Joint Programme on HIV and AIDS:
"Strengthening the HIV and AIDS Response in Mozambique"
FINAL PROGRAMME[1] NARRATIVE REPORT

Programme Title & Project Number
• Programme Title: MOZ101 • Programme Number (if applicable): n/a • MPTF Office Project Reference Number: 00065841

Country, Locality(s), Thematic Area(s)[2]
Mozambique
Thematic/Priority HIV/AIDS response

Participating Organization(s)
• *UNHCR, UNICEF, UNESCO, UNFPA, UNAIDS, UNODC, UNDP, ILO, WHO, WFP, IOM, FAO*

Implementing Partners
• Refer to part I, section d for a complete list of Implementing Partners

Programme/Project Cost (US$)	
MPTF/JP Fund Contribution: • *by Agency (if applicable)*	11,647,582
Agency Contribution • *by Agency (if applicable)*	31,159,759
Government Contribution *(if applicable)*	
Other Contributions (donors) *(if applicable)*	
TOTAL:	**42,807,341**

Programme Duration (months)	
Overall Duration *(months)*	36 months
Start Date[3] *(dd.mm.yyyy)*	31 December 2008
End Date (or Revised End Date)[4]	31 December 2011
Operational Closure Date[5] 31	31 December 2011
Expected Financial Closure Date:	31 December 2011

Final Programme/ Project Evaluation
Evaluation Completed ■ Yes ☐ No Date: _____ Evaluation Report - Attached ☐ Yes ■ No

Submitted By
○ Name: Raul de Melo Cabral ○ Title: UNAIDS Country Coordinator ○ Participating Organization (Lead): UNAIDS ○ Contact information: +258 21484510

[1] The term "programme' is used for programmes, joint programmes and projects.
[2] Priority Area for the Peacebuilding Fund; Sector for the UNDG ITF.
[3] The start date is the date of the first transfer of the funds from the MPTF Office as Administrative Agent. Transfer date is available on the MPTF Office GATEWAY.
[4] As per approval by the relevant decision-making body/Steering Committee.
[5] All activities for which a Participating Organization is responsible under an approved MPTF programme have been completed. Agencies to advise the MPTF Office.

FINAL PROGRAMME REPORT

I. PURPOSE

a. Provide a brief introduction to the programme/ project.

The HIV Joint Programme (JP) of the UNDAF HIV Pillar had the overall objective of strengthening the national response to HIV and AIDS. Specifically it aimed at instilling responsibility on individuals, civil society, public and private institutions whether national or local, for halting the spread of HIV and AIDS amongst high risk populations as well as to mitigate the impact of AIDS (Outcome 3 of UNDAF 2010 - 2011, Pillar on HIV and AIDS). The aligned Joint Programme is composed of six components, as follows, 1) Prevention, including a) counselling and testing, b) communication for behaviour change, c) most at risk groups, d) male circumcision and e) young people; 2) prevention of mother to child transmission; 3) treatment; 4) impact mitigation; 5) mainstreaming of HIV and gender and 6) monitoring and evaluation.

b. Provide a list of the main outputs and outcomes of the programme as per the approved programmatic document.

During the UNDAF bridge period (2010–2011), the original ten prevention components were grouped into six in order to enable a more effective alignment with the key strategic areas of the National Strategic Plan (2010–2014) approved in 2010. Therefore, the Joint Programme had six components reflecting the Outcomes of the UNDAF HIV Pillar:

1) Prevention (including: Counselling and testing; Communication for Development; Most Vulnerable population groups; Male Circumcision (MC); and Adolescents and youngsters),
2) Prevention of mother-to-child transmission (PMTCT),
3) Treatment,
4) Impact Mitigation,
5) Mainstreaming of HIV and AIDS and Gender and,
6) Monitoring and Evaluation.

1) Prevention: This component aimed at ensuring support to the HIV Prevention Acceleration Strategy and covered five specific action areas:

a) Counselling and Testing - support the expansion of counselling and testing activities by: i) integrating these activities into the health professional's routine, ii) expand the services to community level, iii) include clinical staff in the National Health Service, and iv) greater social mobilization to promote greater adherence to testing, subsequent services and treatment.

b) Communication for Development - Ensure the implementation of the National HIV Communication Strategy and guarantee the production and dissemination of information about sexual minorities, such as: Lesbians, Gays, Bisexuals and Transgender (LGBT).

c) High Vulnerability Population Groups - Facilitate the development of programmes, strategies and coordination mechanisms to promote health, focusing on the reduction of HIV transmission among high risk populations.

d) Male Circumcision (MC) - Encourage safe and hygienic male circumcision practices to reduce sexually transmitted infections.

e) Adolescents and youngsters – Build the capacity of youth organizations and facilitate the participation of young people in provincial and district forums, community committees and school councils. Additionally, support the implementation of youth communication programmes in eight provinces, through the National Youth Councils, as well as the expansion of Life Skills extra-curricular activities on PLHIV awareness for children and adolescents aged ten to fourteen.

2) Prevention of mother-to-child transmission (PMTCT) – Create more demand for usage and access to Prevention of mother-to-child transmission services, by using community strategies which increase awareness about the importance of PMTCT, the maternal and child health as well as the impact of the mother's survival on the family.

3) Treatment - Build capacity in the health sector and relevant partners to improve the quality of HIV and AIDS services offered, and the usage of existing resources to support the component of care and nutritional support.

4) Mitigation - Provide support to the Ministry of Women and Social Action and other relevant ministries to ensure access for at least 205,000 orphaned and vulnerable children and their families, to social protection and the six basic services outlined in the National Plan of Action for Orphans and Vulnerable Children (food and nutrition, health, education, psychosocial care and support, legal, and financial support) and provide advocacy to ensure the inclusion of vulnerable children's special needs into national policies.

5) Mainstreaming of HIV, AIDS and Gender - Create necessary mechanisms to ensure the effective integration of HIV, AIDS and Gender in all national strategies and plans.

6) Monitoring and Evaluation – Support the development and usage of standard monitoring and evaluation mechanisms and carry out studies and analysis on the HIV response, therefore establishing and consolidating common report and monitoring mechanisms for the financial costs of HIV and AIDS.

c. Explain how the Programme relates to the Strategic (UN) Planning Framework guiding the operations of the Fund.

The JP outputs all relate to the HIV UNDAF outputs as follows,

UNDAF output 3.1, HIV inclusive prevention programme covering five key areas of the National Strategy of the Acceleration of HIV Prevention (ATS, Condoms, GAR, CM and CMC) implemented and expanded. This relates to the prevention component of the JP.

UNDAF output 3.2, Capacity of MISAU and of the main stakeholders increased to provide annually, by 2011, integrated and inclusive PMTCT services of at least 65,000 pregnant women and their children exposed. This relates to the PMTCT component of the JP.

UNDAF output 3.3, Increased capacity of MISAU and of the main stakeholders to improve the coverage of 30% for at least 40% of PLHIV, both in adults and in children, benefiting from a standard support package in at least one of the following areas: ARV therapy, prophylaxis and treatment of opportunistic infections, nutritional support, home care and counseling. This relates to the treatment component of the JP.

UNDAF output 3.4, 50% of the target of OVCs covered by action plan of vulnerable children (or at least 205,000 annually) together with their families have access to basic services and to social protection schemes. This relates to the mitigation component of the JP.

UNDAF output 3.5, The provincial plans of public sectors, action plans of civil society networks and

business plans of the private sector integrate HIV and AIDS and gender and natural disasters including the corresponding budget for their implementation. This relates to the HIV mainstreaming component of the JP.

UNDAF output 3.6, A unique and coherent national system of M&E strengthened that collects and disseminates strategic information to inform, support and assess the national response of HIV. This relates to the monitoring and evaluation component of the JP.

d. List primary implementing partners and stakeholders including key beneficiaries.

