MOZAMBIQUE

NATIONAL AIDS SPENDING ASSESSMENT (NASA) FOR THE PERIOD: 2004-2006

LEVEL AND FLOW OF RESOURCES AND EXPENDITURES TO THE NATIONAL HIV AND AIDS RESPONSE

January 2008

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iii FOREWORD

Sub-Saharan Africa is home to approximately 11% of the global population and nearly two-thirds of all people living with HIV. Despite the unprecedented loss of life, millions orphaned, and economic impacts in this region, the increased level of funding for HIV and AIDS does not meet the resource need to address HIV and AIDS. According to the recently released UNAIDS estimates of the financial resources required for Universal Access to prevention, treatment, care and support, there is a global funding gap of US$8.1billion in 2007

In Mozambique funding for the national response to HIV and AIDS increased from approximately US$48.5 million in 2004 to US$96.6 million in 2006. Substantial progress has been achieved in "making this money work" and bringing essential HIV services to those in need. The government and its development partners have worked to expand critical HIV and AIDS programmes such as the provision of antiretrovirals which has increased ten-fold between 2004 and 2007. However, we continue to experience challenges in translating increased funding into comprehensive HIV and AIDS prevention and mitigation programmes. For example, the current pace of scale-up of strong HIV prevention measures has not been commensurate with the expansion of the HIV epidemic. As a result, it is unlikely for Mozambique to achieve universal access by the agreed target date of 2010; or to see a halt and reversal of the HIV epidemic by 2015, as provided in the Millennium Development Goals (MDGs).

In order to achieve sustained universal access to HIV and AIDS services in Mozambique we need to dedicate more long-term, predictable financing to the national response to HIV and AIDS. However, achieving universal access in Mozambique will require not only the mobilization of resources but also a disciplined resource allocation and tracking process in order to ensure the provision of crucial services.

The analysis of the sources and uses of funds is important, but specially in situations of scarcity of resources, due to the high importance of effective allocation. Identifying the financial sources and providers of HIV services; the financial gaps and the functional overlapping; as well as the total amount of resources devoted to HIV and AIDS, will provide opportunities to improve the results of the investments we are making. On the other hand, it is also important to keep track of resources, to ensure the strengthening of local capacities to use the additional funding for HIV and AIDS programmes.

Although the need to monitor public and international trends in HIV and AIDS expenditure is clear, we recognize that the actual process presents some challenges. These challenges include the lack of clear HIV and AIDS budget lines within the national budget; the mainstreaming of HIV and AIDS work within wider programme areas such as health, education, and poverty reduction; and the positive shift from more easily tracked project based funding to general budget support and sector wide support.

Despite these challenges of expenditure reporting, we must endeavor to strengthen our reporting systems so that we are able to quantify how much Mozambique spends on HIV and AIDS and primary health care in general. There is need for greater clarity from the government and all partners in reporting of these commitments and expenditure. Calls for increased funding to support mainstreaming, integrated projects and focused interventions must go hand-in-hand with an ability to clearly show where the resources are going.

Major efforts are underway to strengthen public financial management systems in Mozambique including the roll out of SISTAFE. The challenge is to ensure that SISTAFE can be tailored to provide disaggregated expenditure data.

Signed by:

iv PREFACE

The Government and its development partners remain at the forefront of efforts to move towards universal access to HIV prevention, treatment, care and support in Mozambique. A comprehensive, scaled-up HIV prevention response is needed to avert more new infections from occurring. Unless we can prevent new infections, future treatment costs will continue to mount. Similarly, treatment access is essential to efforts to preserve the productivity of adults and their households, reduce costly hospitalization, and alleviate the epidemic's impact on the economy and human development. Unless treatment programmes keep pace with need, HIV-related mortality is likely to increase, further intensifying the epidemic's impact.

Given the many challenges that must be overcome to provide HIV services, high levels of funding will be needed to move towards universal access in the coming years. It is critical for us to have a clear understanding of what is being spent on HIV and AIDS in order to know if that expenditure is appropriately targeted to interventions that are likely to be most effective. Moreover, it will also allow us to better understand how present efforts are likely to fall short of what will be needed to reverse the epidemic in Mozambique. The importance of financial monitoring to estimate the total amount of HIV and AIDS spending cannot be overemphasized. It also allows for greater transparency and accountability to domestic oversight bodies (e.g. Parliament), to the public and to donors.

In 2006, the Mozambique Government committed itself to undertake a comprehensive National AIDS Spending Assessment of public, international and private HIV and AIDS expenditure in Mozambique. This report detailing HIV and AIDS expenditure for the period 2004-2006 is a realization of this commitment.

The assessment shows that the Mozambique has spent an estimated US$204,120,637 on HIV and AIDS between 2004 and 2006. The proportion of public domestic expenditure on HIV and AIDS has doubled during this reporting period from US$7,326,297 to US$14,301,520. In line with PARPA commitments, the proportion of highest spending during the reporting period went to prevention (40%) and care and treatment (29%). The analysis shows that the general population is the main beneficiary of spending. Most of these resources are being spent by public HIV service providers (and through public-private partnerships with NGOs).

HIV and AIDS expenditure has also supported investments in health systems strengthening, which in turn will substantially buttress efforts to achieve other health-related MDGs. However, despite the human resource constraints in the health sector, the report indicates that only 6% of the resources have been spent on human resources strengthening.

The report makes several recommendations. Key among them includes: the need to allocate more resources to strengthen our human capital to deliver health care including HIV and AIDS services; and the need to increase funding for orphaned and vulnerable children. The importance of strengthening government systems to collect disaggregated expenditure data.; and the need to obtain a better understanding of the resources needs in order to ensure that Mozambique is able to bring essential HIV programmes to scale. A comprehensive costing of the National multisectoral HIV and AIDS Strategy that takes into account the most recent estimates of HIV prevalence, the number of people living with HIV should be a priority in 2008.

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V ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANEMO	Associação de Enfermeiros de Moçambique
ARV	Anti Retroviral
ART	Anti Retroviral Therapy
ASC	AIDS Spending Category
BP	Beneficiary Population
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CCS	Comité de Coordenação Sectorial
CDC	Centre for Disease Control
CNCS	Conselho Nacional de Combate ao HIV/SIDA (National AIDS Council)
CPD	Country Programme Document
CSO	Civil Society Organisation
CT	Counselling and Testing
DBS	Direct Budget Support
DH	Day Hospital
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
ETSDS	Expenditure Tracking and Service Delivery Survey
FBO	Faith Based Organisation
FDC	Foundation for Community Development
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoM	Government of Mozambique
GMS	Grant Management System
HAI	Health Alliance International
HER	Health Expenditure Review
HIV	Human Immunodeficiency Virus
HIV+	Human Immunodeficiency Virus - Positive
IEC	Information Education and Communication
INE	Instituto Nacional de Estatística (National Institute of Statistics)
IO	International Organisation
LFA	Local Fund Agent
MAP	Multi-Country AIDS Programme
M&E	Monitoring and Evaluation
MADER	Ministry of Agriculture
MDG	Millennium Development Goals
MINEC	Ministry of Education and Culture
MISAU	Ministry of Health
MONASO	Mozambique Network of AIDS Service Organisations
MOU	Memorandum of Understanding
MSF	Medicine San Frontiers
MTFF	Medium Term Fiscal Framework
MTEF	Medium Term Expenditure Framework
NACP	National AIDS Control Programme
NAA	National AIDS Accounts
NASA	National AIDS Spending Assessment
NEC	Not elsewhere classified
NGO	Non Governmental Organisation
NHA	National Health Accounts
OE	State Budget
OMM	Organização da Mulher Moçambicana
OVC	Orphaned and Vulnerable Children
PARPA	Action Plan for the Reduction of Absolute Poverty
PEN	National Strategic Plan for Combating HIV/AIDS
PLWH	People Living With HIV
POA	Programme of Activities
PMTCT	Prevention of Mother to Child Transmission
RO	Recipient Organisation
SADC	Southern African Development Community

SAT	Southern Africa Aids Trust
SIDA	Swedish Development Agency
SNP	Sindicato Nacional de Professores
SISTAFE	State Financial Administration System
SRO	Sub Recipient Organisation
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TB	Tuberculosis
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
UTOMI	Associação Moçambicana de Combate Ao SIDA
WB	World Bank
WHO	World Health Organisation

vi Basic Fact Sheet on Mozambique HIV and AIDS Expenditure for the period 2004-2006

HIV and AIDS Expenditure by Funding Sources:

Total Spending: US$ 204,120,637
Public: US$ 33,161,251 (16 %)
International: US$ 166,792,556 (82%)
Private: US$ 4,166,830 (2%)

HIV and AIDS Expenditure by Financing Agent:

Public: US$ 65,893,356 (32%)
International: US$ 125,305,799 (62%)
Private: US$ 12,921,482 (6%)

HIV and AIDS Expenditure by Service Provider:

Public Providers: US$ 93,993,442 (46%)
Private Non-Profit: US$ 77,468,243 (38%)
Private for Profit: US$ 2,438,562 (1%)
Bilateral and Multilaterals: US$ 19,905,542 (10%)
Others: US$ 10,314,848 (5%)

HIV and AIDS Expenditure by Programmatic Area:

PREVENTION (40% of total Expenditure)

- Total Expenditure US$ 82,099,340
- Main Item: Other prevention activities $ 13,586,269 (17%)
  Communication for social & behavior change US$10,639,706 (17%)

CARE and TREATMENT (29% of total Expenditure)

- Total Expenditure US$ 58,982,953
- Main Item ARV US$32,953,411 (56%)
  Home Based Care: US$14,985,227 (25%)

OVC ACTIVITIES (7% of total Expenditure)

- Total Expenditure US$ 15,164,408
- Main Item: Community support US$4,860,159 (33%)
  Other OVC services US$4,607,792 (30%)

PROGRAM MANAGEMENT ACTIVITIES (15% of total Expenditure)

- Total Expenditure US$31,584,163
- Main Item: Program Administration US$13,065,037 (41%)
  Planning and Coordination US$11,671,730 (37%)

HIV and Expenditure by Beneficiary:

General Population: US$ 93,086,523 (46%)
People Living with HIV: US$ 58,177,430 (29%)
MARPS: US$ 331,000 (0.4%)

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X Executive Summary

Funding for HIV and AIDS programmes in Mozambique come from three main sources: public, external (international) and private sources. Like many developing countries, Mozambique's national response to HIV and AIDS is to a large extent sustained by external assistance secured from international, multilateral and bilateral organisations alongside foundations and NGOs supporting the HIV and AIDS response. These sources channel HIV and AIDS funding using three main funding mechanisms: through the state budget, through Sector-Wide Approach (SWAp) for health sector financing; and/or vertical project funding.

In 2006, the government committed itself to undertake a full National AIDS Spending Assessment (NASA) to exhaustively track actual HIV and AIDS spending from public, international and private sources (UNGASS, 2005). The assessment focused on tracking national level HIV expenditure for the period 2004, 2005 and 2006. Data collection covered domestic, external and private spending on HIV and AIDS, including funds channelled through the government. The assessment did not cover total household out-of-pocket expenditure on HIV and AIDS only out-of-pocket payment for services and drugs.

Most of the key sources of data (detailed expenditure records) were obtained from the majority of primary sources for the reporting period. Secondary sources were used only where primary sources were not available. In other cases costing techniques were used to estimate some of the expenditures on HIV and AIDS related activities using best available data and the most suitable assumptions. There were a number of limitations to this study. Key among them was the problem relating to missing HIV expenditure information especially in the sectoral ministries. It is therefore difficult to draw firm conclusions about HIV and AIDS financial flows to certain sectors. However, on the basis of information provided by funding sources and service providers, the study attempts to reconstruct some sectoral spending on HIV and AIDS programmes. It was also difficult to carry out a detailed comparison of expenditure by priority HIV and AIDS intervention areas due to the lack of a costed National Strategic Framework (NSF) and differences in NSF categories and the NASA categories.

Main Findings

The NASA estimations show that overall; **Mozambique spent a total of US$204,120,637 on HIV and AIDS between 2004 and 2006**. Although HIV expenditure increased by only 5% from 2004 to 2005, total expenditure increased by 18% between 2005 and 2006. HIV and AIDS spending in 2006 made up nearly half of total spending during the reporting period. External financing sources account for 82% of all HIV expenditure during 2004-2006. Public funds constituted 16% of the total HIV and AIDS expenditure, while private sources of funding accounted for only 2%.

