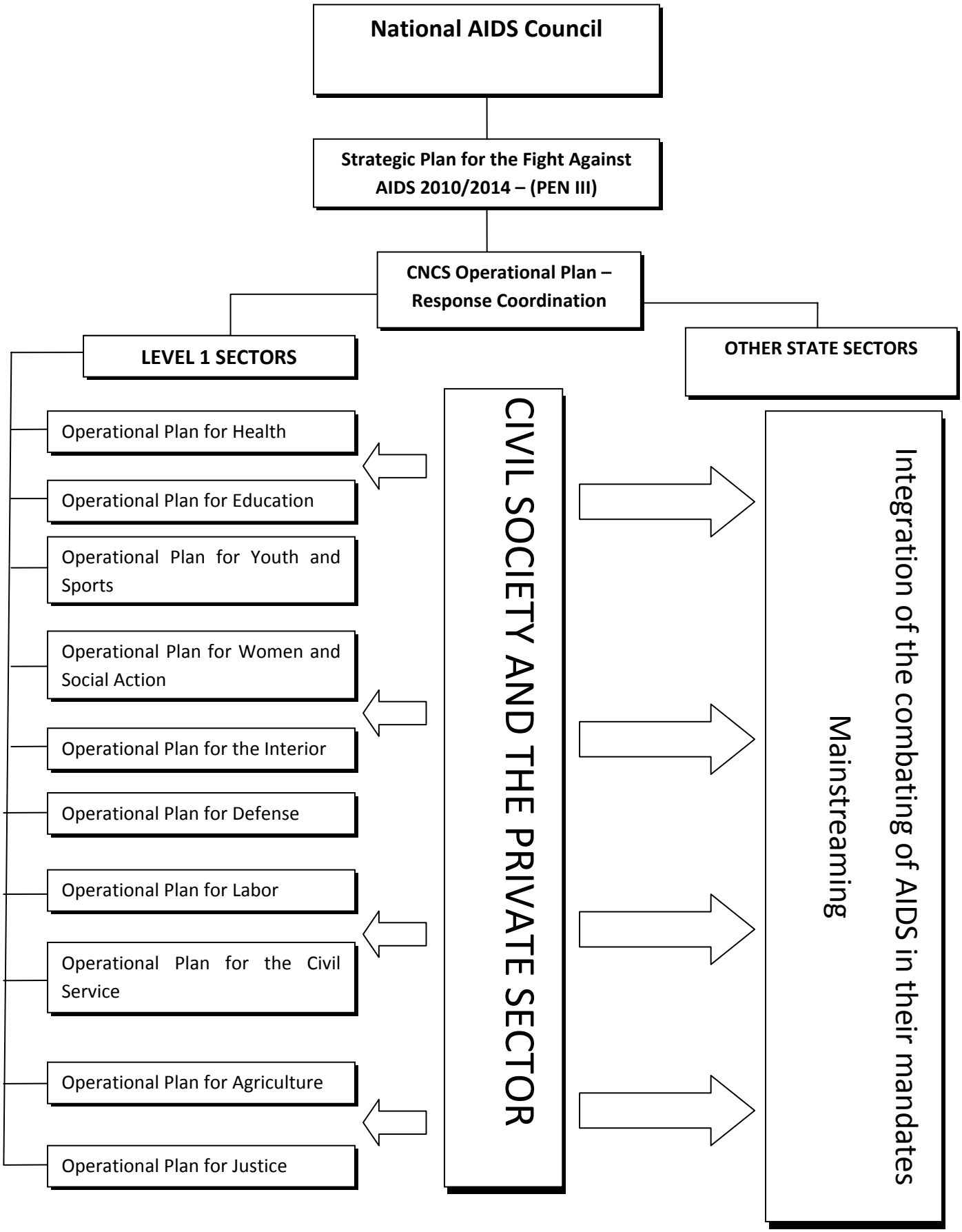
On the first level, in light of the above-mentioned hierarchical criterion, operational plans will be required to incorporate, fundamentally, the main actions recommended in this document, which are essential for the alteration of the course of the epidemic in the country. This is an added responsibility, in addition to the requirement that HIV/AIDS matters be dealt with in cross–cutting frameworks, as the multisectoral approach recommends, which will guide the action of the sectors comprising the second level of the criterion.