Programme areas	Implementation Partners		Agencies UN Participants
	Government	Others	
1. Prevention			
1a) Counselling and Testing (CT)	MoH, DPSs, DDSs, NAC	PSI, CDC, IMT, AMETRAMO	**UNFPA (Lead Agency)**, UNESCO, UNICEF, UNHCR
1b) Communication for Development	MoH, DPSs, DDSs, MINED, MoW,	Rensida, MISA, IMT, FORCOM, GTO, ARPAC, Lambda, PI, RM, TVM, AMETRAMO, ICS	**UNICEF (Lead Agency)**, IOM, UNFPA, UNESCO
1c) Most vulnerable Population groups	MJD, MoW, DPM, MINC', MINJUS	Lambda, IMT, Pathfinder, WLSA, AMETRAMO, ATPM, SINTRAT, TEBA, Ecosida, Cornelder	**UNFPA (Lead Agency)**,UNESCO, UNODC, UNICEF, ILO, IOM
1d) Male Circumcision (MC)	MoH, DPSs	NPCS	**WHO (Lead Agency)**, UNESCO, UNAIDS.
1e) Adolescents and young people	MJD, MINED	CNJ, Youth Associations, RENSIDA, N'WETI, RM, FORCOM	**UNFPA (Lead Agency)**, UNICEF
2. PMTCT	MoH	CUAMM, CHAI, ICRH	**UNICEF (Lead Agency)**,WHO, WFP
3. Treatment	MoH, DPSs	PLWHIV, CHAI, DSF, CUAMM	**WHO(Lead Agency),**UNICEF, WFP
4. Mitigation	MMAS, DPMAS, DPE, DPA, DPJD	ADEL,UGC,FDC,Help Age, Handicap, Action Aid, Aga Khan F. , DSF, , WR, IRD, Associacao Avante Mulher, PHUKA UNANHA, A. Luz Verde, A. Anda, UNAC_Tete, Africare, CCF , KUPHUNANA, A. Luz Verde, A. KUPHUNANA	**UNICEF (Lead Agency)**, WFP, FAO, ILO

5. Mainstreaming of HIV, AIDS and gender	NAC, MPD, MINTRAB, MINED, UEM MINT, Min.Int (Migração)	(OSCs) MONASO, RENSIDA, KINDLIMUKA, UNAC, U.G.C, FDC, Private Sector, ECOSIDA (CTA); (Unions) OTM-CS, ASSOTI, ADELs, CONSILMO, CDC,FEMATRO, SINTRAT, AEFUM	**UNDP Lead Agency),** UNIFEM, UNAIDS, ILO, IOM, UNESCO, UNFPA
6. Monitoring and evaluation	NAC, MJD, MoW, MoH, MINED NPCS	CDC, INS, USAID MEASURE, FHI, DANIDA, INE, UEM ECOSIDA	**UNAIDS (Lead Agency),** UNFPA, IOM, UNDP, UNODC, WHO, ILO, UNICEF

II. ASSESSMENT OF PROGRAMME/ PROJECT RESULTS

a. Report on the key outputs achieved and explain any variance in achieved versus planned results.

Prevention

Counselling and testing (CT)

Counseling and Testing is an entry point for all other HIV services as well as an opportunity to promote behaviour change and HIV prevention. In 2008 MoH approved and disseminated two important documents that reinforce CT strategy. The documents are "Guidelines for CT initiated by the provider in the Clinical Context" and "Strategic/Operational document for the Implementation of Counseling and Testing Units (UATS)". In addition, in 2009 the "Guidelines for Counselling and Testing in the Community" was produced and disseminated.

In addition, in 2010 MoH introduced a new strategy where all young people accessing the health services would be counselled and tested at any entry point in the health facility. For this effect MoH has sent directives and guidelines for all of the provinces. It is expected that this will reduce the lost opportunities for CT and increase the number of youngsters tested for HIV. In addition, MoH has been supported in the capacity building of service providers in all of the provinces.

Another important strategic direction taken by the MoH was related to the initiation of Counselling and Testing in the Community. This strategy aimed to contribute to the increased access to communities to CT services and therefore increase the overall number of people that could have access to this intervention. As a result of this initiative in 2011 approximately 695,179 people were tested.

As a result of these policies and advocacies in 2010 and 2011 approximately 2,551,319 and 2,882,543 respectively have been counselled and tested in various services in the National Health System. Regarding the percentage of young people who received counselling and testing in YFC units, an average 57% of young people were assisted in their first consultation. This is equivalent to 152,350 during 2011, a substantial rise compared to the 36% coverage in 2010. On the whole all provinces achieved the target of 15% of young people assisted by the YFC that had access to and used the HCT services.

Communication

The current National Strategic Plan for the period 2010-2014 (NSP III), supported by the Presidential initiative for a multi-sectoral response to HIV and AIDS, inspired the development of the National Communication Strategies for HIV and the Acceleration of Prevention strategy. UN supported CNCS to develop the Communication Operational plan for the biennium 2010-2011 which has used as a joint planning and monitoring tool by CNCS to assess the implementation of all communication activities in the country.

Technical support and advocacy from the UN and other partners contributed to the National AIDS Council recognizing in 2010 the central role that well-coordinated prevention efforts can play in reducing new infections in Mozambique and defined communication for prevention as a key strategic priority in the newly-developed National Strategic Plan (PEN III) and overall in the recently defined CNCS roles and responsibilities framework. A National Technical Communication Group is now operationalized under the coordination of CNCS. The group is functioning as a technical advisory board to the CNCS Communication Unit where all the communication for development initiatives are evaluated jointly and has seen a growing and active involvement from key civil society partners and strategic donors. In addition, support was provided for the functioning of six Provincial Communication Groups and revitalisations of four additional ones, but due to the NAC lack or under skilled human resources capacity the implementation of the communication plans requires more efforts.

Altogether, nine local Community Radios in Nhamatanda (Sofala) and Mossuril (Nampula) and 27 participants, include four participants from the Maratane refugees camp in Nampula, were trained in applying the socio-cultural approaches in producing and broadcasting HIV & AIDS and gender based violence related programmes. These broadcasts have innovative and diversified approaches (debates, radio soaps, and documentaries) and are contextualized to the socio-cultural realities of the concerned communities. Six of the trained Community Radios continued to be supported in broadcasting related programmes.

Approximately 1,750,000 people (70 per cent children and youth) from 75 priority districts were reached through multimedia mobile unit activities and community theatre activities, promoting HIV prevention, during the year. Almost 20,000 people received HIV counselling and testing at the mobile unit tents, in partnership with local health providers and NGOs. More than 150 young people were integrated in community radio activities, in eight provinces. In addition, a network of 10 senior FORCOM trainers received a TOT to deliver trainings of children and adult radio producers, on how to produce effective programming on Prevention of HIV. Over 1,410 children and young people are actively participating as producers and presenters in child-to-child media programmes in 11 provinces, tackling issues related to sexual and reproductive health, and HIV prevention. Regional trainings were undertaken with the Institute for Social Communication (ICS) and Theatre Network (GTO) provincial focal points in order to improve the quality of the theatre plays and mobile units performances on HIV, multiple and concurrent partners, malaria and hygiene promotion.

The Ministry of Education,in partnership with RENSIDA, Radio Mozambique and N'weti has continued to expand its national life skills programme that combines knowledge building with communication strategies for the Window of Hope generation (10-14 year olds) and encompasses a school and radio component. The programme, implemented in 2,000 schools in 79 districts in all provinces of Mozambique, helps children improve their life skills and acquire knowledge and information to protect themselves from risky behaviours, with an emphasis on HIV prevention.

Stigma and discrimination activities were successfully mainstreamed in the education sector, and orphans and vulnerable children provincial programmes. With UNICEF's support, a total of 75 OVC activists were trained in three regional protection trainings and 81 new school activists in the seven Child Friendly School (CFS) districts, reaching over 100,000 school children. Trainers will involve activists in at least 33 priority districts to tackle stigma and discrimination faced by children, and to apply the acquired knowledge in their community and school-based monitoring and training activities.

Technical and financial assistance was provided to the (IMT) - Institute for Traditional Medicine to ensure the participative elaboration of the Ministry of Health National Strategic Plan for the Promotion of Traditional Health Systems. The Strategic Plan promoted traditional health systems that are scientifically sound and contribute to the provision of improved public health services in a coordinated manner. Immune system strengthened particular PLHIV through nutrition education based on nutrition values of traditional food. One brochure was produced and complemented by radio programme broadcasting in selected districts. This was followed by technical support provided to IMT and ARPAC (Archive of Cultural Heritage/Institute for Sociocultural Investigation) for the development and implementation of capacity building activities targeting NGO's, CBO's, local public service providers and traditional leaders to promote the application of appropriate socio-cultural approaches to HIV and AIDS and SRH education at community level. This included the developing of relevant planning, monitoring and evaluation tools. Technical and financial support was also provided to Instituto Nacional para o Desenvolvimento da Educação (INDE; National Institute for the Development of Education) for the development of HIV & AIDS and SRH competencies related learning achievement measuring instruments for teacher training trainers. Altogether 21 Teacher Training Institutes (Institutos de Formação de Professores) were covered by this activity.