The NASA estimations regarding HIV service providers show that public organizations provide the majority of these services in Mozambique. An estimated **US$93,993,442 (46% of total expenditure) was spent by public service providers over the three year period**. Private sector HIV service providers mainly consist of for-profit and non-for profit organisations. The results from the NASA confirm the general trend that the provision of HIV services has relied heavily on Private non-profit providers (NGOs). The public-private partnership with the MOH, which acts as a "contractor" of services, enable HIV services to be delivered to those in need, and also integrates NGO activities and staff into government run facilities. Between 2004 and 2006, NGOs spent US$77,468,243 (38%) on HIV and AIDS. Some bilateral and multilaterals organizations are also involved in the provision of various HIV and AIDS services. Between 2004 and 2006, bilateral and multilaterals share of HIV service provider spending decreased from 13% of total HIV service provider spending in 2004 to 7% in 2006.

A further disaggregation of data by the NASA AIDS Spending Categories show that the **key spending priorities between 2004 and 2006 have been on prevention (40%); care and treatment (30%); and programme management and administrative strengthening (15%).** Total expenditure on prevention programmes declined from 48% of total funding in 2004 to 34% in 2006; while expenditure on treatment and care increased from 21% of total spending in 2004 to 37% in 2006. Another important key intervention area where spending has being decreasing over the years is human resources recruitment and retention incentives. Spending fell from 9% of total spending in 2004 to a low 5% in 2006. Total spending on Orphans and Vulnerable Children (OVC) and HIV and AIDS related research remains low at 7% and 8% of total spending respectively between 2004 and 2006.

The overall decline in expenditure on prevention programmes as a share of total expenditure over the study period should be monitored given the importance of intensifying prevention so as to turn the tide of the epidemic in Mozambique. The results show that between 2004-2006, 96% of HIV prevention expenditure was spent on the following ten activities: communication for social and behavioral change (13%), prevention, diagnosis and treatment of STI (10%), condom social marketing (10%), PMTCT (11%), counseling and testing

(8%), prevention for youth out-of-school (9%), prevention for youth in school (8%), community mobilization (7%), programmatic interventions for vulnerable populations (3%) and other prevention activities (17%).

There was a reversal in trend in care and treatment spending. **Total expenditure on care and treatment increased from US$10,336,214 in 2004 to US$13,020,739 in 2005 and to a high US$35,626,000 in 2006, a 173% increase from 2005**. In 2004 about 64% of the total spent on care and treatment was spent on ART and 17% on Opportunistic infections' (OI) treatment. By 2006, this configuration of spending had changed. Although ART remained the main treatment spending category the share of Home Based Care (HBC) expenditure increased nearly ten-fold from US$ 1,068,880 in 2004 to US$ 9,681,318 in 2006. Other spending categories such as Nutritional support associated to ARV therapy also constituted a major share of the total expenditure in 2006.

A summary of OVC spending from the study shows that total spending on OVC increased slightly from US$3 million in 2004 to US$4.1 million in 2005 and increased further to $7.4 million in 2006. Generally there was more targeted spending on OVC in 2006 than in 2004 and 2005. In 2006, about 32% of the total spent on OVC was on OVC family/home support; 32% on OVC community support 2006; 13% on administrative costs; 11% on unspecified services; 9% on education and 3% on basic health care.

Resources for the national response to HIV and AIDS have contributed to the improvement of infrastructure, procurement and distribution, upgrading of laboratory facilities and blood banks, nutrition, and logistics management. Total spending on programme management and administrative strengthening activities increased from 2004 to 2006. **On average over 85% of total spending for this category was on administrative, planning and coordinating activities for all the years under study.**

An insufficient number of trained and retained public sector health personnel constitute a major constraint in scaling up HIV and AIDS care and treatment in Mozambique. **Spending on human resources and retention incentives has remained the same from 2004 to 2006.** In all three years, most of the spending went into training with the rest into monetary incentives for other staff on HIV and AIDS related activities. Human capacity constraints cannot be overlooked. Currently, there are a limited number of personnel to plan, manage and implement the many initiatives to the national response outlined in the PEN II.

The lack of a disaggregated data on HIV and AIDS spending by gender made it difficult to assess whether activities targeting women and girls and men and boys are well resourced. This also raises questions regarding the delivery of programmes to address gender related issues that lead to feminisation of the HIV epidemic in Mozambique.
Between 2004 and 2006, 98% of total HIV and AIDS spending during the reporting period benefited the following populations: people living with HIV (PLWH), OVC, children born or to be born to HIV mothers, people attending STI clinics, children and youth out of the school, youth at school, factory employees and children in school and other populations. In 2004, 22% of the total spending benefited People living with HIV (PLWH), about 9% on OVC and the rest spread evenly between the other groups. In 2005, 61% of total spending was spent on general population, 16% on PLWH and 6% on OVC. In 2006 spending on PLWH increased to 40% of the total spending as a result of the increase in spending on ART.

Conclusions and Recommendations

Substantial amounts of resources have been invested in the national response to HIV and AIDS. The growth in funding for HIV and AIDS prevention and care has outpaced that for most other public health programmes. However, an insufficient number of trained and retained public sector health personnel constitute a major constraint in scaling up HIV and AIDS care and treatment in Mozambique. It is therefore difficult to judge whether the implementation of these HIV and AIDS related programmes will reach the desired groups in all the provinces across the country.

HIV and AIDS expenditure data on the flow of resources from funding agencies to implementers and target groups is vital for effective planning of HIV and AIDS programmes and efficient use of resources. There is the need to institutionalize the NASA process in Mozambique for the ease of data collection and reporting on HIV and AIDS spending.

The heavy reliance on external funding raises questions of sustainability of HV and AIDS programmes in Mozambique. The internal budget allocation to the CNCS has sharply decreased in the past three years and while the shortfall has been made up by external sources of funding. It is worth noting that the harmonization and alignment of donor support through the channeling of funds through a common fund reduces the duplication of programmes and ensures a more efficient allocation of resource.

One major limitation of the study was the inability to undertake a comprehensive assessment of out-of-pocket (OOP) payment on HIV and AIDS related activities. It is recommended that some questions related to HIV

spending be incorporated into existing household surveys to enable the government to establish the proportion of households with catastrophic HIV and AIDS expenditure in Mozambique.

The key recommendations from this study are centered on the need to have a costed National Strategic Plan to ensure a needs-based resource allocation mechanism. The advantages of such a process are two-fold. First it helps in resource mobilisation both internally and externally to ensure adequate provision of resources to areas where they are most needed. Secondly it provides the basis for an immediate assessment of funding gaps; which could justify the need for more adequate budgetary allocations to national response.

xi Structure of the Report

The report is organized into six sections. The remainder of the report is organized as follows. Section 2 outlines the methodology and the process adopted by the NASA assessment team. It covers the data collection approach, sources of data, data processing, analysis, assumptions and estimations, challenges and remedial actions.

The third section presents an overview of the country context. It discusses the national response to the AIDS epidemic and provides further description of the current funding modalities, covering current processes and modalities for the planning, budgeting and financing of the HIV response in Mozambique.

The findings of the NASA estimations are presented in Section 4. This section closely examines volume of spending by funding source and by thematic area. It also examines allocation of AIDS spending in Mozambique in relation to the objectives and targets of the National Strategic Plan and in comparison to other countries in the region. The summary and recommendations of the study are presented in Section 5.

1 Introduction

1.1 Context for the Assessment

The need for a review to assess how and where HIV and AIDS funding is being channeled, and to what effect was also one of the key recommendations of the joint Government and development partner's Joint Review in March 2006 (GoM/PAP 2006). The Joint Review noted that the current State budget classifications do not provide a comprehensive picture of government and other sources of funding for the National HIV and AIDS response other than resources allocated to the National AIDS Council (CNCS). Like other countries in Southern Africa, Mozambique expenditure systems do not currently provide a single accurate source of detailed HIV and AIDS expenditure in terms of financial sources and agents, services providers, beneficiaries, and HIV programmes. In order to ensure a coordinated and adequately resourced response, it is essential to institutionalize a sustainable government-wide system for tracking on- and off-budget HIV and AIDS related resources and expenditures across sectors.

In the past nine years Mozambique has conducted two key assessments of national health expenditure. The first survey was conducted in 1999, as part of the Ministry of Health's initiative to formulate a Health Financing Strategy for Mozambique. The Ministry of Health (MoH) with support from USAID, commissioned a Health Expenditure Review (HER) which included a National Health Accounts (NHA). The purpose of the HER was to assess all the financial flows in the private and public health sectors, from the sources of financing to where resources are turned into health care outputs. The review also sought to establish what and where health related resources (money and in kind payments) are flowing from and to which stakeholders and finally how these resources are being used. In 2001, the Government and the World Bank carried out another health sector survey, the Expenditure Tracking and Service Delivery Survey (ETSDS) as part of the Public Expenditure Reform. The objective of ETSDS was to provide quantitative and qualitative evidence on how current health systems and procedures impact on efficiency, equity and quality in the delivery of primary health care. The two expenditure reviews by USAID and the World Bank highlight the presence of fairly accurate and complete health-related expenditure data in some areas example from the MoH and donors, and notable gaps in the quality of information in other areas.

While the NHA is a useful tool to illustrate the financing of the health sector and how funds flow from financing sources, through financing agents to destinations where health services are delivered by different types of health care providers; its classifications do not track HIV and AIDS financial flows beyond the health sector. Other assessment studies have also highlighted significant funding flows to the provinces through international and national non-governmental organisations but these funds are not properly traced by statistics and MoH information system (Costa, J. et al, 2006).

In 2005, the National AIDS Spending Assessment (NASA) methodology was used to collect information on Government HIV and AIDS expenditure for UNGASS reporting. The overall objective of the assessment was to track transactions on total domestic public HIV and AIDS expenditure across education, social development, welfare sectors, as well as for other sectors that were clearly beyond any conceptualisation of the health care service delivery system. The assessment tracked expenditure across eight programmatic areas namely: prevention, treatment and care, orphans and vulnerable children, AIDS programme development, human resources, social mitigation, community development and enhanced environment, and HIV and AIDS-related research. Due to the limited time frame within which the assessment was undertaken, it was difficult to collect information for all eight NASA classifications and comprehensively track HIV expenditures from financing sources to providers and beneficiaries.

In 2006, the government committed itself to undertake a NASA to exhaustively track actual HIV and AIDS spending from public, international and private sources (GoM, 2005). To this end, the CNCS was charged to work with other strategic ministries, multilateral and bilateral organizations to improve the estimation of HIV and AIDS expenditures in Mozambique as part of its key M&E function.

1.2 Objectives and Purpose

The overall objective of this NASA activity is to contribute to the strengthening of National AIDS Spending Assessments in Mozambique in order to support the coordination, harmonization and alignment of HIV and AIDS resource use. The specific objectives of the study were the following:

- To catalyze and facilitate actions which strengthen capacities to effectively track expenditures on HIV and AIDS and synthesize this data into strategic information for decision-making.
- To leverage both technical and financial support to develop a mechanism for institutionalizing HIV Spending Assessments.
- To track the allocation of HIV and AIDS funds, from their origin down to the end point of service delivery, among the different financing sources (public, private or external) and among the different providers and beneficiaries (target groups).

Key issues that are addressed by this NASA study are as follows:

- What is actually disbursed and spent in each component of the multisectoral HIV response? Are increased allocations of expenditure going to priority HIV interventions?
- What is the allocation of AIDS spending in relation to the objectives and targets of the National HIV/AIDS Strategic Plan (PEN II)?
- Where do HIV and AIDS funds go – Who are the main service providers and beneficiaries of these services?
- Are sufficient resources invested to enhance capacity for scaling up human resources?
- Does international donor assistance replace or induce a reduction of government expenditures for HIV and AIDS programmes and activities?

1.3 Scope of the Assessment

The assessment focused on tracking national level HIV expenditure available at central level for the period 2004, 2005 and 2006. Data collection covered domestic, external and private spending on HIV and AIDS, including funds channeled through the government. The assessment did not cover total household out-of-pocket expenditure on HIV and AIDS only out-of-pocket payment for services and drugs. In 2008, the CNCS plans to undertake provincial NASA in select provinces to provide supplementary information to data obtained at the national level and build capacity to undertake provincial NASA.

2 Study Design and Methodology

2.1 Approach

The National HIV and AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. The tool tracks actual expenditure (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV and AIDS[1].

The need to track HIV expenditure stems from the fact that decisions regarding allocations for HIV and AIDS related activities must be based on the true effect of previous expenditure patterns on profile of the epidemic in the various regions in the country. NASA is expected to provide information that will contribute to a better understanding of a country's financial absorptive capacity, as well as on issues about the equity, the efficiency and the effectiveness of the resource allocation process.

In addition to establishing a continuous information system of the financing of HIV and AIDS, NASA facilitates a standardized reporting of indicators monitoring progress towards the achievement of the target of the *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS)[2].

NASA follows a system of expenditure tracking that involves the systematic capturing of the flow of resources by different financial sources to service providers, through diverse mechanisms of transaction. A transaction comprises of all the elements of the financial flow, the transfer of resources from a financial source to a service provider, which spends the money in different budgetary items to produce functions (or interventions) in response to addressing HIV and AIDS to the benefit of specific target groups or to address unspecific populations (or the general population). NASA uses both top-down and bottom-up techniques for obtaining and consolidating information. The top-down approach tracks sources of funds from donor reports, commitment reports, government budgets whilst the bottom-up tracks expenditures from service providers' expenditure records, facility level records and governmental department expenditure accounts.