The participation of civil society and of the private sector, side by side with Government, in the response to HIV and AIDS should continue to promote the development of synergies and the complementary nature of efforts, allowing for the extension of activities into the whole national territory and producing visible impact in the community. As such, the involvement of civil society and of private sector actors in this response, within the scope of the above-mentioned complementary nature of efforts, and development of synergies, will take place at the level of each responsible sector, taking into account the inclination, thematic speciality and interest of each actor.

Civil society actors, brought together through the provincial, national and district coordination platforms, are encouraged to develop comprehensive operational plans of intervention which are pragmatic, and which confront sustainability challenges.

The private sector is also challenged to undertake more vigorous action for the protection of its human resources, through robust HIV / AIDS prevention and mitigation programs at the work place. At the same time, it is encouraged to promote synergies and actions in partnership with the government and civil society, in critical areas such as testing, advocacy, treatment, and scientific research, among others, where resources and investments could have more resonance, and give rise to better returns.

The implementation of PEN III is summarized in the following diagram:


National AIDS Council
Strategic Plan for the Fight Against AIDS 2010/2014 – (PEN III)
CNCS Operational Plan – Response Coordination
LEVEL 1 SECTORS
OTHER STATE SECTORS
Operational Plan for Health
Operational Plan for Education
Operational Plan for Youth and Sports
Operational Plan for Women and Social Action
Operational Plan for the Interior
Operational Plan for Defense
Operational Plan for Labor
Operational Plan for the Civil Service
Operational Plan for Agriculture
Operational Plan for Justice
CIVIL SOCIETY AND THE PRIVATE SECTOR
Integration of the combating of AIDS in their mandates
Mainstreaming

h) Main risks for the success of implementation

The implementation of a strategic plan is always confronted by adverse factors, which can put joint efforts to reach certain results at risk. As risks and threats, such as internal and external factors, can negatively influence the plan's implementation process, and make it difficult to achieve the expected results, they must be identified in advance and taken into consideration. In the case of this strategic plan, projected risks and threats are recorded as challenges, as set out below:

- **Lack of coordination among actors:** the mandatory strengthening of coordination between various stakeholders is an essential condition for the avoidance of perpetuated parallel or isolated action, not directed at a shared vision of priorities and approach, which could contribute to a possible dilution of efforts and to not achieving the expected impact. This could imply operational gaps, and the duplication of efforts and resources. Therefore, commitment, and the strengthening of leadership at all levels, is crucial for increased integration and the use of synergies among actors. Weak coordination may place the principles of rationalization and of multisectoralism, at risk.
- **Lack of an inclusive approach to the treatment of high risk population groups**: interaction with high risk population groups, especially emerging ones, in the context of the national response to HIV and AIDS, such as men who have sex with men, disabled people, and the elderly (not only those affected, but also those infected by HIV) needs great skill on the part of those who provide services, and tight control of an environment of stigma and discrimination, as a way of accelerating prevention and equitable access to available services. Minimizing the risk of the exclusion, discrimination and stigmatization of population groups needing specific services is indispensable for the creation of a favorable environment, and for endowing service providers with human rights skills.
- **Discontinuity of the flow of interventions**: breaks in treatment, or the lack of stock of condoms and other materials, can pose a risk to achieving results. Sporadic programs, without continuity at community level, can provoke the collapse of the desired results and discredit the HIV and AIDS response system. Therefore, it is necessary to ensure that programs are designed to respond to results, in the medium and long term, and to involve beneficiaries. In the case of treatment and nutrition and food support programs, there must be good connection between the health services and the communities;
- **Lack of consideration in the selection of target groups:** the selection of target groups which are vulnerable to the impact of HIV and AIDS, in the environment of poverty in which the greater part of the population lives, is a process that demands skill and consideration, and there is always a risk of choosing the “elite“ (privileged) and target groups which may come to be stigmatized. .
- **A low level of consideration of the potential of the income generating activities:** if not well designed and applied, or, if done so without taking into account the economic and financial viability of investments in this area, interventions of this nature can be unsustainable. This lack of sustainability can be associated with a lack of socio-economic analysis, due to the nature of the emergency which in most cases characterizes the response to the impact of HIV and AIDS.
- **Non-observance of social and cultural assumptions**: the possible, in some cases, marginalization of positive cultural factors and influential community agents, who could be mobilized so as to improve the efficiency of the HIV and AIDS approach, can lead to a loss of opportunities for dialogue, and the involvement of important actors, capable of providing input into the

Mozambicanisation of the message, with the potential for having an impact on interventions aimed at transforming behaviors at community, family and individual level.