MARPS

In 2007 a coordinated national effort regarding most at risk populations was initiated followed by the approval of the accelerated strategy for prevention in 2008 where a working group to address the issues around MARPS was created. This group had the task to harmonize and improve coordination between institutions that had the mandate to work with MARPS. In what concerns MSM an association, (Lambda Association) was created with the aim to develop prevention interventions around MSM.. Prior to 2010 there were no counselling and testing services for MSM. Lambda association through the training of 947 counselors provided an opportunity for MSM to access these services. More recently, Lambda association has supported MoH in improving guidelines for Counseling and Testing in order that these address the specific needs of MSM. As a result of the advocacy around the need to address MARPS needs, in 2010 around 1521 people and 2011 around 1585 people benefited from interventions from Lambda association, such as education and provision of safe sex products. In 2011 around 29.688 condoms were distributed.

In what relates to Sex Work the programs in place that implement activities around this particular group usually do so through two main interventions, (1) health education at community level, with distribution of IEC material and condoms, and (2) expansion of health services speficicaly tailored to address the specific needs of Sex Workers. The "inclusão project" was created to address the needs of Sex workers, MSM, Gays, Lesbians and Transgender as well as people with disabilities. Another project (projecto 100% vida) was created to address specifically the needs of Sex Workers in some of the provinces, police agents, prison population and people with disabilities.

The activity of Strengthening HIV messaging targeting MARPS along the Nacala transport corridor has built the capacity of community radio stations along the Nacala corridor to share HIV prevention messaging targeting people living along and around the corridor. The objective was to increase access to comprehensive HIV information along the Nacala corridor in Mozambique through creating a platform for communities to come together and speak about HIV and other health issues which affect them (especially looking at men and their approach to health-related topics). The programmes were produced by a team of community radio staff from 6 local community radio stations (Radio Comunitaria de Nacala; Radio comunitaria de Erati; Radio comunitaria de Namialo; radio Comunitaria de Ribaue; Radio Comunitaria de Cuamba; Radio Comunitaria de Mandimba) along the corridor. The activity increased awareness of health and specifically HIV vulnerabilities faced by migration-affected populations; promoted gender and culturally-sensitive HIV prevention practices; Addressed discriminatory and stigmatising beliefs related to migrants and HIV; Created a process of dialogue relating to migrants' health; encouraged men to be open to dialogue about HIV prevention and practices.

While another important activity has been the strengthening of HIV prevention with MARPS in the ports sector. Based on recommendations of the 2010 A*ssessment of Health Vulnerabilities of Migrant and Non-Migrant Workers in the Ports of Mozambique* (IOM 2010), UNTTAM built the capacity to provide migrant-sensitive HIV prevention services to labour migrants and host communities in the Port of Beira. Three *Gender, Migration and HIV* trainings were conducted – two in Beira Port itself at the port authority (Cornelder) offices, and one in Maputo, for Maputo-based port sector stakeholders. A national consultation on HIV in the ports sector was held in May 2011, and a set of recommendations for moving forward in the sector was agreed on.

Male Circumcision

Male circumcision is a cost effective HIV prevention intervention that was piloted in five selected health facilities with the objective of assessing potential key issues when scaling up access to voluntary medical male circumcision (VMMC) and identifying best MC scaling up options for Mozambique. The pilot was conducted successfully with the support of JPHIEGO and the UN. Key findings of the pilot were presented to the ministry of health, CNCS and partners who endorsed the findings. A final report of the pilot was also finalized and disseminated to the public and interested partners.

Male circumcision was mainstreamed and integrated in annual work plans of 13 districts in Gaza and Maputo province exceeding the three initially targeted districts. This was largely due to the leadership and commitment of the governors and senior staff of Gaza and Maputo province in supporting MC as an HIV prevention intervention. The mainstreaming of MC in annual work plans is on-going in the province of Inhambane and more than half of the district work plans have already integrated MC components.

Fifty health care service providers involved in scaling up access to safe male circumcision services were trained in MC techniques, management of infections and complications post MC, HIV counselling and testing and advocacy. A pool of six MC trainers was formed and trained to facilitate future cascade training of health care service providers involved in scaling up access to safe MC services. No male circumcision policy is available yet. This is due to the lack of consensus among key stakeholders on whether a stand-alone MC policy is the best option to guarantee better results in scaling up access to MC services or should MC be integrated as a component of a global health policy.

Adolescents and young people

Through the "Geração Biz Programme" effective advocacy and capacity building have strengthened the commitment to, and implementation of the youth HIV/SRH program by the Government through the multisectorial management structure of Ministries of Youth and Sports, Education and Health. Currently, the Programme is institutionalised and owned by the Government. This was possible thanks to a two years transition plan, that involved building capacity of Government staff through training and supervision. Recently, in response to vulnerability of girls and young women which is part of the epidemiological pattern , PGB´s strategies and materials have been revisited in order to address more adequately and specifically needs of girls. gy. Through the work of PGB around 400 youth associations were created, and are developing into social actors in some provinces.

PMTCT

The geographical coverage of PMTCT services supported by the UN has progressively expanded throughout the life of the JP. The number of PMTCT integrated sites in MCH services across the country rose from 744 in 2009, to 909 in 2010 and 1,063 in 2011, allowing more women and children to benefit from PMTCT services. Of those, 461 are supported by UN agencies. The MoH data from in 2011, indicate that out of 1,063,012 pregnant women attended ANC, 869,490 were tested for HIV (82%). Out of the 74,945 diagnosed HIV-positive, 69,730 received ARVs for PMTCT (69%); out of

these, 8,643 (or 12 per cent) were initiated on HAART. 43,386 exposed babies received ARV for PMTCT (58% of women diagnosed positive).

In regard to the provision of nutritional supplements to malnourished pregnant and lactating women and children, the support has been expanded from only those HIV+ to all those at risk in health facilities with PMTCT services. The UN supported MISAU/FANTA in training of DPS and health personnel on the Nutritional Rehabilitation Programme Volume I, and provided technical support to DPS and health centers for logistics and monitoring. The manual Volume I of the Nutritional Rehabilitation Programme of MISAU was distributed to Health Centers by the UN, as well as job aids (MUAC tapes, registry books, reference tables). The UN also procured scales and altimeters for health centers (both for children and adults). In addition, malnourished pregnant and lactating women and children in ART/TB received a food basket (Cesta Básica programme of MISAU supported by the UN by provision of technical support for implementation, including monitoring and evaluation).

Despite progress made, there are areas that need more focus namely, quality implementation and monitoring of the PMTCT activities especially at decentralized level; the M&E system; the generation of evidence for policy making through operational research. Additionally, follow up adherence mechanisms through mother support groups need particular attention, as well as male and community involvement.

Treatment

Technical and financial support was provided to expand the number of public health facilities providing integrated treatment, care and support for HIV infected patients. The number of health facilities providing treatment, care and support services increases from 222 to 260 in December 2011 which represent an increase of 17%. Although district and more remote areas were prioritized, the target initial planned of 304 health facilities providing integrated HIV treatment, care and support services could not be reached due to reduce funding from key developing partners. However, the MOH exceeded the treatment target of 240,000 by putting more than 260,000 people on treatment by the end of December 2011. More than 23,000 children less than 15 years old were put on treatment out of the 23,800 initially planned.

Given the exponential increase in people on antiretroviral treatment, an HIV/AIDS drug resistance monitoring and surveillance system was reinforced with the training of more than 100 health staff on Early Warning indicators of potential ARV drug resistance. More than 500 health staff were trained in HIV treatment protocols and more than 100 in ARV logistic management and rational use of ARV and essential health commodities.

Malnourished HIV patients received nutritional supplements. In addition, patients in ART/TB treatment received a food basket (Cesta Básica programme of MISAU supported by the UN by provision of technical support for implementation, including monitoring and evaluation). The development of manual Volume II and job aids for nutritional rehabilitation of malnourished adult patients, including people living with HIV on pre-ART and ART, is in progress. The UN capacitated DPS and health personnel on anthropometric measurements and evaluation, and provided technical support to DPS and health centers for logistics and monitoring. The UN also procured scales and altimeters for health centres.

Mitigation

The Ministry of Women and Social Action (MMAS) and its provincial directorates were supported to improve capacities to co-ordinate the multi-sectoral response to OVC through the Technical Working Groups on OVC, that bring together different line ministries and civil society partners. In conjunction with MMAS, and in partnership with leading international and national non-governmental organisations, 184,016 OVC were supported to access at least three of six basic services identified in the National Plan of Action for OVC (health, nutrition, psycho-social support, education, legal aid and financial assistance), followed by an additional 233,413 in 2010 and 196,767 in 2011.