In cases where there are missing data, costing techniques are used to estimate actual expenditure based on internationally accepted costing methods and standards used to retrogressively measure past actual expenditure. Ingredient and step-down costing is used for direct and shared expenditure for HIV and AIDS, whilst shared costs are allocated on the most appropriate utilization factor.

As part of its methodology, NASA employs double entry tables or matrices to represent the origin and destination of resources, avoiding double-accounting the expenditures by reconstructing the resources flows for every transaction from funding source to service provider and beneficiary population, rather than just adding up the expenditures of every agent that commits resources to HIV and AIDS activities.

The feasibility of NASA relies on background information, identification of key players and potential information sources, understanding users' and informants' interests, as well as the development of an inter-institutional group responsible for facilitating access to information, participating in the data analysis, and contributing to the data dissemination.

To date more than twenty countries have estimated National AIDS Accounts (NAAs), most of which have developed institutionalized arrangements for continuous tracking. A database of around 100 country/years of estimates has been generated.

2.2 NASA Classifications

After experimentation and after an evaluation of past response to the drivers of the HIV epidemic, and the ways to address these drivers, NASA programme and budget lines have been structured in eight spending classes or chapters of AIDS Spending Categories namely: Prevention, Care and treatment, Orphans and vulnerable children, Program management and administration strengthening, Incentives for human resources, Social protections and

[1] UNAIDS, 2006: National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV/AIDS financing flows and expenditures at country level. (draft- work in progress).

[2] *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS)

social services, Enablement of environment and community programs and Research. The beneficiary populations are classified under seven main categories with a number of sub-groups in each category to enable a further disaggregating of the data collected. For full description of beneficiary groupings please refer to Appendix 3.

2.3 Data Collection and Processing

2.3.1 Advocacy and Sensitization of key stakeholders

Prior to the national AIDS assessment, CNCS in collaboration with UNAIDS[3], WHO and UNICEF held several consultative meetings in September 2006 with key stakeholders including key Government policy making institutions to formally introduce NASA, and emphasize the need for accurate expenditure data to ensure that the assessment provides a comprehensive picture of HIV spending in Mozambique. Capacity building workshops involving all key stakeholders as well as training of members of the Mozambique NASA team was conducted in October 2006 with technical support from UNAIDS[4].

2.3.2 NASA Team

The focal points for the assessment in Mozambique were the Deputy Executive Secretary of the National AIDS Council (CNCS) and the National Director of Planning and Cooperation of the Ministry of Health. The assessment team included the Head of the CNCS Planning and M&E Unit, CNCS M&E Officers, the UNAIDS M&E Advisor, the WHO Health Economist, UNICEF Head of Policy and Planning and the Lead National Consultant. A team of seven national consultants (the Lead consultant and six junior consultants) were responsible for the data collection and analysis. The Team of consultants also participated in working group meetings and briefing and validation meetings. The National team was supported by international consultants at various stages of the assessment.

2.3.3 Sources of Data

In collaboration with CNCS, the Team of consultants identified and mapped all HIV financial sources, financial agents, service providers, and AIDS spending categories.

Most of the key sources of data (detailed expenditure records) were obtained from the majority of primary sources, for 2004, 2005 and 2006. Secondary sources were used only where primary sources were not available (e.g. expenditure of NGOs who received direct funding from donors which were not captured by the CNCS, donor report or more detailed data on expenditure). In other cases costing techniques were used to estimate some of the expenditures of HIV and AIDS related activities using the best available data and most suitable assumptions.

Table 1: No. and % of Organizations that provided Expenditure data (Sample n=180)

Questionnaires	Sample
Sector Ministries	33
Universities	10
Bilateral Organizations	17
Multilateral Organizations	14
International NGOs	51
National NGOs	25
Private Companies	30
Total	180

Table 2: Number of organizations with activities during the period of analysis

Questionnaire	2004		2005		2006	
	No.	%	No.	%	No.	%
Sector Ministries	20	15%	20	14%	31	19%
University	7	5%	7	5%	9	6%
Bilateral Organizations	15	11%	17	12%	16	10%
Multilateral Organizations	11	8%	13	9%	14	9%
International NGOs	46	34%	46	32%	47	29%
National NGOs	22	16%	22	15%	22	13%

[3] In September 2006, Jose Antonio Izazola, UNAIDS Chief of Resource Tracking Unit in Geneva undertook a mission to Mozambique and met with key Government officials from MPD, MISAU, INE, CNCS, MMAS, bilateral and multilateral partners and NGOs

[4] A total of 40 experts participated in the National NASA training workshop from NAC, public sector ministries and NGOs

Private Companies	16	12%	17	12%	24	15%
Total	137	100%	142	100%	163	100%

Table 3: **Number and Percentage of Organizations that provided data for each year**

	2004		2005		2006	
	No.	%	No.	%	No.	%
Sector Ministries	10	50%	9	45%	20	65%
University	2	29%	2	29%	7	78%
Bilateral Organizations	10	67%	13	76%	15	94%
Multilateral Organizations	9	82%	11	85%	11	79%
International NGOs	16	35%	17	37%	24	51%
National NGOs	6	27%	8	36%	14	64%
Private Companies	3	19%	5	29%	14	58%
Total	56	41%	65	46%	105	64%

For the list of institutions visited to collect HIV and AIDS expenditure data and the status of data collected refer to Appendix 6.6 and 6.7. The institutions were grouped into the following categories; Public, External, NGOs and Businesses. Private spending did include only out-of-pocket payment for services and drugs as well as expenditure incurred by corporations. Details of the status of the data collected with comments are presented in Appendix 6

2.3.4. Data Collection

The assessment was undertaken through a desk review of key policy documents, programme documentation and institutional budgetary and expenditure reports for the period 2004-2006. This review was accompanied by two 3-month periods of data collection in October-December 2006 and July-October 2007.

Letters introducing NASA and requesting data were sent out by CNCS to the various government ministries, NGOs, businesses and bilateral and multilateral organizations in order to formally gain access to the required data.

The standard NASA Questionnaires were adjusted to suit the Mozambican context. The qualitative questions regarding funding processes and challenges were removed because of the lengthy nature of the questionnaire. CNCS sent the adjusted questionnaires (see Appendix 5) to key respondents, and consultants meet with each organization to introduce the questionnaires and agree on a date for submission of data. Each organization was asked to allocate spending, using various criteria, into different programmes to enable a functional classification of HIV and AIDS expenditures. Funds could be allocated to various HIV service providers (intermediaries) such as NGOs, CBOs, academic institutions. NASA consultants were also on hand to support organizations to complete the questionnaires. On average consultants visited each institution more than three times resulting in more than 400 separate visits.

2.3.5 Data Processing

The expenditure data collected was first captured in Excel® sheets, and checked and balanced. All the information obtained/collected was verified as far as possible, to ensure the validity of data from the records of the source, the agents and the providers and also to avoid double counting. The data was then transferred to the NASA Resource Tracking Software (RTS), which has been developed to facilitate the NASA data processing. It provides a step-by-step guidance along the estimation process and makes it easier to monitor the crosschecking among the different classification axes. The RTS results databases were then exported to Excel® to produce summary tables and graphics for analysis.

2.4 Assumptions and Estimations

NASA methodology allows for further disaggregation of the data to show provider expenditures by HIV and AIDS functions and to identify the categories of beneficiaries that receive funding. However, given the nature of the data received a number of assumptions were made which apply in interpreting the findings and recommendations of this study.

- Problems of missing HIV expenditure information were more acute in respect of the sectoral ministries. It is therefore difficult to draw firm conclusions about HIV and AIDS financial flows to certain sectors. However, on the basis of information provided by funding sources and service providers, the study attempts to reconstruct some sectoral spending on HIV and AIDS
- In the case of pooled funding (CNCS Common Fund and MOH PROSAUDE), the specific donor contribution to the different HIV programmes was assumed to be in equal proportion as the contribution to the total pooled fund. The same rationale was also applied to any under spending. In addition, where detailed expenditure records of providers were not available, then the study assumed equal split of funds between the key programmes, unless instructed otherwise. Crude estimates were made of the proportion which could be considered HIV and AIDS expenditure, but these require further discussion and validation.
- MOH classified as a financing source because it assigns the unearrmarked public and international resources to HIV and not to any other alternative use. The MOH was also classified as a HIV service provider even though some NGOs have been "contracted" to provide those services.
- CNCS classified as a financing source for some transactions because of the absence of a comprehensive system for tracking HIV expenditure.
- USG expenditure data is based on a number of sources and assumptions. CDC provided information on HIV and AIDS financial commitments and a list of organizations that received CDC funding during the reporting period. Expenditure data was then obtained from some of these recipient organizations. Expenditure data for CDC's own activities was not captured. The assessment obtained a list of partners who received USAID funding and also managed to provide aggregate expenditure data for 2004-2005 and estimated expenditure for 2006. In order to minimise the potential for double counting, the assessment utilised the aggregate expenditure data reported by USAID for its own activities.
- Costing estimations were used to determine the actual expenditure on ARTs, PMTCTs, GATVs etc). In this case, the unit cost of providing these services was based on the costing estimations conducted in close consultation with the MOH and its implementing partners The actual expenditure was therefore the unit cost multiplied by the number of cases treated or number of drugs provided.
- Where the data on beneficiaries were not disaggregated and detailed enough the bulk of it was assumed to be targeted to the general population. However for prevention programs such as mass media and HIV- Related Information and education with no specific target group we assumed the general population as the key beneficiaries.
- A few development partners had different financial reporting periods from that used by the government (January-December) e.g. USAID (October-September). Effort was made to capture the actual expenditure within each fiscal year, according to the government's fiscal year. Where this proved difficult, this was handled by allocating the expenditure to the year closest to the disbursement. While recognizing this is not accurate, the magnitude of error is small, and there is likely to be some balancing between cases.
- The end of year exchange rate of the US dollar to the Meticais was used for each year of the study.

2.5 Limitations of the Assessment

Tracking the HIV and AIDS expenditure has proved challenging and there are a number of limitations to the study. The major ones include the following:

- **Availability of HIV expenditure data:**
  Data limitations made it difficult to evaluate HIV expenditure in a number of areas including: Opportunistic Infections, Public sector resource envelope (with the exception of MOH), private household out-of-pocket expenditure on HIV and AIDS, organizational overheads, and production factors (capital and recurrent expenditure). This can be attributed to several reasons including:
  - Numerous and diverse sources and flows of HIV and AIDS funds in Mozambique
  - Delayed receipt of data from the relevant government bodies. This was largely due to administrative/bureaucratic procedures in some of the institutions visited and non-response from the several line ministries even after an official letter was sent by CNCS.
  - Integrated nature of Government accounts with the exception of specific HIV and AIDS budget lines. For example, HIV and AIDS expenditure overlaps with sexual and reproductive health programme, and integrated into non-health sectors expenditure.

- Lack of routine financial reporting to the CNCS. As a result, the CNCS does not routinely collate data on HIV and expenditures and was unable to deliver reliable and timely data on allocations and expenditures.
- Mixed responses to efforts to solicit information from development partners. Some donors did not avail expenditure data.
- Paucity of information on private out-of-pocket household expenditure on HIV and AIDS in National household surveys. Due to the cost of collecting specific household out-of-pocket expenditure this assessment did not obtain this data.
- The current reporting of financial information among stakeholders does not conform to the needs of NASA framework.

- **Quality of data:**
  - The nature of data given and the difficulty in determining which proportion of expenditure could be attributed to HIV and AIDS related activities made it difficult to carry out an in-depth analysis of spending.
  - Variation in the level of detailed expenditure data for the three years: 2004, 2005 and 2006.
  - Data which summarized expenditure across two financial years.

- NASA AIDS Spending Categories and target groups/beneficiaries are not organised in a way that allowed the NAC to capture all HIV-related activities sufficiently. For example, capacity strengthening of the Government is not captured (training is, but capacity building is a lot broader than training) and for the target group of Youth, one needs to select either youth in school or out of school but there is no general category of Youth.

- **Inability to carry out a detailed comparison of expenditure going to priority HIV interventions:** This was due to two key reasons:
  - Lack of a costed HIV Strategic Plan which made it difficult to compare budgets for the thematic areas of the NSF to actual expenditure.
  - Different categories between the HIV Strategic Plan and NASA with the exception of treatment and prevention
  - Unavailability of gender-disaggregated data made it impossible to analyse how the national response is addressing the feminization of the epidemic

2.6 Piloting NASA in the Provinces

In 2008, the CNCS plans to conduct provincial AIDS spending assessments in select provinces in the Center and South of Mozambique. The provinces were selected based on two criteria, namely: (i) HIV epidemiological profile; and (ii) High volume/levels of HIV service delivery.