- **Absence of considering response funding through domestic channels**: the high level of dependence of the HIV and AIDS response funding system on external funding, made available for short periods of time, and subject to high levels of fluctuation in terms of availability, can threaten the regular flow of AIDS response action if medium and long term fiscal scenarios are not formulated, which could imply a lack of adequate funding for the PEN III.

Effective implementation of PEN III should take into account a series of presuppositions, namely human resources, the availability of material resources, in terms of quality and quantity, and the timely allocation of financial resources. There must be good interaction among the four main components (prevention, vulnerabilities and risk, treatment and care and mitigation) and cross–cutting issues (investigation, coordination, communication, and monitoring and evaluation).

In the process of managing risks and threats, strong leadership is needed. It is vital to ensure the commitment of institutional leaders at all levels to the promotion of action in response to HIV and AIDS, which must be strategically anchored to the PEN III, and continuously informed by the development of the processes for implementation of actions.

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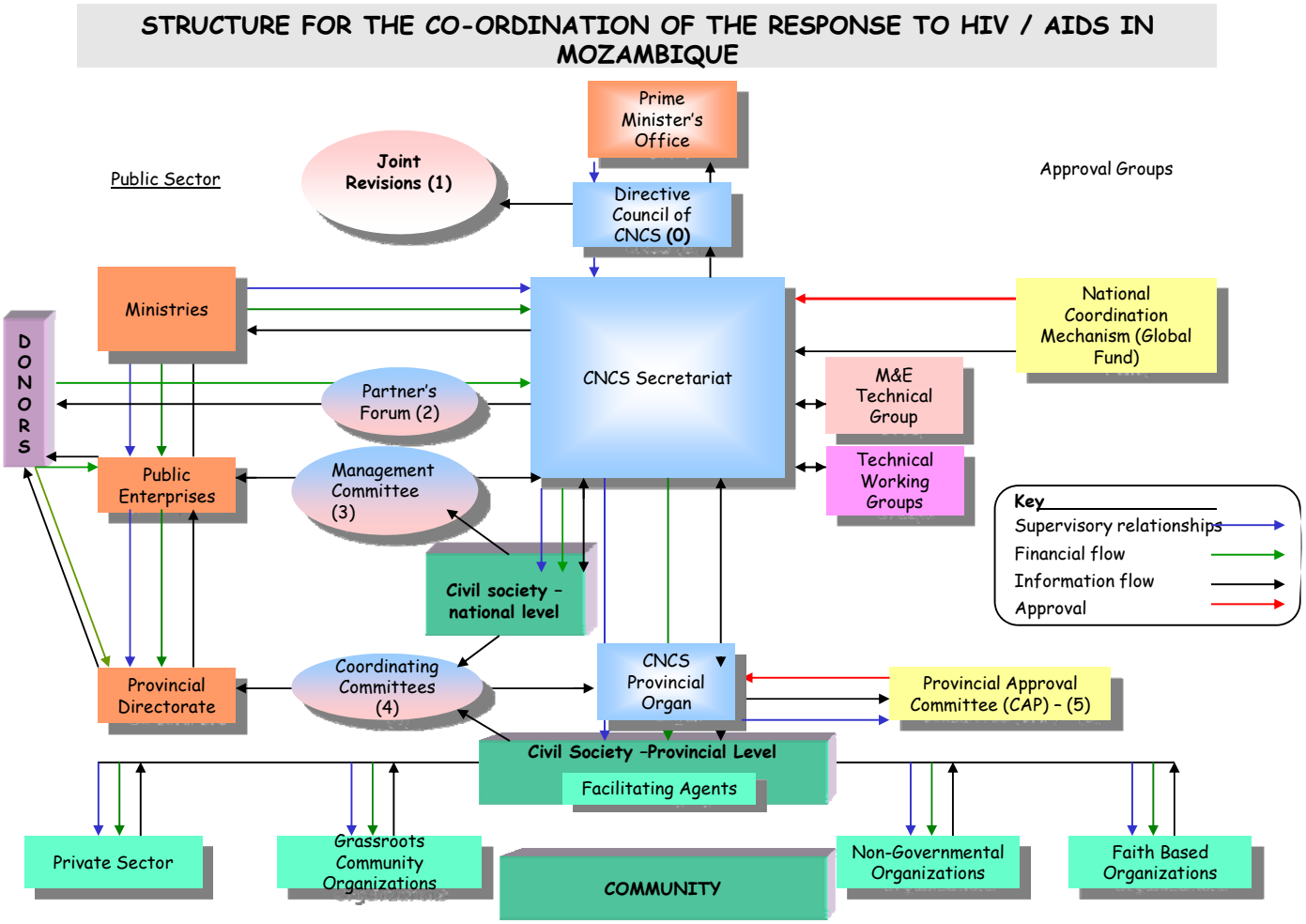
Annex 1 – Structure for the Coordination of the Response to AIDS