The cooperative members, small farmers associations are being supported, through the LEDAs, in the development of small business under economic empowerment perspective, by having training on SIYB, savings and micro-credit, crops production among other activities. Actually the program supported 3,800 people in developing small business through the promotion of credit and savings schemes in Maputo, Manica and Sofala provinces. The Institute for Vocational Training and Employment (INEFP) was supported by the JP to assist associations and CBO's in Sofala and Gaza provinces. Therefore, 500 people were trained on business development and short courses on vocational training were also provided. After the trainings kits were provided to participants aiming to promote self-employment and through it to reduce the vulnerability of affected and infected people.

Mainstreaming

The HIV mainstreaming component was able to support the development of specialists on HIV mainstreaming, advocacy, monitoring and evaluation through training over 500 'training of trainers', young professionals, students, planners, budgeters and HIV Focal Points on mainstreaming HIV and AIDS in sectoral plans and programmes to ensure the mainstreaming of HIV in the key selected Government sectors and Civil Society Organizations. In addition, the issue of HIV was successfully institutionalized at the University of Eduardo Mondlane (UEM) and in the Matalane police academy. A course on the Economics of HIV is being lectured by the Faculty of Economics of UEM and a course on gender base violence, HIV and Human Rights for new police recruits is being lectured at the Matalane Police Academy.

The development of mainstreaming tools, such as the manuals for mainstreaming of HIV in the plans and programmes, HIV policies in the work place, the matrix for integration of gender in Government sectors and the HIV national strategic plans allows the NAC to better coordinate efforts of different sectors. Results achieved and lessons learnt from the implementation of the National Strategic Plan I and II were taken into consideration and will help to improve the mainstreaming and coordination of HIV and AIDS in the public and private sector. A cross cutting issues matrix developed by MPD will allow the NAC to be informed about how sectors are integrating Gender and HIV in their plans and programmes.

Through the Business Coalition (ECOSIDA) and the Trade Union Organizations, 600 SME have developed under the Code of Conduct, Recommendation 200 and the Law 5/2002 HIV and AIDS workplace policies. Social partners were supported in mainstreaming TB matters in the HIV and AIDS workplace Policies. In order to strengthen the monitoring and supervision capacity of Ministry of Labour on HIV legislation the UN provided capacity building for General Inspectorate by training 150 labour inspectors on HIV and AIDS Legislation. Three regional workshops were organized with the purpose to train labour inspectors from eleven provinces on HIV and AIDS legislation and the use of the guide book.

The JP ensured that Government, Civil Society Organizations and Parliament were represented in the international HIV forums and fulfilling human rights commitments by supporting the participation of Mozambique in national and international events, including the World AIDS Conference, the Law Southern Africa dialogue and the High Level Meeting on AIDS in June 2011. The participation of Mozambique in these events contributed to raise awareness at country level on emerging issues at global level with regard to HIV and AIDS, especially the issue of rights of key populations which was seen as a taboo, and was also an opportunity to promote relations between these different groups of society and international partners.

Populations at most risk are being reached by HIV programmes focusing on truck drivers and sex workers in hot spot points at community level along transportation corridors. To increase understanding of the on-the-ground dynamics of HIV transmission, the UN conducted a study of HIV vulnerabilities along the Maputo-Swazi Corridor – including hot spots in Swaziland. In what concerns the humanitarian efforts, emergency actors were supported in the development of key tools, including

the elaboration of an emergency contingency Plan, which ensure that HIV and AIDS and Gender needs are integrated into emergency plans and activities and that HIV and AIDS and Gender are standing agenda points in the community emergency response.

Monitoring and Evaluation
In regard to the monitoring and evaluation outputs, the following observations can be made. The operational monitoring and evaluation plan was developed, budgeted and financing of at least 50% was made available, however only 20% of the plan was implemented due to NAC human resources challenges in terms of capacity and capability.

Reports and feedback show that during this period the capacity of the NAC has been strengthened at district and provincial level with the provincial monitoring and evaluation operational completed, monitoring and evaluation seminars undertaken for the district plans, with corresponding supervision visits and technical assistance. However, due to human resource challenges, further capacity building at both central and decentralised level is necessary. Additionally, the NAC and ECoSIDA, developed a national monitoring and evaluation sub system for the private sector to feed the national system and training was provided in five provinces to roll out the system.

In terms of the production and dissemination of strategic information, several studies have been finalised in which can be included the UNGASS 2010, the GARPR 2012, Tete and Beira hot spot and corridor mapping, HIV estimates exercise, demographic impact study, the national HIV epidemiological surveillance survey and the National prevalence study on risk and behaviour. However, the anticipated National AIDS Spending Assessment (NASA) and integration of NASA into NAC has been delayed due to NAC capacity issues.

b. Report on how achieved outputs have contributed to the achievement of the outcomes and explain any variance in actual versus planned contributions to the outcomes. Highlight any institutional and/ or behavioural changes amongst beneficiaries at the outcome level.

Prevention
In the context of the Strategy for Acceleration of Prevention, a series of interventions have been implemented and supported by the UN over the last three years, HIV prevention efforts focused on supporting the CNCS and the education, protection, and health sectors in the finalisation of decentralised communication for development strategies focused on tackling the drivers of the epidemic, provision of information in schools and out of schools as well as provision of Health Services for adolescents and youngsters in youth friendly services with a focus in multiple and concurrent partnerships as well as stigma and discrimination. Among some of the key interventions the following outcomes can be mentioned.

Counselling and testing

Data from surveys has shown that the policies and strategies for improving counselling and testing and therefore contribute for hiv prevention have produced modest but important results. According to INSIDA 2009, 73% of women and 72% of man aged 15-49 know where to access CT services. In addition, 37% of women and 19% of man have already been tested. The national counselling and testing campaign initially foreseen in 2010 and then 2011 did not take place due to national bottlenecks despite proactive support from the UN and other technical partners.

Communication
Multiple Concurrent Partnership National Campaign: in 2010, CNCS intensified the implementation of the first, focused, and coordinated campaign addressing key drivers of the epidemic (multiple and concurrent partners; and condom use). The campaign, whose key message was "Andar fora é maningue arriscado" , targeted the adult population as well as young people and included radio and

TV spots for six months, as well as community mobilisation through provincial and regional training of all communication partners. A second phase of the campaign is planned for 2012.

Community mobilisation activities have been further strengthened. The main channels for social mobilisation remain community radio (child-to-child, youth-to-youth, and mainstream programming), public radio and television (child-to-child and adolescent programming), participatory school clubs (linked to peer radio activity), participatory theatre (through community performance, school training, and radio content development), and multimedia mobile units.

There has been the mainstreaming of the socio-cultural approach to SRH and HIV & AIDS prevention through knowledge and evidence production on the bases of pilots, advocacy, capacity building and interventionsat various levels. Both central and local level governments (Zavala, Inhambane and Mossuril, Nampula) were trained in applying the social-cultural approaches, resulting in its integration to the annual work plan of specially established HIV & AIDS groups within the respective institutions.

MARPS

Prior to the national strategy Acceleration of Prevention MARP activities were a scarce. Within the scope of the strategy, activities have been initated in this important area which are opening service provision and access to MARPs, for example the inclusion project which addresses the needs of sex workers and geographical targeting along the Nacala corridor. Studies are also collecting better information about MARP needs, for example, the assessment of health vulnerabilites of migrant and no migration workers in the Port of Mozambique which has resulted in a set of Government recomendations.

Male circumcision

The duration of the JP has seen the Government move retincent to MC to most recently a firm commitment to the scale up of services foreseen in 2012 and beyond. No male circumcision policy is available yet. This is due to the lack of consensus among key stakeholders on whether a stand-alone MC policy is the best option to guarantee better results in scaling up access to MC services or should MC be integrated as a component of a global health policy.

Adolescents and young people

In 2011, with a view to address their specific needs and particular vulnerability, the youth movement was created that aims to boost and promote youth participation in important decision-making forums, and, promote the ownership of the prevention response in young people. This movement was launched by the President and is being rolled out to the provinces. The youth movement agenda includes the most important interventions around youth, such as, increased participation in decision-making and education for behaviour change. With the involvement of the highest level of national leadership, the movement has provided new impetus to the response of HIV prevention.

During the cycle, through the multisectorial Government Program ("Geração Biz Program") which aimed to promote Sexual and Reproductive Health (SRH) and HIV prevention in schools, out of schools (in the communities) and through provision of Health Services, the program managed to reach an increasing number of adolescents and young people each year. The main interventions provided to these adolescents were provision of adequate information on SRH and HIV, promotion of utilization of Youth Friendly Services, Counselling and Testing for HIV and promotion of family planning with a focus in consisten condom use. The program have been consistently refocused to address young girls particular needs through a more gender sensitive approach. As a result this aspect has been reflected in the most recent indicators of the INSIDA 2009 and DHS 2011 surveys that have illustrated a modest but important improve in the indicators.