The provincial assessments are scheduled to take place between February and April. The assessments will include consultations with key stakeholders; regional capacity building workshops; mapping to identify funding sources and agents, HIV service providers and AIDS spending categories; data collection and analysis; and provincial report development and validation.

It is expected that these provincial assessments will provide invaluable information, from the perspective of district programme implementers; regarding financial flows from sources of funds to agents of funding and HIV service providers; actual expenditure according to programmatic areas and provincial priorities; and the key beneficiaries of HIV services.

3 Overview of the Country Context

3.1 HIV and AIDS Situation

3.1.1 Regional Context

Sub-Saharan Africa and the Southern African Development Community (SADC) region in particular, carry the heaviest burden of HIV and AIDS in the world. Although the region has just over 10% of the world's population, it is home to more than two-thirds (68%) of all people infected with HIV. Moreover, over three quarters (76%) of all AIDS-related deaths in 2007 occurred in this region. Some 1.7 million [1.4 million-2.4 million] people were newly infected with HIV in 2007, bringing to 22.5 million [20.9 million-24.3 million] the total number of people living with the virus. Unlike other regions, the majority of people (61%) living with HIV in sub-Saharan Africa are women[5]. Within the region, Southern Africa is at the epicenter of the global HIV epidemic - national adult HIV prevalence exceeded 15% in eight Southern African countries in 2005.

The scale of the epidemic makes HIV and AIDS the single greatest threat to attaining SADC's over-arching objective of sustainable and equitable economic growth and socio-economic development that will ensure poverty alleviation. The epidemic if unabated will continue to erode the hard won economic gains and intensify poverty and human suffering. Similarly, the level of the epidemic makes the attainment of many of the globally agreed Millennium Development Goals (MDGs) difficult.

The continued high levels of HIV prevalence and the limited success in turning the tide of the epidemic in the region resulted in the Special Summit on HIV and AIDS by SADC Heads of State and Government in Maseru, in 2003. One of the outcomes of the Summit was the Declaration on HIV and AIDS. The Declaration provides the highest political commitment on HIV and AIDS in the region and articulates priority areas requiring urgent attention and action in various areas.

Domestic public expenditure from governments has also significantly increased in low-income sub-Saharan African countries, and more moderately in middle income countries. In 2005, domestic resources reached US$ 2.5 billion (UNAIDS, 2006). In many of the Sub-Saharan countries however, the funding for prevention, treatment and care has depended largely on external sources of funding such as: the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the World Bank, the Presidential Emergency Plan for AIDS Relief (PEPFAR), as well as many other cooperation agencies allocate resources in the region, most of it as bilateral assistance to development. In relatively few years, the availability of resources has dramatically increased for some of these countries, at a pace unlikely to encompass the absorptive capacity of the institutional arrangements and health care systems.

3.1.2 Mozambique Context

The Government of Mozambique has engaged in an ambitious economic, social and political reform agenda, and has made efforts to consolidate macro-economic stability, as a result of which the country is experiencing strong economic growth, averaging nine per cent between 1997 and 2003.

In spite of these achievements, many development challenges remain. Mozambique remains one of the poorest countries in the world and was ranked 168th out of 177 in the 2006 Human Development Index. High rates of poverty, poor health indicators and high illiteracy persist[6]. The national Millennium Development Goal (MDG) progress report indicated that of the 11 MDG targets for which data were available, only five have the potential of being met without a considerable acceleration of efforts – those relating to poverty, under-five mortality, maternal mortality, malaria and the establishment of an open trading and financial system[7]. Underlying and compounding all of these challenges is the vulnerability of the country to the combined effects of the 'Triple Threat' of protracted natural disasters, HIV and AIDS and weakened national capacities.

Mozambique is one of the biggest recipients of aid in Africa (some 12-15 percent of GDP, accounting for more than half of total public spending).[8] This aid has assisted Government to improve access to and quality of services. The Government has also invested heavily in public sector reform, capacity development and an ambitious decentralisation programme, with the objective of improving efficiency, enhancing transparency and devolving responsibility from the heavily centralised state ministries to the provinces and districts. The limited operational and managerial capacity of some sectors remains a concern,

[5] UNAIDS/WHO (2007): AIDS Epidemic Update
[6] INE (2004): Inquerito Agregados Familiares sobre Orcamento Familiar 2002/3.
[7] GOM (2005): Report on the MDGs
[8] World Bank (2005): Mozambique Country Economic Memorandum

particularly at the sub-national levels and in relation to the recruitment and retention of qualified human resources, a problem that is being exacerbated by the AIDS pandemic.

The single greatest threat to development in Mozambique is HIV and AIDS and the pandemic is threatening to undermine all of the results achieved by the Government over the last decade. Although Mozambique's epidemic is lagging behind those of most other countries in the Southern African region, sentinel surveillance data shows a worsening epidemic overall, with rising infections in all regions. Approximately 1.6 million Mozambicans are currently living with HIV, and in the age group 15-49 the prevalence of infection is estimated at 16%. The highest prevalence is found in the three central provinces: Manica (19%), Zambezia (18.4%), and Sofala (26.5%), along the transport corridors to Zimbabwe, Zambia, and Malawi. Estimates for Maputo city are around 20.7%. High prevalence rates (19.9%) are also recorded in Gaza, which is home to migrant miners who work in South Africa. Current projections suggest that by 2010 the number of people infected will rise to 1.9 million.

Table 4: Estimated HIV prevalence rates among pregnant women (15-49 years) ANC by province, region and national 2001-2007

Province	2001	2002	2004	2007
Southern Region	15% (10%-17%)	16% (12%-18%)	19% (14%-21%)	21% (16%-23%)
Central Region	18% (16%-20%)	18% (17%-20%)	19% (17%-21%)	18% (17%-12%)
Northern Region	7% (6%-8%)	8% (6%-9%)	9% (7%-19%)	9% (7%-10%)
National	14% (12%-14%)	15% (13%-15%)	16% (14%-16%)	16% (14%-17%)

[Source: MISAU/INE, 2007]

The annual increase in new AIDS cases is expected to rocket from 61,000 in 2000 to 170,000 by 2010, thereby putting additional burden on already overstretched health services. Youth aged 15-24 are the most heavily affected and account for 60% of new HIV infections. Half of the nearly 1.6 million people already living with HIV are between the ages of 15 and 24. A disproportionate number of HIV infections occur in girls and women in this age group - prevalence among women is three times higher than that among men.

These trends would contribute to an estimated 27% drop in life expectancy by 2010 - expected to drop from 43 to 36 years rather than increasing to 50 years (World Bank, 2005); and substantially increase the number of orphans to 900,000 by the end of this decade. Infant mortality rates are expected to be 25% higher than they would otherwise be (World Bank, 2003). Apart from the immediate effect on the population, estimates indicate that AIDS has indirect costs in reduced GDP growth rate (as much as 1 percent each year) and major new expenditure on health treatment and replacing lost staff. It is estimated that 25% more medical staff will need to be trained just to maintain numbers; a similar percentage probably applies to education. If Mozambique is to attain the MDGs, it requires an urgent halt and reversal of the incidence of HIV, improvements in the efficiency of service delivery to the poor, employment creation, increases in the state revenue, reductions in foreign aid dependency, and effective preparedness for recurrent natural disasters. Particular focus will need to be placed on reaching the most disadvantaged communities in order to reduce the prevailing disparities, increase participation in development processes and ensure that the development gains are experienced by all Mozambicans.

3.2 The National Response to the AIDS Epidemic

3.2.1 Policy Context

In May 2005, the **Government of Mozambique adopted a new Five-Year Plan** for the period 2005-2009. This Plan is the main planning document which establishes the priorities and agenda for the Government. It also forms the basis for the medium term planning structure. The main objectives of the plan are: (i) to reduce the levels of absolute poverty, which will be pursued through activities in the areas of education, health and rural development; (ii) rapid and sustainable economic growth, focusing attention on the creation of an economic environment that favours private sector activity; (iii) economic development of the country, with an initial focus on rural areas, and the reduction of regional imbalances; (iv) consolidation of peace, national unity, justice, democracy and national awareness, as indispensable conditions for the harmonious development of the country; (v) to combat corruption, crime and red tape; and (vi) to strengthen sovereignty and international cooperation.

The Government also produced a **National Action Plan for the Reduction of Absolute Poverty** (PARPA II), 2006-2009, which operationalises the Five-Year Plan. PARPA II sets out the country's medium term strategy to promote growth and reduce poverty, as defined through the three pillars of: 1) Governance; 2) Human Capital; and 3) Economic Development. HIV and AIDS is treated as a cross cutting issue in this key Government plan. It is also the key planning tool that projects the resource envelope and sets time bound targets for with indicators to monitor poverty reduction and economic growth. Annually, the Government produces an Economic and Social Plan (PES) which outlines the priorities for the following year and is linked to sectoral plans.

Plans are also underway to reflect HIV and AIDS more clearly in the **Medium Term Expenditure Framework (MTEF)**. The Government aims to use the MTFF in preparing the budget so as to introduce a medium-term perspective to budget programming and consequently to improve the delivery of public services and increase the degree of predictability of available resources, thereby permitting strategic planning.

The **National response to HIV and AIDS epidemic** in Mozambique started in 1988 with the establishment of a prevention and control programme in the Ministry of Health. In 2000, the Government approved a National Strategy (PEN); and established the National Council to Combat AIDS (CNCS). The first National Strategic Plan to Combat HIV/AIDS, 2000-2002 (National PEN) which seeked to slow the spread of HIV infections and to mitigate the effects of the epidemic, though a multi-sectoral approach, focused mainly on prevention activities. Treatment and providing ARV therapy was not envisaged because of the high cost of ARV at that time, and the complexity of implementation.

The second generation National Strategic Plan (PEN II) for the period 2005-2009, developed in 2004, is the current guiding strategy for the implementation of the National response. It encompasses existing plans, including those of the line Ministries. The main objectives underlined in PEN II are the promotion of interventions to reduce the level of new infections and increase the care and treatment of people living with HIV and finally engage all stakeholders in mitigation process that will ensure that people living with HIV (PLWH) are treated humanely and their rights are protected. A comprehensive costing of the National Strategic Framework has not been undertaken.

Since 2005, HIV and AIDS has been mainstreamed into many national policy framework documents as well as the current Action Plan for the Reduction of Absolute Poverty 2006-2009 (PARPA II), showing the government's commitment to adopt a comprehensive approach to the national response of the HIV and AIDS epidemic. Several Ministries have now elaborated HIV and AIDS plans. The current policy framework of the health sector emphasizes primary health care and the need to halt the negative impact of endemic diseases especially HIV. Specifically, the National Strategic Plan for STI/HIV/AIDS 2004-2008 (PEN-Saude) outlines the HIV prevention, care and treatment efforts of the health sector.

Figure 1: PEN II 2005-2009 Objectives, Specific objectives and Strategies

3.2.2 Institutional Framework

National AIDS Council (CNCS)

The National Council to Combat HIV/AIDS (CNCS) was created in 2000 by the Decree 10/2000 of the Council of Ministers, and is responsible for coordinating HIV and AIDS activities (including prevention, education, and care) among major partners (Government, civil society, donors, national and international NGO). As part of its mission, it seeks to improve and expand the quality and coverage of services as well as for mobilizing resources to fund the multi-sector response to the pandemic. Its Board is chaired by the Prime Minister and includes the Minister of Health as Vice President, Ministers of Planning and Finance, Foreign Affairs, Education, Social Welfare and Youth and Sport, and representatives of civil society. An Executive Secretariat, which has the mandate to lead, catalyze, coordinate and monitor all activities in support of the National Strategy, but which does not implement programs, serves the CNCS. The Secretariat functions in close cooperation with the Ministry of Health (MOH) and other ministries. It has a national office in Maputo with a provincial nucleus in each of the ten provinces, and an eleventh in Maputo City. Each Ministry also has an HIV and AIDS focal point.

National AIDS Control Programme (NACP)

While CNCS is responsible for overall coordination, MOH is responsible for implementing treatment and all health related aspects of HIV and AIDS. The Ministry of Health (MoH) has had an active National AIDS Control Programme (NACP) since the mid 1980s. The Programme is responsible for the nation-wide health sector response to HIV and AIDS. Initially the programme focused mainly on prevention including provision of condoms, counselling and testing services, and treatment for Sexually Transmitted Infections (STIs). Prompted by the increasing international and national emphasis on the provision of antiretroviral (ARV) treatment in developing countries, and the favourable environment in terms of decreasing costs and availability of generic ARVs, the Ministry of Health subsequently developed the National Strategic Plan for STIs/HIV and AIDS – health sector (2004-2008) through a joint process of consultation with its national and international partners. The approach taken to this strategy development was to ensure that issues such as long-term sustainability would begin to be addressed together with the broader needs of the health sector, using the focus on antiretroviral treatment as the impetus to ensure a balanced approach to HIV and AIDS in the health sector. PENSAUDE takes into account on the one hand the escalating HIV epidemic, an overburdened health system, attrition of health workers due to AIDS related mortality; and on the other hand reduction in prices of antiretroviral drugs and increased funding.