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(0) – In addition to members of the Government and individuals, the CNCS Directive Council includes representatives from civil society groups. As a strategic-policy mechanism for the articulation and direction of the Executive Secretariat, it is a privileged place at which civil society may put forward its agenda, and obtain a response from this body;

(1) - Joint Revisions are conducted on a biennial and annual basis, and Government and its international and national partners are brought to the same platform. These are preceded by technical planning meetings, the production of reports with indicators agreed upon, and critical analysis of Response scenarios;

(2) The Partner's Forum is a mechanism by which the Executive Secretariat and national response Partners (international partners, civil society, private and public sector) articulate developments in the CNCS's Annual Operational Plan, on a monthly basis, and lead the national response, thus constituting a privileged mechanism of coordination;

(3) The Management Committee was conceived as technical forum for the leading of the funding and analysis of its impact, through a Common Fund, a financial mechanism agreed upon between the Government and its international partners. It is led by a Representative of the Minister of Finance and, besides those seats held by sector directors at the level of the CNCS, it has two seats for representatives from international partners of the Common Fund, and a seat for civil society;

(4) At the level of each province, the Provincial Body makes use of a multifunctional mechanism of coordination with several local partners – the Coordination Committee;

(5) - The CAP is a technical body led by the Governor of the Province and is comprised of members of the Provincial Government and representatives from civil society, who serve to approve and to check local funding to the response, as well as to monitor the impact of programs.

Note: (i) The formally institutionalized national response goes further at the provincial level. In the districts, the NPCS facilitates the creation of District Councils, which are a non-institutionalized, healthy coordination mechanism with different and uniform experiences. In the last few years, during which the District has been defined as a development pillar, District Governments have increasingly assumed the leadership of the local response and, as such, local coordination of efforts made.

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Note: (ii) At the level of several sectors, there are mechanisms for the coordination of sector efforts with partners who the planned interventions by the Government in the area of HIV and AIDS. In Health, besides the GT-SWAP, we have the CNCS (National Health Coordinating Council), which is a mechanism for the articulation of PEN Health, and other relevant issues, with partners in this sector. The same thing happens in the Education sector.

(iii) The resolutions of these bodies are sent to the CNCS through sector-based focal points, or through formal inter-institutional relationship mechanisms.

(iv) The Public Sector has functional HIV/AIDS focal points, who have a responsibility to help plan out, make approve, implement, monitor and assess Sector Plans in the struggle against AIDS;

(v) The United Nations has a technical articulation group at system level, the resolutions of which are brought to the national coordinating body, in the context of the principle of the Three Ones, by UNAIDS;

(vi) The American Government, as one of the main donors to the AIDS response, and in addition to internal articulation mechanisms, includes several technical working groups, where the coordination of plans and intentions with other stakeholders is undertaken.

What should be strengthened, in order to improve coordination?

1. It is recommendable to reflect on already consolidated coordination systems and models at the central, provincial and district level. As regards territorial administration, what is stated in Law 8/2003 must be followed, which law establishes the principle and organizational standards, competences and functioning of local State organs. With the purpose of giving momentum to the role of the District in the planning of socio-cultural and economic development, this law allows for the local formulation of Strategic Plans for District Development (PEDD) and District Socio-Economic Plans and Budgets (DSEPB) in which HIV and AIDS are treated as cross-cutting themes. Equally, the coordination of actions in the struggle against AIDS must be undertaken in this context.

2. For the efficiency of coordination efforts, the establishment of mandatory norms must be called for, regarding respect the information flow systems, observance of the strategic priorities defined by the Government, inclusivity and single direction. The rhetoric of the Three Ones is not sufficient for this purpose.

Source: SE/CNCS, 2009 – HIV/AIDS Response Coordinating Structure (Power Point Presentation).