PMTCT

The geographical coverage of PMTCT services has progressively expanded with technical and financial support form the UN. The launching of the Global Plan for the Elimination of new HIV infection in children and consequent development of a costed EMTCT National plan, the update of PMTCT national guidelines (adoption of option A), capacity building of frontline health providers and drugs and commodities forecasting exercise were key achievements. Additionally the first PMTCT national review, an evidence-based tool that enabled a better understanding of the major programme bottlenecks and helped to define a baseline that will allow the monitoring of the progress towards the achievement of EMTCT goals is another noteworthy attainment. Besides that, the UN support was instrumental in the development of the PMTCT component of the PEN III and the GFATM Round 9 proposal and the PMTCT task force was restructured allowing better MoH support and partners coordination.

Being aware of the challenges to achieve the E-MTCT goals at national levels, the Interagency Coordination has become stronger to better support the MoH to drastically reduce the number of new HIV paediatric infections. The UN support has been streamlined along to the four prongs of PMTCT taking on the UN comparative advantages of each agency.

Treatment

The JP has contributed technical and financially to the Ministry of Health's revision and updating of treatment guidelines and strategies to align with the WHO guidelines. In the new guidelines, ART first line regimen is recommended for all HIV infected individuals with CD4 less or equal to 350 cells/mm3 instead of 250 cells/mm3. In case of the existence of a co-infection with tuberculosis, ART should be started two weeks post TB treatment initiation regardless of CD4 counts. The new guidelines will drastically reduce morbidity and mortality due to late initiation of ART.

There are registered improvements in the anthropometric evaluation and registration of nutrition data for nutritional rehabilitation. However, continuous on-the-job training is still necessary because of turn-over of health personnel and complexity of the subject. At national level there are improvements in coordination between MISAU, different UN agencies and clinical partners for implementation of the national nutritional rehabilitation program and development of monitoring tools. However, monitoring needs to be improved in order to allow evaluation of nutritional outcome data. Important lessons have been learnt from the implementation and evaluation of the food basket (Cesta Basica), and after communication and discussion between MISAU and MMAS, this program is moving to the social protection area, more precisely will be integrated in the PASD (Direct Social Action Program) of MMAS. More attention will be paid to the inclusion of pregnant and lactating women, which was shown as a constraint during evaluation of the Cesta Basica program.

Mitigation

As of end 2008, 22% of Mozambican households with OVC were receiving external support[6], a figure second only to Botswana in this region[7] and one that should increase given the continued emphasis of the government, development partners (including USAID-PEPFAR), UN agencies and civil society organisations in reaching marginalised children in the 2009-2011 period. However, there are also increasing numbers of OVC; the most recent estimates are that there are 2.1 million OVC, 670,000 of whom have been orphaned due to AIDS[8]. Moreover, in keeping with the findings of the Joint Learning initiative on Children and AIDS[9], there has been increasing recognition that specifically targeting OVC may lead to further stigma and discrimination, does not address wider household vulnerabilities, and may lead to exclusion of other marginalised children. As such, the Government of Mozambique has decided that upon the expiry of the 2006-2010 National Plan of Action for OVC, the country will develop only one National Plan of Action for Children, though that this plan will

[6] National Institute of Statistics. *Multiple Indicator Cluster Survey*. 2008.
[7] UN. *Children and AIDS: Fifth Stock-taking Report*. 2010.
[8] UNICEF. *State of the World's Children*. 2012.
[9] UNAIDS et al. *Joint Learning Initiative on Children and AIDS*. 2009.

recognised particular vulnerabilities of OVC, namely in terms of access to psycho-social support, placement in alternative care and protection from property disinheritance.

Mainstreaming
During the life of the JP, the Mozambican executive and legislative Government have visibly joined forces to address HIV and AIDS. Mozambique now have two HIV laws, the HIV at the work place law 05/2005 and the law against stigma and discrimination of people living with HIV and AIDS which are being revised to better mainstreaming gender and the Human rights base approach and address the issue of criminalization of HIV. These were the first instruments proposed and drafted by Parliament as previously laws were always proposed by the executive government and submitted to Parliament for final review and approval. Technical assistance to support civil society groups and develop a NSP III civil society operational plan has strengthened the meaningful participation of civil society in the HIV response.

Technical capacity was developed at the level of Government ministries, institutions, companies, workers' organizations and other organizations for integration of HIV and AIDS and TB into business plans and institutional development plans, and for implementation of policies and programmes for the prevention of HIV and mitigation of the impact of AIDS. The Parliamentary was provided capacity building on HIV and AIDS issues including the ILO tools (Code of Practice and the Recommendation 200). Social partners were supported in mainstreaming TB matters in the HIV and AIDS workplace Policies through OTM and ASSOTSI. The cooperative members, small farmers associations were supported in the development of small business under economic empowerment perspective, by having training on SIYB, savings and micro-credit.

As a result of the JP, there is an increased understanding of HIV dynamics along the Maputo-Swazi corridor. Southern Mozambique is the worst-affected region in relation to HIV, linked to the high levels of cross-border migration with neighboring South Africa and Swaziland. To increase understanding go the on-the-ground dynamics of HIV transmission, a study was conducted of HIV vulnerabilities along the Maputo-Swazi Corridor – including hot spots in Swaziland. The assessment concentrated on areas of significant economic activity, where truck and public transport drivers spend long periods of time and where amenities, such as bars, guest houses and restaurants have been established to serve increasing numbers of mobile populations. The study found extremely high reported levels of HIV and high levels of transactional sex, as well as physical abuse of sex workers. All this coupled with relatively low use of condoms. There is a need to clear the debate and allow for frank discussion of the emergency situation for HIV prevention in southern Mozambique.

Monitoring and Evaluation
There are registered improvements in the national monitoring and evaluation system as a mechanism which is available to collect and disseminate strategic information to inform, support and evaluate the national response. There is improved availability and dissemination of key national studies and surveys, for example the national HIV prevalence on risk and behaviour survey 2009 and several other surveys and studies which the JP has been able to directly or indirectly support. This means that Mozambique is in stronger position to understand and respond to the national HIV epidemic. An example of progress has been the opportunity to develop a national sub system for the private sector which shows commitment to strengthening national systems. Another example of success is the multi sector technical group which provides substantive technical assistance to the consolidation and reputation of the national M&E system. However, significant challenges remain; examples include issues with the training and availability of human resources and overall capacity building, weak coordination to implement the national M&E system and weak reporting and traction in systematic feedback of key data to the NAC.

c. Explain the overall contribution of the programme to the Strategy Planning Framework or other strategic documents as relevant, e.g.: MDGs, National Priorities, UNDAF outcomes, etc.

The Joint Programme was developed in the context of the existing UN Joint Team on AIDS in Mozambique (UNTAM) and its Joint Programme of Support. The Joint Programme offered further motivation and opportunities to strengthen existing structures and prioritize joint activities. The organization and management of the overall HIV pillar and UNTAM adhere to UNDG/UNAIDS norms and standards for Joint Teams and Joint Programmes for AIDS. The HIV Joint Programme had the overall objective of strengthening the national response to HIV and AIDS, specifically it aimed at instilling responsibility on individuals, civil society, public and private institutions whether national or local, for halting the spread of HIV and AIDS amongst high risk populations as well as to mitigate the impact of AIDS (Outcome 3 of UNDAF 2010 - 2011, Pillar on HIV and AIDS).

As far as possible existing national framework, structures, mechanisms, and institutional processes are supported, for example, the Joint Programme was initially aligned to the National HIV and AIDS Strategy and HIV is a cross cutting issue in PARPA. In 2009, to assure coherence with Government priorities in the area of HIV and AIDS the HIV Joint Programme was aligned to the National Accelerated Prevention Strategy. Until this point the UNDAF prevention activities had predominantly focused on youth prevention, but with the development of the National Prevention Strategy, it was evident that UN support in the area of prevention needed to become more encompassing. This alignment broadened the scope of the Joint Programme by including areas relevant to HIV prevention that were not initially foreseen in the original Joint Programme and where the UN can offer significant added value.

d. Explain the contribution of key partnerships and collaborations, and explain how such relationships impact on the achievement of results.

Existing UNTAM organizational structures and accountability mechanisms serve as a platform where members can flexibly and quickly respond to the need for developing joint UN positions and provide technical input according to the division of labour. The JP created a supportive and enabling environment for UNTAM through increasing incentives for joint work, better clarity of lead and partner agencies, and consolidating accountability mechanisms. Synergy is created through a joint annual planning exercise as well as several prioritization exercises at technical working group and UNTAM level. For example, the implementation of the UNAIDS Outcome Framework for 2010-11.