The total cost (table: 5) projected for the implementation of MOH's PEN STI/HIV/AIDS-health sector for the period 2004 – 2008 is approximately USD $500 million, of which 20% is destined to capital expenses for the improvement of the Integrated Health network, 12% for the diagnosis and treatment of sexually transmitted infections, and 10% for prophylaxis and treatment of opportunistic infections. The cost per capita, between US$2.5 and US$6 per year, represents a major growth in the sector's expenditure.

The MOH has defined a management structure at national and provincial levels. The various Health departments and administrative units are involved in the continuum of HIV prevention, care and treatment, either directly or indirectly. It has established a management team, technical groups, working groups within MOH as well as an inter-Ministerial working group to coordinate across interventions and sectors. A treatment committee has also been established.

Table 5 -Total and Annual Costs per intervention, Health Sector National Strategic Plan to Combat STI/HIV/AIDS

Intervention	2004	2005	2006	2007	2008	TOTAL
Diagnosis and treatment of STIs	8,663,069	10,355,193	12,123,890	13,975,651	15,913,242	61,031,044
Distribution of condoms	1,324,320	1,586,400	1,746,000	2,082,000	2,376,000	9,114,720
Bio-security	2,761,380	2,781,840	2,801,388	2,822,998	2,844,553	14,012,160
Safe Transfusions	427,200	453,900	480,600	507,300	534,000	2,403,000
YFHS	1,582,000	2,030,000	2,510,000	2,910,000	3,390,000	12,422,000
Clinical Testing Labs and MCH	1,698,854	2,480,599	3,303,663	1,383,910	1,464,613	10,331,639
Prevention of Mother-to-Child Transmission	10,293	20,334	28,253	3,246	3,449	65,575
Treatment of OIs and Chemoprophylaxis	6,484,478	11,861,369	16,761,115	6,312,075	6,706,263	48,125,299
Operation of 129 integrated health networks	5,863,775	14,352,167	36,023,147	51,797,307	66,826,832	174,863,227
Improvement to system (capital expenditure)	7,998,820	23,880,039	27,876,373	27,411,357	12,253,182	99,419,771
Initial Training	2,110,000	3,135,000	3,460,000	3,260,000	2,560,000	14,525,000
In-Service Training	2,881,300	2,058,000	2,058,000	2,058,000	2,058,000	11,113,300
IEC	359,394	366,224	529,876	589,984	662,061	2,507,539
Programme Management	798,316	858,716	849,716	849,716	849,716	4,206,182
Monitoring and Evaluation	1,322,000	789,000	1,287,500	785,500	640,500	4,824,500
Lunch Subsidy	4,795,844	4,795,844	4,795,844	4,795,844	4,795,844	23,979,222
Technical Assistance	629,302	824,010	807,913	833,729	833,565	3,928,518
Others	400,000	400,000	400,000	400,000	400,000	2,000,000
TOTAL	50,110,345	83,028,636	117,843,278	122,778,618	125,111,819	498,872,696

Public/Private Partnerships for HIV and AIDS

Partnerships between the public and private spheres exist to a large extent. Various national and international NGOs, CBOs, religious bodies, youth organisations and media organizations are providing HIV and AIDS related services in support of the objectives set out in the National Strategic Plan (PEN II).

The role of NGOs and CSOs in the National HIV and AIDS response in Mozambique is not limited to the provision of services, but also includes contribution to policy-making, provision of technical assistance, representation of civil society and carrying out advocacy. [9] NGOs are primarily regarded as providers of services however it is important to recognise the additional roles that NGOs play in society.

Service delivery: NGOs may run health services and / or HIV/AIDS services in places where there are no public services available. For example, most of the VCT centres are being run by the NGOs across the country.

Provision of technical assistance: NGOs may provide technical assistance to public and/or private agencies in terms of capacity building / training, etc. Many international NGOs are providing training and assistance to local counterpart agencies. For example AMREF is providing technical support to the MONASO and RENSIDA umbrella organisations.

Contribution to policy-making: NGOs may contribute to national policy-making through participation in policy debates and in the process leading to development of new policies. For example, a number of NAIMA+ members participated in the drafting of the GFATM proposal, which led to the adoption of the Integrated Networks model as a key HIV/AIDS strategy. Also a number of NGOs recently participated in the consultation leading to the development of the new National HIV/AIDS Plan (PEN SIDA).

Development of new models through pilot programmes: NGOs may develop new models for prevention, treatment or care or delivery of services. For example FDC has an agreement with MISAU to run a pilot project on reduction of infant mortality, focusing on innovative systems for cold chain management. MSF was involved in the development of the model of Integrated (Health) Networks.

Representation of civil society: CSOs may represent civil society towards the government and authorities. Examples include professional associations such as the Mozambican Nurses Association ANEMO, the Mozambican association for traditional healers AMETRAMO, or other associations representing specific groups of persons, such as RENSIDA representing people living with HIV/AIDS.

Advocacy: CSOs / NGOs may have as an objective advocacy on specific issues. Examples include the different national Save the Children sections who advocate on the rights of children in Mozambique; or AMOSAPU (Associação Moçambicana de Saúde Publica) which has a contract with MISAU to serve as a focal point in advocacy against the use of tobacco.

[Source: Timmermans, N (2004): The role of NGOs in the health Sector SWAp in Mozambique]

The government recognizes the importance of working with NGOs to implement its health sector strategic plan. The MOH, CNCS, and international NGO have worked together since the 1990s. There are regular informal and formal contacts at both management and policy levels, but more importantly day-to-day interaction at the facility-operational level. The CNCS is working closely with an umbrella organization of NGOs, the Mozambique AIDS Services Organization (MONASO), and with RENSIDA, a network of 18 organizations of PLWH that focuses on orphans and vulnerable children and reducing stigma. International NGOs have grouped themselves into an association called NAIMA to assist the Government in its response to HIV and AIDS. Currently, a contracting system has been set up by the Ministry of Health for outsourcing services, and to date a number of NGOs, both national and international, have been contracted by the Ministry of Health.

[9] Kaarhus & Rebelo, 2003.

3.3 HIV and AIDS Funding Sources and Funding Modalities

The Government of Mozambique has initiated a comprehensive prevention, treatment, and care and support initiatives to reduce future transmission of HIV and meet the growing demand for HIV services. Substantial amounts of resources have been invested in prevention, treatment and care, and the growth in funding for HIV and AIDS prevention and care has outpaced that for most other public health programs.

There are three main sources of HIV and AIDS funding for the National response to HIV and AIDS: Public sources, External (international) Sources and Private Sources. These sources channel HIV and AIDS funding using three main funding mechanisms: the state budget based on the Medium-Term Fiscal Framework (MTFF); Sector-Wide Approach (SWAp) for health sector financing; and/or vertical project funding.

3.3.1 Public Sources of funding for HIV and AIDS

The State Budget (*Orçamento do Estado - OE*), is an important source of financing for Health response to HIV ad AIDS. The Government contribution to total expenditures in health has decreased from 53.8% in 2005 to 40.6% in 2006 and is expected to decrease slightly in 2007. This is matched with an increase in contributions from external sources to finance the health budget resulting in a higher degree of dependency for the sector on external resources. The classifications in State budget do not provide satisfactorily comprehensive picture of government and other sources of funding allocated to HIV and AIDS, apart from those allocated to the CNCS Secretariat.

The internal budget allocation to the CNCS Secretariat has continued to drop since 2004, both in absolute and proportional terms (US$ 4.3 million in 2004 or 18% of total budget, US$ 3.5 million in 2005 or 15% of total budget, and US$ 2.5 million in 2006 or 9% of total budget). While this decrease is proportional to the increase in the external component, this situation is of concern as it makes the CNCS one of the most aid-dependant Government Institutions in Mozambique (GOM/PAP 2006 Joint Review). Furthermore, the donor portfolio composition of the CNCS is limited, with over 60% of the external component depending on one donor only (the World Bank). The allocation of adequate State resources for CNCS Secretariat at national and provincial level is needed to signal political commitment to the national response and ensure its sustainability. Within the framework of the 2008-2010 MTEF exercise, the CNCS Secretariat has forecasted an overall decrease of external financial assistance and has concurrently requested an increase in the internal allocation (US$ 3.5 million in 2008, US$ 3.75 million in 2009 and US$ 4 million in 2010).

3.3.2 International Sources of funding for HIV and AIDS

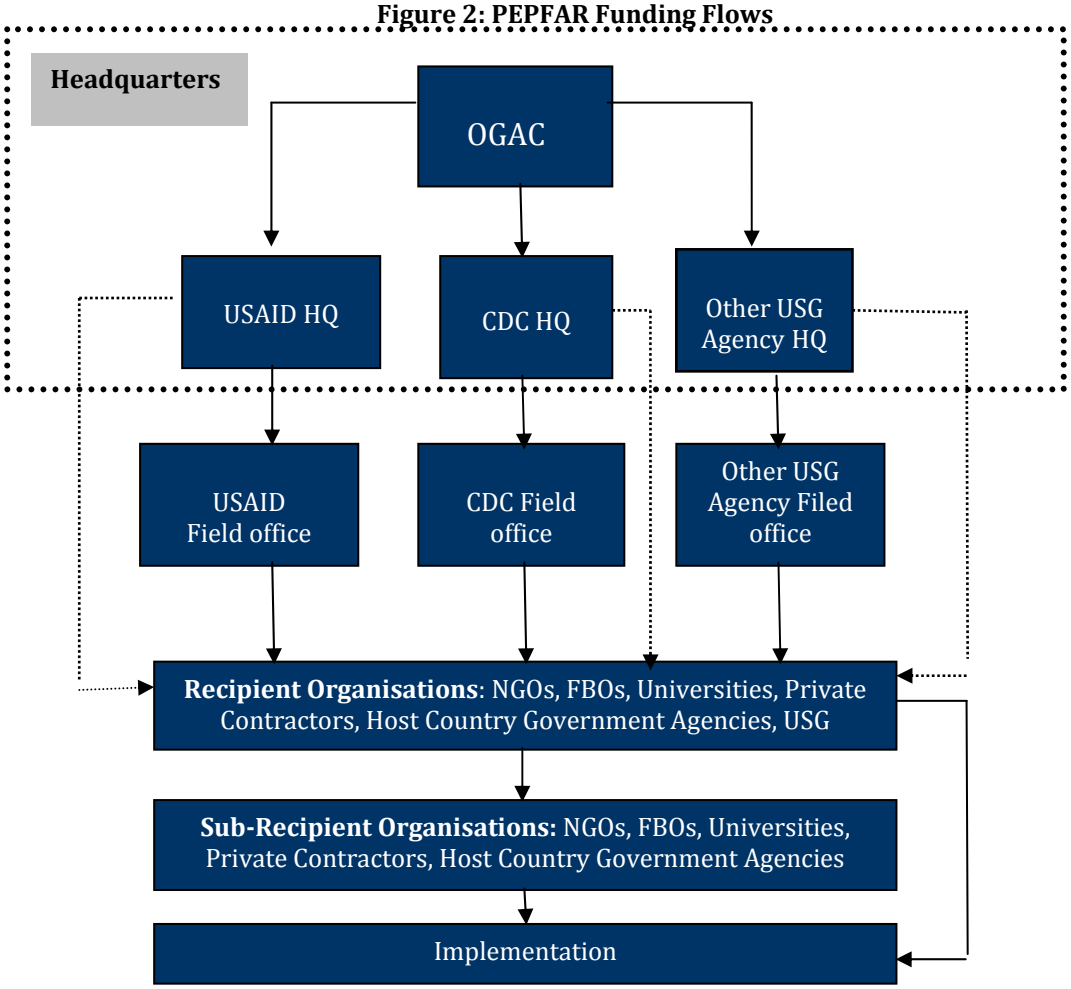
Like many developing countries, Mozambique's national response to HIV and AIDS is to a large extent sustained by external assistance secured from international, multilateral and bilateral organisations alongside foundations and NGOs supporting the HIV and AIDS response. The external sources of funds comprises of all funds from multilateral and bilateral agencies, development partners and some international NGOs. Some of the international organizations are PEPFAR, Global Fund, the World Bank, the UN System and Clinton Foundation, among others.

President Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR is a US Government grant approved in 2004. It supports laboratory activities, blood transfusion, PMTCT, HBC, VCT and Monitoring & Evaluation activities using CDC technical assistance at the central level. It also supports infrastructure rehabilitation and upgrading, and specialized services (including ART) in many DHs. Moreover, the PEPFAR allocates funds for ARV drugs (including pædiatric formulas and 2nd line treatment drugs).