An internationally agreed division of labour which has been functioning since 2006 aims to increase efficiency and reduce duplication through a coherent approach among UN agencies to provide technical support and maximize comparative advantages. It provides national stakeholders with a single framework of how the UN as a whole manages its response and resources at the country level. According to the division labour (most recently updated in 2011) UN agencies develop partnerships and collaboration between each other and with partners (Government, civil society and private sector) according to comparative advantages.

e. Who have been the primary beneficiaries and how they were engaged in the programme/ project implementation? Provide percentages/number of beneficiary groups, if relevant.

The Joint Programme was closely aligned to national strategies and involved both government and national partners and under the leadership of the technical leads, close working relations were maintained. Beneficiary groups were numerous due to the broad scope of the JP, the direct beneficiaries of the JP were line ministries and civil society organisations as listed in Part I section d).

f. Highlight the contribution of the programme on cross-cutting issues pertinent to the results being reported.

During the JP lifetime, the delivering as one comparative advantages were treated as cross cutting issues, they included i) policy and advocacy, ii) normative and technical support, iii) capacity development and iv) civil society partnerships. In the JP annual reporting, these themes were highlighted to show how the UN supports each of these areas demonstrating their strategic

importance. In terms of strategic reporting on outputs there was often duplication between the areas so there was sometimes confusion under which area to report certain themes.

Additionally, the JP has contributed to the cross cutting of gender and this issue has been addressed across the JP, while most particularly in the strategic area of HIV and gender mainstreaming. Another interesting area has been the integration of HIV and gender into the emergency response, the JP was able to support several activities in this area which have resulted in a stronger integration of HIV and gender in the national emergency response. The JP created a greater awareness about the need to mainstream Gender and HRBA in all programmatic interventions.

g. Has the funding provided by the MPTF/JP to the programme been catalytic in attracting funding or other resources from other donors? If so, please elaborate.

The JP was within the scope of the delivering as one experience and as such was not necessarily catalytic in attracting funding however it did provide a structure around which existing agency and donors resources could be directed.

h. Provide an assessment of the programme/ project based on performance indicators as per approved project document using the template in Section IV, if applicable.

Refer to section IV

III. EVALUATION & LESSONS LEARNED

a. Report on any assessments, evaluations or studies undertaken relating to the programme and how they were used during implementation. Has there been a final project evaluation and what are the key findings? Provide reasons if no evaluation of the programme have been done yet?

Three formal programme assessments were undertaken during the lifetime of the JP. Firstly in 2009 to assure coherence with Government priorities in the area of HIV and AIDS the JP was reviewed and subsequently aligned to the National Accelerated Prevention Strategy. Until this point the UNDAF prevention activities had predominantly focused on youth prevention, but with the development of the National Prevention Strategy, it was evident that UN support in the area of prevention needed to become more encompassing. This alignment broadened the scope of the JP by including areas relevant to HIV prevention that were not initially foreseen in the original Joint Programme and where the UN can offer significant added value.

Secondly, in March 2010 an evaluation of the UNDAF HIV pillar including the HIV JP was undertaken which explored three areas of investigations,

1. What has been the experience of the organization structure and management arrangements through which the HIV pillar is implemented?
2. How effective has the UNTAM been in implementing the HIV pillar?
3. What can be learned from the HIV pillar experience?

The evaluation 'scored' against various sets of criteria both specific to Mozambique, the Delivering as One 'Success Factors' established by the Mozambique UNCT, and regional and global criteria. The report made several recommendations, one of which was that the UNTAM should as a matter of urgency revisit its results framework for the UNDAF Extension period and consolidate it as a Joint Programme of Support (joint programming) to include, as required by the Secretary General in his instruction to RCs, '*the entirety of the UN's support to the national response to AIDS'.* In this context, the UNTAM reviewed existing results matrices.

Thirdly, in June 2010, a JP review was undertaken by all delivering as one JPs in Mozambique, for the HIV JP the results of the review supported and complemented the evaluation of the UNDAF HIV pillar undertaken earlier in 2010.

b. Explain, if relevant, challenges such as delays in programme implementation, and the nature of the constraints such as management arrangements, human resources, as well as the actions taken to mitigate, and how such challenges and/or actions impacted on the overall achievement of results.

One of the major challenges of the JP has been that of robust reporting. While annual reporting has shown significant progress in several outputs, an issue has been to update the result indicators of the JP so that progress could be accurately measured. The UNTAM had been working with several different result indicators and was confusing. In December 2009, UNTAM agreed that it was important to update the Joint Programme document and one of the main recommendations of the HIV pillar evaluation in March 2010 was the need to strengthen the Joint Programme's results based management (RBM) and to develop robust results matrices using credible RBM as a fundamental and non-negotiable requirement in order to provide justifications and evidence of the effectiveness and impact of the UN system. The issue was resolved with the updating of the Joint Programme documents including the narrative and M&E matrix using RBM. All Joint Programme documents were up to dated to ensure consistency between national indicators, UNDAF indicators, Joint Programme indicators and individual agencies indicators.

Annual constraints and challenges are referred to in the annual progress reports, some persistent constraints and challenges have included:

- Delay in the disbursement of One Fund funds, which caused delays in disbursement to implementing partners and eventually delays in the implementation of activities,
- Changes in work plan activities in some cases without proper consultation with government counterparts,
- At times, delayed information from the implementing partners resulted in the delay of regular reporting by JP,
- The technical capacity of partners was limited at times and the need for more partner leadership in coordination and implementation at both national and district levels was highlighted.

c. Report key lessons learned that would facilitate future programme design and implementation, including issues related to management arrangements, human resources, resources, etc.

In the context of the UNTAM structure, the Joint Programme has provided the opportunity to increase and strengthen the following aspects:

- Coherent and comprehensive 'Unity of Purpose': taking the UN system in Mozambique beyond a series of agency projects, and equip it, with respect to AIDS, to 'deliver as One'. Greater focus and efficiency in support of the national response (NSP): making the most of the UN's comparative advantage, added value and mandate.

- Consolidation of a thematic Team and formalizing management arrangements in some detail (including team membership, DoL – or at least clear specification of roles, coordination structures and roles): critically important for helping agencies deliver as one. Such a team should be established at (UNDAF) outcome level, to deliver an outcome as one – Joint Programming. It may not be worth trying to squeeze agencies together in this manner at output level. Apart from the requirements of accessing funding from such entities as the Spanish Fund the complexities of setting up the systems to make delivering as one effective at output level (a Joint Programme) are quite likely not good value for money. The UNTAM has found more recognition and fulfillment for the HIV pillar than for the HIV Joint Programme. The team struggled (as have staff working on other joint programmes) with finding coherence and clear UN focus within the framework of a set of outputs: it has tended to become a collection of existing agency 'projects' or activities rather than genuine 'whole is greater than the sum of its parts'.

- Development of robust results matrix (using credible RBM): as a fundamental, non-negotiable requirement for such joint programming; and manage it with RBM (management and reporting by results) in order to provide justification and evidence of effectiveness and impact.

- Increased harmonization and alignment: using the HIV Joint Programme to be both an example, and a focus, for strengthening partnerships and coordination for greater harmonization and alignment of efforts from all partners. Teams should ensure that their joint programming responds to national priorities, clear UN added value and comparative advantage, and ensures coherence, complementarity and cohesion among UN agencies – including clear involvement of all external and internal partners and clear accountability. As far as possible existing national frameworks, structures, mechanisms and institutional processes should be supported, stimulated or nurtured to achieve this. The UNTAM has been able to use effectively and strengthen the national mechanisms (enshrined in the 'Three Ones') for coordination of the 'HIV sector'. The adjustment of the HIV Joint Programme in 2009 to respond more directly to the National Prevention Strategy is a good example of the paramountcy of national priorities.

- A resource mobilization framework: an effective vehicle within the overall resource envelope through which additional resources can be channelled into the national response.

- Greater decentralisation of decision making: increased emphasis on results based management leading to clearer strategic frameworks to direct effective, country-specific interventions, with increased country-level resource mobilization, leading to greater deconcentration and ultimately decentralization of decision-making, allocation of resources and accountability within the UN system.

- Greater accountability: both within the UN, and through its support beyond it, for achieving the promises made by governments and partners – UNGASS, the MDGs, Universal Access, etc.

- Necessity to encourage and sustain a culture of managing for results, with frank accountability for results at all levels.

- Necessity to use consistent methodologies and programming techniques which empower institutions and communities, ensure national ownership and consider sustainalblity issues.

- Intrinsic capabilities and competencies among agency staff to manage such team building and team work, robust RBM and effective joint programming should not be taken for granted. Considerable investment and capacity building, mentoring and guidance may be required. The UNTAM has shown that, with the best of intentions, many agency staff have struggled with both the demands of team work, and effective results-based programming. Their Retreats, capacity-building and team-building exercises have, over the years, significantly strengthened the UNTAM.

IV. INDICATOR BASED PERFORMANCE ASSESSMENT

	Performance Indicators	Indicator Baselines	Planned Indicator Targets	Achieved Indicator Targets	Reasons for Variance (if any)	Source of Verification	Comments (if any)
UNDAF Outcome 3: Individuals, civil society, national and local privates institutions are empowered to halt the spread of HIV among population at higher risk and to mitigate its impact							
Outcome 3.1: Prevention: HIV inclusive prevention programme covering 5 key areas of the National Strategy of the Acceleration of HIV Prevention (ATS, Condoms, GAR, CM and CMC) implemented and expanded							
• % of women and men (15- 49 years and particularly of youths aged 15-24 years) who have used the condom in the last sexual relation. Target: 40% women; 50% men. Baseline: Women 20%; Men 30% • % of women and men (15- 49 years old and particularly youths aged 15-24 years) who have had sexual relations with a partner outside the marriage in the last 12 months. Target: 7% women; 35% men							
Testing and Counselling							
Output 3.1.1 ATS services expanded to cover targeted populations	# of people counselled and tested in the national cmapign	0	250,000	5.000 people tested in informal settings	No national campaign has been undertaken yet, it was delayed in both 2010 and 2011	ASSOTSI Reports	Lack of availability of test kits and broader national funding issues
MARPS							
Output 3.1.3 Ensured the development of programs, strategies and coordination mechanisms for health promotion, including prevention of	# of working groups established at central and provincial level with defiend operational plans	No plan 0	Plan elaborated At least 200 technicians trained	Strategic Plan of the Institute of Traditional medicine was elaborated 215 technicians trained	-	Operational plan reports National validation with involvement of key stakeholders from formal and traditional	The indicator changed

STI/HIV for the MARPs						medicine Report from the consultants	
Output 3.1.4 Strengthened capacity of targeted support structures to implement HIV & AIDS/TB prevention interventions along the transport corridors	# of people trained	0	190 technicians	350 technicians		Training session reports	
Output 3.1.5 Improved knowledge on making MARPs size estimates	# of people trained	0	4	4	-	Training session reports	-
Output 3.1.6 Health and HIV & AIDS Prevention services expanded for the population of LGBTI, Prisoners, Sex Workers and People with disabilities (PWD)	# of LGBTI, prisoners, TS and e PWD reached by health and HIV prevention services	0	90 TS 80 PcD, 15 LGBTI	2,997 sex workers 3,106 MSM 23,364 prisoners	-	General health service records in prisons and night clinics	-
Young people							
Output 3.1.7 Increased	# of youth associations	0	1	400 youth associations	-	Legalisation documents	-

participation of young people in national and provincial fora and community committees and school councils	created and legalised					Parent associations reports at central level	
Output 3.1.8 Youth Provincial Councils (CPJ) implementing peer communication programmes on HIV prevention in 8 provinces and at least 200 young people participating in decision-making fora at provincial, district and community level in 8 provinces	# of young people involved in decision making from at least 8 provinces	Unknown	At least 200 young people	Over 1000 young people from 8 provinces involved in PARPA briefings and youth council meetings	11 youth councils took place 8 PARPA meetings	Meeting reports	-
Output 3.1.9 PLWHA School Awareness extra-curricular programme for children aged 10-14 scaled up in seven CFS districts with particular foci on life skills development for	# of schools and districts where PLHIV school awareness programmes are scaled up	0	7 districts 150 schools	162 new schools in 7 districts	-	Partner and UN reports	-

HIV prevention and protection from violence and abuse							
Male circumcision							
Output 3.1.10 Detailed district and provincial work plans for MC implemented in Gaza, Maputo province, Maputo City and Inhambane	# of disctrict plans where MC is implemented	0	3	13	Mainstreaming of MC component in districts and work plans for Gaza province	District plan reports	-
Output 3.1.11 Improved capacity of health care service providers involved in scaling up access to safe MC services	# of health workers trained to scale up MC services	4	50	50	Achieved as planned	Training reports	-
Output 3.1.12 Monitoring and Evaluation reports of scaling up MC activities produced	# of evaluations undertaken	0	1	1	Achieved as planned	Evalaution reports	-
Output 3.1. 13 Male Circumcision policy available	Policy available: yes or no	No	Yes	No	No stand-alone MC policy but integrated into one HIB/MC/HSS policy	Available policy document	-

Communication							
Output 3.1.14 National Communication for HIV Prevention Strategy and Plan (integrated in PEN III) implemented under enhanced CNCS coordination and civil society (including youth) participation, adequately addressing MCP and stigma as key drivers of the pandemic	# of youth associations and CBOs trainied in BCC	0	150 CBOs	150 CBOs	Included CBOs, FBOs, networks	CBO training reports	
	# of activists with knowledge and applying to their work the subject of stigma and discrimination	3	11	400 activists from 19 PLHIV associations 1,410 children involved in child to child media programmes	1,750,000 people reached through multimedia mobile unit	Stigma and discrimination Activity reports	-
	# of media programmes produced and disseminated	1	3	3 national campaigns supported covering MCP	Additional campaign for the All Africa Games	Copies of transmitted radio programmes	Capacity building for 8 community radios involving 24 journalists
	# of specific communication strategies developed at local level	0	1	NSP III Operational plan for communication strategy	-	Strategy	-
Outcome 3.2: Treatment and care: Increased capacity of MISAU and of the main stakeholders to improve the coverage of 30% for at least 40% of PLHIV, both in adults and in children, benefiting from a standard support package in at least one of the following areas: ARV therapy, prophylaxis and treatment of opportunistic infections, nutritional support, home care and counselling							
• Number and percentage of adults with advanced HIV infection that receive ARV therapy according to national protocols (coverage of ARV therapy) (Baseline: 15,900 (2005); Target: 195,000) • Eligible HIV positive children (<15 years) that receive ARV therapy (Baseline: 1,500 (2005); Target: 23,000)							
Output 3.2.1	# of people on	15,000(2009)	26,000	19,108 (2011)		SIS	-

Policies, guidelines and strategies for HIV/AIDS Treatment, Care and nutritional support developed/ updated	ART who receive mothly nutritional supplementation		people	(+ 3,138 on food basket in 2011)		MISAU/DPS	
Output 3.2.2 Technical support provided to the MoH to strengthen an integrated delivery of treatment, care and support for HIV/AIDS	# of HUs that offer ART services in accordance with the updated national protocols	222 HU (2009)	304 HU	260 HU	Reduction in funding from international partners	SIS MISAU	-
Output 3.2.3 To support the country in increasing equitable access to ARVs of assured quality for the prevention and treatment of HIV/AIDS and promote the rational use of ART and essential commodities	# of health technicians trained in the execution of the standard support package in accordance with national norms	150 (2009)	650 (2011))	650	Achieved as planned	Training course reports	-
Output 3.2.4 Train of trainers on the delivery of	# of HUs visited for treatment resistance	17 US (2007)	At least 2 HUs in each	15 in 5 provinces	Reduction in funding form international	Supervision and trip reports	-

integrated HIV/AIDS, ART Care and nutritional support	surveillance		provinces, 2010 (35 HU)		partners		
Output 3.2.5 HIV/AIDS Drug Resistance Monitoring and Surveillance System strengthened	# of health technicians trained for treatment and care of HIV and AIDS in children	165 trained techicians (start of 2010)	For all of country	100	Reduction in funding form international partners	Training reports	-
Output 3.2.6 The national pediatric HIV care and treatment response strengthened through increased coordination, capacity, and a functioning information system	# of children attended to for treatment and care in the 156 units supported by UNICEF	1,500	23,000	23,053 in 261 sites	175 sites received UNICEF support	UN reports, SIS	-
Output 3.2.7 Care, treatment and nutrition services for children living with HIV/AIDS strengthened in existing 146 and 10 new sites (156 UNICEF-supported sites total), contributing to reaching the MOH target for	% of HU providing treatment and care of HIV and AIDS for children	186 US (2009)	222 US	261 sites	175 sites received UNICEF support	SIS	