The In-country PEPFAR Team is led by the US Ambassador and involves staff from various agencies. The lead PEPFAR agencies are the US Agency for International Development (USAID) and the Centre for Disease Control and Prevention (CDC). PEPFAR funding is sent from a variety of U.S. government agencies to a host of recipient organisations (ROs) in each country. The funds are often received through in-country field offices of U.S. Agencies but some of the funds are also chanelled directly to ROs from U.S. Agencies' headquarters. Some government agencies are also recipients of PEPFAR funds. Half or more of PEPFAR's sub recipient organization (SRO) funding goes to local recipients, but the total funding provided to local SROs is modest because most PEPFAR funds are not sub-granted.

Figure 2: PEPFAR Funding Flows



(Solid lines represent country-managed funds. Dashed lines represent centrally-managed funds)
[Source: Ooman et al., 2007]

Global Fund for AIDS, Tuberculosis and Malaria (GFATM)

The Global Fund provides grants for HIV and AIDS, tuberculosis and malaria. Mozambique was one of the first countries to apply to the Global Fund (GF). The Fund aims to operate within a broader network of partners, whereby it's funding is complemented by the activities, expertise and resources of other agencies, national governments, NGOs, civil society organizations, and private sector partners.

The first Global Fund proposal was submitted in March 2002, but it was not accepted. In September 2002, the CCM submitted a second version with various amendments to the GF 2nd Round. This version was approved in January 2003. The GF proposal encompassed all of the AIDS core components (ART and OIT, AST, PMTCT, HBC, YFS, ITS), and the general services (laboratory, pharmacy, blood transfusion). Other funds were aimed at initial and in-service training. The CNCS (NAC) and MOH are the principal recipients

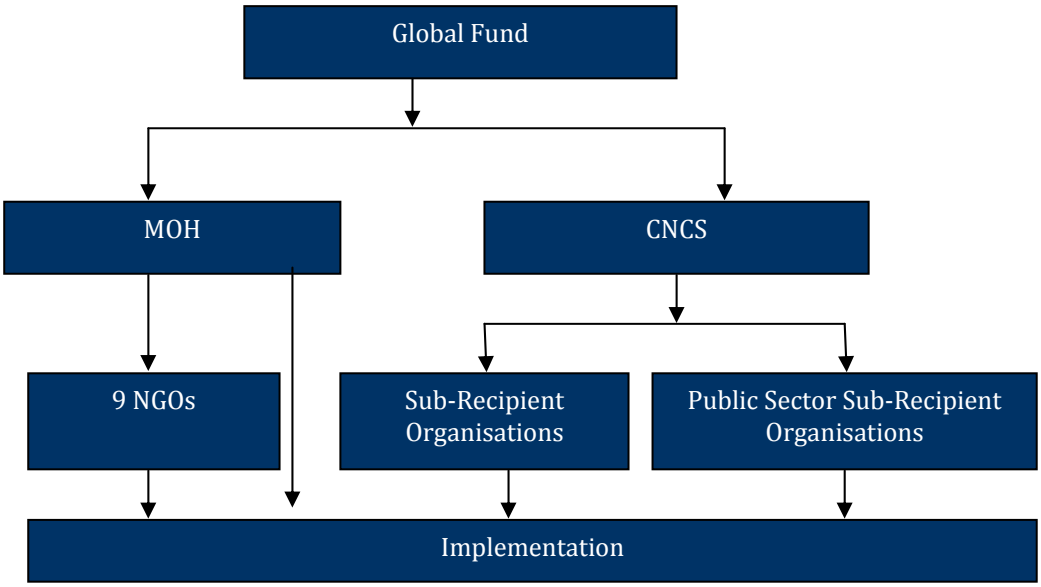
The AIDS component of the Global Fund Round 2 proposal received an overall five-year budget of US$109m (US$84.8m for the Ministry of Health, US$24.5m for the CNCS) of total funding for Mozambique of US$155m. Mozambique was the first country to receive and manage the GF through the donor backed common fund (PROSAUDE). Its first substantial amount was disbursed to the Ministry of Health in October 2004. Table: 5 shows Global Fund financing channelled through MOH Common Fund (PROSAUDE) for AIDS, TB and Malaria. The GF also contributes to the NAC common fund.

Table 6: Available Global AIDS, TB and Malaria Funds through Ministry of Health Common Fund (PROSAUDE)

Component	2005	2006	Total
Malaria	7,076,835	5,140,557	12,217,392
AIDS	8,475,099	13,484,585	21,959,684
TB	3,692,740	5,509,400	9,202,140
Total	19,246,679	24,136,548	43,383,227

[Source: GOM (2006): Global Fund Proposal]

Figure 3: Global Fund Funding Flows in Mozambique



[Source: Ooman et al., 2007] Slightly modified

World Bank Multi-Country AIDS Programme

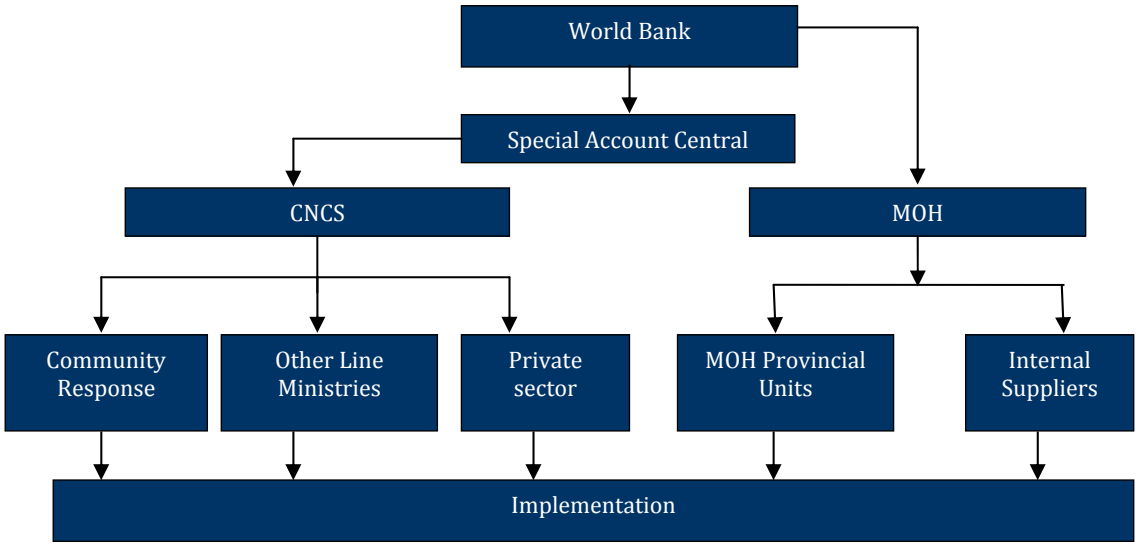
World Bank Multi-Country AIDS Programme for Africa (MAP) and Treatment Acceleration Programme (TAP) support the national HIV response in Mozambique. **MAP** is a grant approved in 2003, with a span of five years. Its development objective is to *slow the spread of HIV in Mozambique and mitigate the effects of the epidemic through prevention, care, treatment and mitigation*. It mostly supports interventions through the NAC, and through support to civil society and community projects. The WB has allocated US$55 million[10] for this goal. . The MAP also allocated US$15m to the Ministry of Health, in order to fund prevention (equipment for bio-security & laboratory, laboratory system strengthening), drugs for OIs, training courses, VTC, epidemiologic surveillance, traditional medicine operational research, monitoring and evaluation. Eventually, MAP funds may be redistributed between the two recipients (Ministry of Health and NAC) according to their factual expenditure capacity.

The **TAP** (Treatment Acceleration Program), a new WB initiative, was launched in 2004 to complement the MAP in three African Countries: Mozambique, Burkina-Faso and Ghana. For Mozambique, the initiative aims to support the ART scale-up through the disbursement of about US$21.7m. This International Development Association (IDA) grant is expected to cover 3 years (2005-7). The program and the grant is shared by the

[10] This grant has appreciated in value fromUS$55m originally to US$62.6 million today as a result of special drawing rights (SDR) against the US dollar (WB Supervision Mission Aide Memoire, March 2007)

Ministry of Health (investments and drugs) and three non-profit organizations – the Community of Sant'Egidio, Health Alliance International, and Pathfinder International, all with on-going treatment projects deemed worth expanding, signed on as implementing partners for activity management. TAP funds support salaries, management, drugs, equipment and on-the-job training (TAP 2004). The World Health Organization (WHO) and the United Nations Economic Commission for Africa (UNECA) are providing technical and project coordination support to facilitate an inter-country learning process.

Figure 4: **World Bank MAP Funding Flows**



[Source: Ooman et al., 2007]

(iv) United Nations

In order to respond more effectively to the challenges of meeting the MDGs, the UN in Mozambique has in recent years been moving towards improved coordination and increased alignment with national priorities. The UN is part of the SWAp fora, while their financial contributions are channelled through the implementing partners on the basis of agreed Country Programme Documents (CPD), *and not through the Common Funds*. The UN system, in collaboration with the Government, develops the United Nations Development Assistance Framework (UNDAF), which provides a common strategic framework for the operational activities in the country. The first generation UNDAF in Mozambique covered the period 1998-2001, the second one 2002-2006 and in April 2006, a three year UNDAF was approved for the period 2007-2009, to align the UN planning cycles with the PARPA II planning cycle covering 2006-2009. The third generation UNDAF is based on four pillars, Governance, Human Capital, HIV and AIDS and Economic Development. The decision to dedicate one of the pillars to HIV and AIDS is based on the critical impact that the epidemic has on development in Mozambique. The total resources of the UNDAF amount to US$349,585,000, of which US$101,553,000 has been dedicated to support the national response to HIV and AIDS.

According to the table 7 between 2004 and 2006, the UN committed US$ 51,458,633 to HIV and AIDS.

Table 7: UN Financial Commitments to HIV and AIDS for the period 2004-2006 (US$)

	Resources (US$)							
	2004		2005		2006		Total 2004/06	
Agency	Committed	Spent	Committed	Spent*	Committed	Spent	Committed	Spent
FAO	1,068,500	1,068,500	1,514,000	1,200,000	1,462,930	1,462,392	4,045,430	3,730,892
UNAIDS	299,223	180,057	277,760	100,140	949,799	470,000	1,526,782	750,197
UNDP	3,353,999	2,300,000	1,394,470	869,877	1400000	1392220	6,148,469	4,562,097
UNESCO	150,728	185,728	225,558	225,558			376,286	411,286
UNFPA	3,982,000	5,890,000	4,200,000	3,641,000	1,982,000	4,996,384	10,164,000	14,527,384
UNICEF	5,175,953	4,771,914	4,659,792	3,747,753	5,000,000	6,480,000	14,835,745	14,999,667
UNIDO	100,000	100,000	275,000	275,000	400000	10,000	775,000	385,000

WFP	1,708,500	3,509,606	10,000,000	5,352,504			11,708,500	8,862,110
WHO	1,973,000	620,000	2,578,000	960,000	1,750,000	1,650,000	6,301,000	3,230,000
Total	17,811,903	18,625,805	25,124,580	16,371,832	12,944,729	16,460,996	55,881,212	51,458,633

[Source: UNAIDS (2007): Mapping of UN Resources for HIV and AIDS in Mozambique]

3.4 Mechanisms for Funding the HIV and AIDS Response in Mozambique

The composition of funding mechanisms for the national response to HIV and AIDS in Mozambique has evolved overtime. This section provides an overview of the portfolio of international funding mechanisms that currently exist in Mozambique.

3.4.1 Programme Funding Modality – General Budget Support and Sector Budget Support

Development partners in Mozambique are increasingly shifting from more easily tracked project based funding to providing funding through direct budget support and sector wide support which either go directly into the central government budget and are fungible in that such funding can be spent in any sector; or funds that go to a known sector and involve more than one donor contributing funds to a common pool.

Flexible modalities such as GBS and common funds now comprise around 40 per cent of gross aid commitments. These shifts have been led in Mozambique by the Programme Aid Partnership (PAP), a group of 19 bilateral and multilateral donors providing GBS to the State Budget. The Government and its partners signed a Memorandum of Understanding (MoU) in 2004, which sets out the principles, terms and operations for the Programme Aid Partnership (PAP). This is one of the largest joint programmes in Africa, both in terms of volume and the number of donors involved. The PAP is organised around a structure of 24 thematic groups, including a group on HIV, in which Government, donors, the UN and civil society participate to monitor progress against the PARPA II indicators, notably through a Joint Review process twice a year.