children on ART by end . *(AMP key result*							
Outcome 3.3 PMTCT: Capacity of MISAU and of the main stakeholders increased to provide annually, by 2011, integrated and inclusive PTV services of at least 65,000 pregnant women and their children exposed							
HIV positive pregnant women receiving ARV prophylaxis to prevent the transmission of HIV from mother to child. (Baseline: 46,868; Target: 65,000 children born from HIV positive women that received ARV prophylaxis at childbirth to prevent the transmission of HIV from mother to child							
Output 3.3.1 The PMTCT National Operational Plan strengthened, through strengthened capacity, a strengthened information system, and implementation of the PMTCT plan in the context of Prevention Accelerated Plan	# of HU where PMTCT is provided	30 (2005)	861 (2011)	1,063 (2011)		QAD health sector Indicators 16	
	# of monitored HU where provided PMTCT services are supported by UN	30 (2005)	347	461 (2011)		MISAU and partners implementation reports Agency databases	
Output 3.3.2 Quality integrated PMTCT services in ANC, maternity, postpartum, and CCR are provided in existing 318 supported sites and at least 29 new sites (total 347 supported sites)	# of HU with PMTCT services supported by UN with adequately trained staff	30 (2005)	347	461 (2011)		UNICEF, DPSs and partner annual reports	
	% of HIV positive pregnant women who receive nutritional support in HUs with PMTCT	3,500 (2009)	7,500	6,682 (2011)		DPSs reports	

(AMP key result	# of malnourished children receiving nutritional supports in HUs with PMTCT	3,500	7,500	11,110 (2011)		DPSs reports	
	# of people trained in all aspects of PMTCT, including nutrition and the number of supervised HUs	N/A	100% (347 US)	100% (461 -2011)		UNICEF, DPSs and partner annual reports	
Output 3.3.3 Increased utilization of and adherence to PMTCT services: 80% acceptance of HIV testing for pregnant women and 80% uptake of ARV prophylaxis for pregnant HIV + women and children in integrated PMTCT services nationally, contributing to reaching the MOH target for PMTCT by end 2010 (AMP key result)	% of pregnant women counselled and tested for HIV and who reveice the results in HUs with PMTCT services	65% (2004)	80%	82% (2011)		SMI/MISAU annual programme report	
	% of exposed children who receive prophylaxis with cotrimoxazole	N/A	40%	44% (2011)		SMI/MISAU programme report	

Output 3.3.4 Strengthen the Interagency Coordination mechanisms within PMTCT sub group	# of joint visits undertaken (UNICEF, OMS, PMA e MISAU)	1 (2009)	2/year (2011)	Not done		Trip reports	
Outcome 3.4 Mitigation: 50% of the target of OVCs covered by action plan of vulnerable children (or at least 205,000 annually) together with their families have access to basic services and to social protection schemes							
• Vulnerable children covered and identified by community systems that received 6 basic services, in the last 12 months: education, health, cash transfer, food assistance, psycho-social support, and legal support (including birth registration). Baseline: 65,000 vulnerable children; Target: 205,000 vulnerable children • Direct Food Support (WFP) and basic packages (UNICEF) are provided using the mechanism of the implementation of the Programme of INAS Direct Social Support. Baseline: 3,000 beneficiaries receiving basic support package (2006); Target: 14,000 beneficiaries receiving basic support package (cumulative of 2007-2011)							
Output 3.4.1 Capacity of Ministry of Women and Social Action strengthened to coordinate the implementation of the National Action Plan for Children and to deliver social protection programmes	# MMAS directorates at provincial and district level with uptodate information on service provision in the public sector services and civil society interventions	5 (2006)	11 provinces, 7 model districts and all districts in Sofala province	All 11 provinces and 54 districts	-	PASC annual implementation report DPMAS trimestral reports, monitoring visit reports, minutes of GTCOV, NUMCOV	-

Output 3.4.2 At least 205,000 OVC together with their families have access to six basic services as defined in the PACOV (i.e. health, nutrition, education, and psycho-social care, legal assistance, financial support) and/or are supported with a basic package of materials	# of OVC identified by comunity based systems who received the 6 basic services in the previous 12 months	65,000 (2005)	205,000	2009: 184,016 2010: 233,413 2011: 196,767	2009 was a transition year, as the target was increased from 165,00 and it took some time to ramp up programme activities	DPMAS trimestral reports; NGO semestral reports, RNSIDA trimestral reports, monitoring visit reports Reports from implementing partners (INEFP, UGC, ADEL Manica e ADEL Sofala	-
	# of households economically empowered through training on Business development	900 people (2008)	1,100 people	4,300 people			
Outcome 3.5 Mainstreaming: The provincial plans of public sectors, action plans of civil society networks and business plans of the private sector integrate HIV and AIDS and gender and natural disasters including the corresponding budget for their implementation							
• % of sectoral plans integrating HIV and AIDS and gender and natural disasters in the provinces of Maputo, Sofala, Manica, Zambézia and Tete (Baseline: 0%; Target: 50% of sectoral plans integrating HIV and AIDS and gender and natural disasters in the provinces of Maputo, Sofala, Manica, Zambézia and Tete)							
Output 3.5.1 National mechanisms for the establishment of mass specialists on HIV-AIDS and feminization of HIV-AIDS for the creation and strengthening of Government institutions,	# of small and medium businesses with strategies for HIV, gender and natural disaster	220 formal and informal SMEs implemented HIV strategies and programmes	550 SMES with strategies for HIV, gender and natural disaster	600 SMEs implemented strategies and programmes on HIV and AIDS, 80% of government sectors (9 priority sectors) mainstreaming HIV into plans	-	Reports on the planned programme of acvtities based on the strategy	-

association, associations of informal vendors, civil society (including junior associations and centers)							
Output 3.5.2 Tools and methodologies for monitory and integration of HIV-AIDS and Gender applied for 180 Government focal points, Trade Unions in the planning and execution of sectoral programmes and action plan	# of Government technicians, employees and unions that use the tools, knowledge of monitoring and mainstreaming of HIV into the planning and execution of sectoral programmes and actions plans	0	180 government technicians, 50 employees and 100 unions	200 Ministry of Labour and ECoSIDA technicians trained; 530 specialist trained on HIV and AIDS mainstreaming; 4 manuals on HIV mainstreaming,	-	Routine monitoring documents Action plan reports	Also covered advocacy, monitory and evaluation
Output 3.5.3 Integration of HIV-AIDS and Gender in emergency trainings plans of Government and Civil Society Organizations	# of civil society networks with capacity in HIV, gender and natural disaster mainstreaming in their action plans	At least 3 civil society networks	4 networks with HIV and gender mainstreamed in to their action plans	-	-	Routine monitoring documents Action plan reports	-
Output 3.5.4 Conception of	# of tranings integrating sexual	0	At least 4 trainings were	-	-	Training reports	-

training programmes for marginalized groups (prisoners, people living with disabilities, etc) that integrate Sexual and reproductive Health, HIV-AIDS and Gender component	reproductive health, HIV and gender		undertaken				
Outcome 3.6 Monitoring and evaluation: A unique and coherent national system of M&E strengthened that collects and disseminates strategic information to inform, support and assess the national response of HIV							
• Percentage of activities of integrated and budgeted national plan of M&E (PIMA) implemented. (Target: 80% (2010) of activities implemented, baseline: to determine in 2009)							
Output 3.6.1 Integrated operational plan and budgeted (PIMA), funded and sponsored by at least a 50	% of financing secured for the implmentation of the national costed M&E plan	N/A	At least 50% (2010) of financing secured	50%	-	Annual review of implementation and financing of the PIMA	Human resource and capacity issues limited implementation rates rather than lack of financing

Output 3.6.2 Strengthened the capacity of NAC and other partners at central and provincial levels to use information based on evidence of HIV in the planning process and decision making	# of trimester reports produced by the CNCS and central and provincial level	1 annual report	4 trimester reports and 1 annual report	1 annual report and provincial reports from 10 provinces	Trimester reports are not produced on a systematic basis	CNCS annual and trimester report	Capacity issues effected number of trimester reports
Output 3.6.3 Strategic Information to document the HIV national response produced and disseminated, including the institutionalization of the study on AIDS expenses (NASA, UNGASS, and other studies and evaluations	# of reports and studies realised and disseminated by the CNCS	N/A	4 studies: (NASA, UNGASS 2010, Qualitative study on MCP and gender,and mapping of hot spots and corridors	At least 7 studies were completed	NASA 2009/2010 has not yet been started	Reports and studies disseminated for UNGASS, NASA, MOT etc.	A national monitoring and evaluation sub system for the private sector was developed and implemented by NAC and ECoSIDA.