Figure 5: Comparative advantages and disadvantages of Programme Support

Advantages:	**Disadvantages:**
▪ Aid that is better aligned with government strategies and explicitly linked to PRS. Enhanced policy dialogue; incentive for policy formulation at sector level which contributes to enhanced coherence across modalities ▪ Provides strong incentive for rational, policy driven resource allocation ▪ Government has a better handle on external resources and can plan the allocation of its own resources accordingly ▪ Designed to strengthen the planning, allocation and operational efficiency of public expenditure as well as the public finance and management systems for disbursement, procurement and accounting ▪ Can be useful in addressing cross cutting issues such as HIV and AIDS which increases visibility and mainstreaming across sectors ▪ Potential diminished downstream transaction costs through the	▪ High fiduciary risk ▪ Partnership approach makes heavy demands on what is often a narrow band of senior middle-level public servants ▪ Problematic unless macroeconomic stability and elementary fiscal discipline have been established ▪ Displaces government funding (allocated to other sectors or not increasing e.g. Funding to CNCS ▪ Budget does not give sufficient detail in terms of allocation of expenditure by programme that could facilitate an assessment of whether allocation is aligned ▪ Places particular demands on donor capacities – requires high levels of interpersonal skills, ability to take a long-term view and leave space for partner autonomy

[Source: International Department of the University of Birmingham (200?): Briefing papers: Joint Evaluation of GBS 1994-2004 – When & how to use budget support]

HIV and AIDS Funds channeled through CNCS

According to the situation analysis of the NSP (PEN II), funding through external sources channeled through the National AIDS Council (CNCS) increased by 400 percent from US$ 1 million in 2002 to US$ 5 million in 2003. Most of the external funding to the CNCS is now channeled through a Common Fund arrangement. Procedures and systems for the management of the funds were established and the Fund became operational during the second half of 2002. The CNCS Common Fund was created to support HIV and AIDS activities carried out by government, the private sector and civil society organisations.

In 2004, the Global Fund to Fight AIDS, TB and Malaria (GFATM) agreed to channel its funding through the CNCS common fund, making Mozambique the first country to place GFATM money into a common fund and on-budget arrangement[11]. The Common Fund receives contributions from seven donors, namely: CIDA, DFID, DANIDA, GFATM, Irish Aid, SIDA and the World Bank. GTZ is in the process of also becoming a contributor to the Common Fund. The World Bank is channeling US$60 million through the CNCS Common Fund through the MAP initiative.

[11] Dickison et al, 2007

Table 8: **External Sources disbursements to NAC (CNCS) Common Fund for the period: 2004-2006 (US$)**

	2004	%	2005	%	2006	%
Irlanda	1,238.75	29%	1,201.00	32%	1,835.63	22%
Suecia	433.70	10%	-	-	962.82	11%
DFID	1,710.33	40%	895.50	24%	1,804.30	21%
CIDA	898.51	21%	1,702.06	45%	1,998.19	23%
Global Fund					1,933.94	23%
Total	4,281.28	-	3,798.56	-	8,534.87	-

[Source: CNCS Annual Reports 2004-2006]

Funding Channeled through the Health Sector

In the health sector, there are three pooled donor funding mechanisms: one for drugs and medical supplies (Drugs Common Fund); a second for provincial funding for recurrent costs, including salaries and minor or medium investments (Provincial Common Fund); and a third sector-wide on-budget pool (PROSAUDE). The Common Funds are currently supported by AECI, AFD, Catalunya, CIDA, DANIDA, DFID, FINIDA, Flanders Cooperation, Irish Aid, NORAD, the Netherlands, SDC, EU, UNFPA and DFID. Their main advantage is direct management by the Ministry of Health.

All stakeholders jointly approve the sector annual operational plans and budgets implementing the National Strategic Plan for the Health Sector (PESS). The State Budget (known as the OE) mainly covers salaries and investments. A new state budget financial management system has been launched (SISTAFE), which is expected to significantly improve financial flows. A group of donors (18) has already commenced some degree of general budget support and this practice is likely to increase.

At present, there are monthly operational meetings of the health SWAp partners, led by the Ministry of Health; twice-yearly high level policy meetings (CCS); annual operational plans and budgets; and annual joint evaluations. In addition to a Memorandum of Understanding for the general on-treasury pool (PROSAUDE), a revised Code of Conduct for the Ministry of Health and partners, terms of reference for the SWAp meetings, a revised PESS and a new National Health Policy now exist.

Bilateral donors such as Irish Aid have significantly increased their funding to the health sector as a result of a partnership with the Clinton Foundation HIV/AIDS Initiative. As a result of this partnership, Irish Aid channels additional funding through the MOH common funds as part of its untied, unearmarked support to the Ministry of Health, to be directed by the Ministry to whichever one of the three common pools it chooses, based on needs and other available funding on an annual basis. Although this additional funding arose on the basis of an increasing focus on HIV/AIDS care and treatment Irish Aid chose not to earmark the funds within the sector but rather to focus on strengthening the existing systems. This additional funding to the health sector amounted to Euro 6,700,000 for 2004, Euro 7,500,000 for 2005 and Euro 11,500,000 for 2006.

The main advantages that are cited of common fund arrangements include improved coordination of health related activity; transparent processes which includes provisions for donor oversight; and strengthening, simplification and harmonization of financial, reporting and M&E systems.

Table 9: Source of External Funds: Disbursements to Health Common Funds for the period 2004-2006 (US$ '000)

	2004*	**%**	**2005**	**%**	**2006**	**%**
AFD	1,224.8	3%	3,529.2	5%	3,460.5	4%
CIDA	2,469.1	6%	4,309.9	6%	2,880.6	4%
Catalunya	-	-	629.7	1%	35.2	-
Cooperacão Flamenga	-	-	-	-	1,247.3	2%
DANIDA	1,750.0	4%	1,115.3	2%	757.5	1%
DFID	5,916.0	14%	1,754.8	2%	6,131.8	8%
Espanha	-	-	2,485.3	4%	1,189.8	2%
Finlândia	3,111.3	7%	4,451.3	6%	4,128.4	5%
FNUAP	-	-	50.0	-	25.0	-
Global Fund	1000	2%	-	-	21,453.5	27%
Irlanda	8,496.1	19%	12,013.0	17%	15,674.1	20%
Noruega	8,728.4	20%	16,981.9	24%	8,590.9	11%
Países Baixos	2,200.0	5%	4,640.0	7%	1,807.2	2%

SDC	2,869.4	7%	3,846.7	5%	2,545.2	3%
União Europeia	5,871.0	13%	13,357.6	19%	8,122.5	10%
Not identified contributions			1,191.3			
Fundos Comuns	43,636.1	100%	70,356.0	100%	78,049.5	100%

[Source: MOH DAG Annual reports] *Contributions to Medicines Common Fund excluded

Table 10: Summary External Disbursements to the Health Common Funds (US$ '000)

	2004	%	2005	%	2006	%
Common Fund (PROSAUDE)	31,458.4	43%	29,988.7	43%	37,415.1	48%
Common Fund for Provinces (FCP)	12,177.7	17%	18,871.2	27%	13,836.3	18%
Common Fund for Medicines (FCMED)	30,163.7	41%	21,496.2	31%	26,798.2	34%
Total	**73,799.8**		**70,356.0**		**78,049.5**	

[Source: MOH DAG Annual reports]

HIV and AIDS Funding Chanelled through other Strategic Ministries

In Mozambique, the Sector Wide Approach is also being implemented in other sectors, including education and agriculture. In the education sector, the Ministry of Education (MINED) and donor agencies developed a common education strategy, which is supported by an education common fund (FASE). NGOs have not yet been fully involved in the education SWAP and FASE is only used to support public sector activities. However, donor agencies are championing the cause of civil society and NGOs and promoting their involvement in the SWAP through the NGO education umbrella organisation Movimento Para Educação para Todos (MPET). All major NGOs active in education are represented in the MPET, which facilitates communication with MINED and donors.

In the agriculture sector, a common agriculture sector strategy is being implemented, supported by the agriculture common fund (PROAGRI), used to support activities implemented by the Ministry of Agriculture (MADER), the private sector and NGOs. NGOs are already being contracted by MADER.

3.4.2 Project Funding Mechanism

Vertical donor funding continues to occupy the centre stage of the response. This particularly applies to project aid which goes directly to public sector initiatives or channelled directly to the implementing partners (national or international NGOs, and some government institutions). There has been a significant increase in the availability of vertical funding for HIV and AIDS related activities through programmes such as the United States (U.S) Government's PEPFAR. According to one assessment, PEPFAR funding has increased rapidly in the last five years and currently provides the largest share of funds[12]. In order to avoid duplication of efforts and concentration of resources in a particular intervention, the CNCS has requested all partners to provide information regarding HIV expenditure (what, where, and level of contribution) to ensure that they are on-budget.

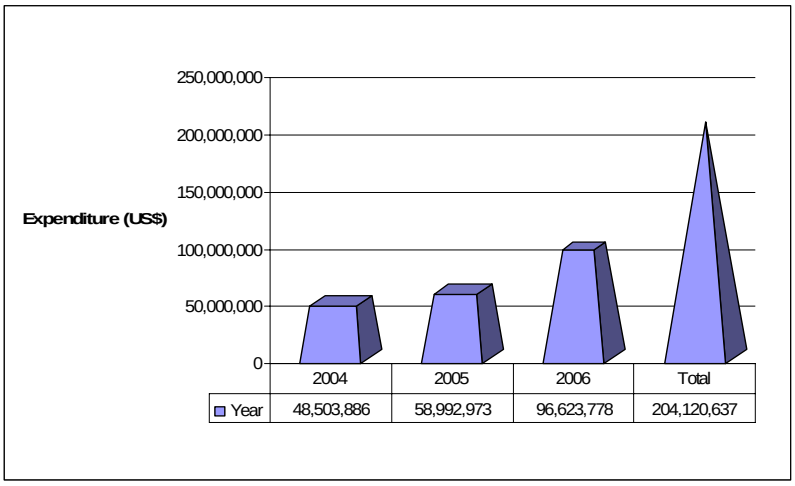
[12] Oomman et al., 2007

4 NASA Estimations and Main Policy Findings

4.1 Overview of HIV and AIDS Expenditure for 2004-2006

Bearing in mind the limitations and assumptions detailed in section 2, the National AIDS Spending Assessment (NASA), approximates US$204,120,637 was spent in Mozambique on HIV and AIDS between 2004 and 2006. The assessment findings show that HIV and AIDS expenditure has doubled during the reporting period. Although reported HIV and AIDS expenditure increased by only 5% from 2004 to 2005, total reported expenditure increased by 18% between 2005 and 2006. HIV and AIDS spending in 2006 made up nearly half of total spending during the reporting period. Figure 6 presents the total HIV and AIDS expenditure for the period under consideration.

Figure 6: Total HIV and AIDS Expenditure (US$), Mozambique NASA 2004-2006



Due to the lack of a fully costed National HIV and AIDS Plan (PEN II), it is difficult to evaluate whether the actual allocations spent between 2004 and 2006 meet or fall short of the estimated required resources for scale up towards universal access to prevention, treatment, care and support in Mozambique. The lack of reliable and consistent disaggregated data on spending by gender also makes it difficult to assess efforts to issues related to equity.

4.2 HIV Expenditure by Financing Source, Agent and Service Providers

4.2.1 Financing Sources

Financing sources are entities that provide money to financing agents to be pooled and distributed. There are three main sources of HV and AIDS funding in Mozambique, namely: public sources, international sources and private sources.

Table 11: Summary of HIV and AIDS Financing Sources (US$), Mozambique NASA 2004-2006

Source	2004	%	2005	%	2006	%	Total	%
Public	7,326,297	15%	11,533,434	20%	14,301,520	15%	33,161,251	16%
Private	2,301,227	5%	747,175	1%	1,118,428	1%	4,166,830	2%
International	38,876,362	80%	46,712,364	79%	81,203,830	84%	166,792,556	82%
Total (US$)	48,503,886		58,992,973		96,623,778		204,120,637	

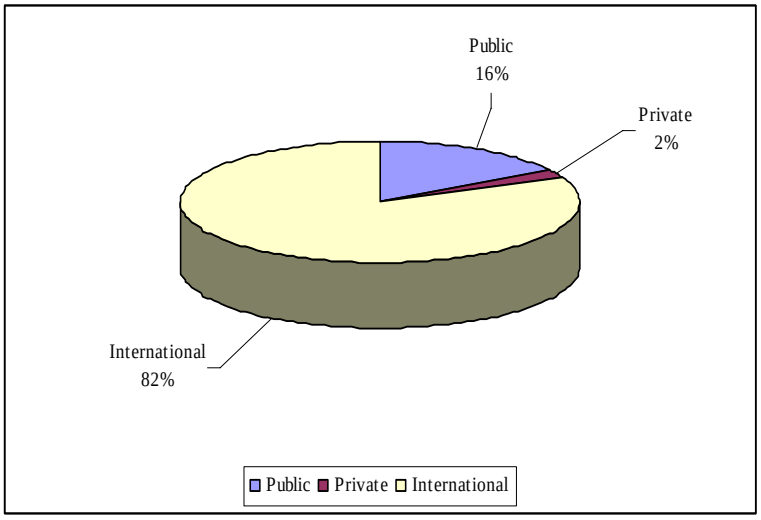
Table 12 clearly shows this increasing trend in funding in nominal terms from all public, international, private funding sources.

Table 12: Public, International and Private HIV and AIDS Financing Sources (US$), Mozambique NASA 2004 – 2006

Financial Source	2004	2005	2006
Public	7,326,297	11,533,434	14,301,520
Ministry (or equivalent sector entity) of Health	4,012,798	7,831,261	9,153,290
National AIDS Coordinating Authority (CNCS)	128,608	407,594	5,091,152
Central Government entities not elsewhere classified	3,184,891	3,265,991	20,840
Other Public Financing Sources	-	28,588	36,238
Private	2,301,227	747,175	1,118,428
Households' funds	-	-	519,890
Not-for-profit institutions (other than social insurance)	-	126,202	168,821
For-profit institutions – Corporations	-	186,300	257,816
Private Financing Sources not elsewhere classified	2,301,227	434,673	171,901
International	38,876,362	46,712,364	81,203,830
Direct bilateral contributions	21,419,098	24,198,269	44,714,530
Multilateral Agencies managing external resources	12,156,270	18,021,229	30,604,117
International not-for-profit organizations and foundations	5,300,994	4,492,866	5,885,183
Total (US$)	48,503,886	58,992,973	96,623,778

External financing sources accounts for 82% of the national HIV and AIDS expenditure during 2004-2006. Public funds constituted 16% of the total HIV and AIDS expenditure, while private sources of funding accounted for only 2%. It is critical to note that the assessment only captures private household out of pocket HIV and AIDS expenditure on condoms in 2006

Figure 7: Percentage share of HIV and AIDS Financing by Source, Mozambique NASA 2004-2006



Public Financing Sources:

The share of HIV and AIDS spending from public sources of funding almost doubled from US$7,326,297 in 2004 to US$14,301,520 in 2006, an increase of US$6,975,223. Public spending constituted 16% of total HIV and AIDS expenditure between 2004 and 2006.

Financing from the CNCS and the Ministry of Health constitute the main public sources of funding. CNCS increased spending from 2% in 2004 to 35% of total public expenditure in 2006. This figure includes funding of sub-projects implemented by CSO and some public and private sector institutions with funds provided for by bi and multi-laterals sources. The main source of public funds for the reporting period is the Ministry of Health (MOH). It accounts for over 63% of all finances earmarked for HIV and AIDS during the reporting period. HIV and AIDS financing from the MOH increased from US$4,012,798 in 2004 to US$ 9,153,290 in 2006.

Table 13: HIV and AIDS Spending by Public Source of Funding (US$), Mozambique NASA 2004-2006

Organization	2004	%	2005	%	2006	%	Total	%
Ministry (or equivalent sector entity) of Health	4,012,798	54%	7,831,261	67%	9,153,290	64%	20,997,349	63%
National AIDS Coordinating Authority (CNCS)	128,608	2%	407,594	3%	5,091,152	35%	5,627,354	17%

Ministry (or equivalent sector entity) of Finance	3,177,622	43%	3,073,967	26%	-	-	6,251,589	19%
Other ministries (or equivalent sector entities)	7,269	0.10%	15,699	0.10%	-	-	22,968	0%
Central Government entities not elsewhere classified	-	-	176,325	1.50%	20,840	0.10%	197,165	1%
Parastatal organizations	-	-	28,588	0.20%	-	-	28,588	0%
Public Financing Sources not elsewhere classified	-	-	-	-	36,238	0.30%	36,238	0%
Total (US$)	7,326,297		11,533,434		14,301,520		33,161,251	

International Financing Sources:

Over the reporting period International organizations were the largest contributor at 82% of total HIV and AIDS expenditure. Bilateral agencies were the largest financing source at approximately 54% each year. Multilateral funding for HIV increased from 31% in 2004 to 38% in 2006. It is observed that donor funds are mainly allocated to the public sector and other development partners.

Table 14: Summary of HIV and AIDS International Financing Sources (US$), Mozambique NASA 2004-2006

	2004		2005		2006	%	Total	%
Direct bilateral contributions	21,419,098	55%	24,198,269	52%	44,714,530	55%	90,331,897	54%
Multilateral Agencies managing external resources	12,156,270	31%	18,021,229	39%	30,604,117	38%	60,781,616	36%
International not-for-profit organizations & foundations	5,300,994	14%	4,492,866	10%	5,885,183	7%	15,679,043	9%
Total spending (US$)	38,876,362		46,712,364		81,203,830		166,792,556	

Figure 8: HIV and AIDS Expenditure by International Source of Financing (US$), Mozambique NASA 2004-2006

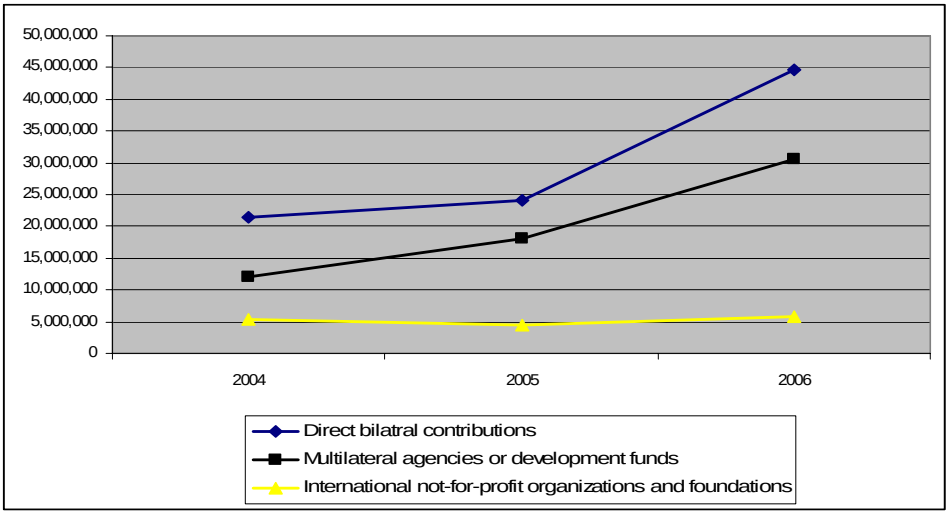


Figure 9: Percentage Share of HIV and AIDS Expenditure by International source Mozambique NASA 2004-2006

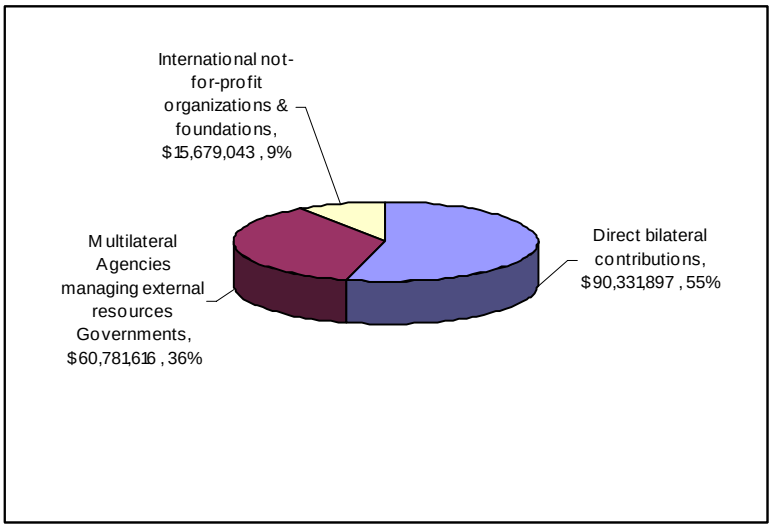


Table 15: HIV Expenditure by International Sources of Financing (US$), Mozambique NASA 2004-2006

	2004	2005	2006
Bilateral Organization	21,419,098	24,198,269	44,714,530
Government of Australia	38,668	324,442	282,012
Government of Belgium	678,299	458,088	765,660
Government of Canada	530,721	1,621,871	2,835,919
Government of Denmark	1,013,050	1,386,584	310,697
Government of Finland	-	-	177,633
Government of France	1,033,039	27,000	1,266,207
Government of Germany	141,033	89,555	-
Government of Ireland	2,027,771	551,058	2,962,426
Government of Italy	-	122,700	829,400
Government of Japan	-	140,000	-
Government of Luxembourg	-	-	1,383,861
Government of Netherlands	-	381,000	893,049
Government of Norway	449,008	226,590	2,040,470
Government of Portugal	-	-	105,239
Government of Spain	-	490,488	301,870
Government of Sweden	262,367	1,995,189	2,869,587
Government of Switzerland	269,000	592,000	592,500
Government of United Kingdom	1,473,000	2,290,282	3,888,718
Government of United States	11,017,875	11,382,931	20,939,668
Government. Of non-DAC countries/Bilateral Agencies	2,485,267	2,118,491	2,269,614
Multilateral funds or development funds	12,156,270	18,021,229	30,604,117
UNAIDS	41,980	86,452	8,860
World Health Organization (WHO)	1,064,023	1,527,671	1,564,682
United Nations Children's Fund (UNICEF)	3,570,185	2,545,714	5,547,407
World Food Program (WFP)	-	4,291,239	10,368,920
United Nations Development Program (UNDP)	461,011	1,171,332	325,031
United Nations Population Fund (UNFPA)	3,176,086	1,616,378	1,436,348
United Nations Educational, Scientific and Cultural Organization (UNESCO)	-	50,000	62,000
World Bank (WB)	3,377,675	6,131,886	9,211,131
The Global Fund for AIDS, Tuberculosis and Malaria	-	-	649,960
Commission of the European Communities	-	-	1,096,276
Multilateral funds or development funds n.e.c.	465,310	600,557	333,502
International not-for-profit organizations/foundations	5,300,994	4,492,866	5,885,183
Médicins sans Frontières	3,345,520	714,030	2,613,481
Family Health International	-	-	2,462
Care International	-	-	70,292
Foundation Mérieux	-	-	245,174
International not-for-profit organizations and foundations	1,955,474	3,778,836	2,953,774
Total (US$)	38,876,362	46,712,364	81,203,830

Private Financing Sources:

The total share of Private expenditure on HIV and AIDS over the three years is 2%. Since the assessment did not collect household out-of-pocket payment on HIV and AIDS, this percentage does not represent the total contribution of private expenditure on HIV and AIDS. As can be discerned from the table 16 below, the private HIV and AIDS expenditure has decreased from 55% in 2004 to 27% in 2006.

Table 16: HIV and AIDS Private Financing Sources (US$), Mozambique NASA 2004-2006

Source	2004	2005	2006
Households' funds	-	-	519,890
Not-for-profit institutions (other than social insurance)	-	126,202	168,821
For-profit institutions - Corporations	-	186,300	257,816
Private Financing Sources not elsewhere classified	2,301,227	434,673	171,901
Total (US$)	2,301,227	747,175	1,118,428
%	55%	18%	27%

4.2.2 Financing Agents

Financing agents are entities that pool financial resources collected from one or different financing sources and transfer them to pay for or to purchase health care or other services or goods to address HIV-AIDS related activities. While financing sources decide to allocate resources to the national HIV response, financing agents have the ability to decide the type of activity or product to fund or purchase.

The main financing agents of HIV and AIDS activities in Mozambique are the National AIDS Council (CNCS), Ministry of Health (MISAU), bilateral agencies, multilateral agencies, NGOs, and private firms and corporations.

Table 17: Total HIV and AIDS Expenditure by Financing Agent (US$), Mozambique NASA 2004-2006

	2004	2005	2006	Total
Public	13,826,423 (29%)	21,978,502 (37%)	30,088,431 (31%)	65,893,356 (32%)
Ministry of Health	4,013,000	8,200,000	13,500,000	25,713,000
CNCS	8,824,000	13,132,000	16,270,000	38,226,000
Other Public	990,000	647,000	318,000	1,955,000
Private	4,303,753 (9%)	2,797,935 (5%)	5,819,794 (6%)	12,921,482 (6%)
International	30,373,710(63%)	34,216,536 (58%)	60,715,553 (63%)	125,305,799 (62%)
Bilaterals	141,000	2,149,600	8,144,200	10,434,800
Multilaterals	12,950,100	15,288,400	24,138,600	52,377,100
International NGOs	14,783,800	16,778,600	28,416,700	59,979,100
Other International	2,498,700	-	16,100	2,514,800
Total (US$)	48,503,886 (24%)	58,992,973 (29%)	96,623,778 (47%)	204,120,637

As expected among public financing agents both CNCS and MOH play a major role in deciding what HIV activities to fund.

Figure 10: Percentage share of the various financing Agents, Mozambique NASA 2004-2006

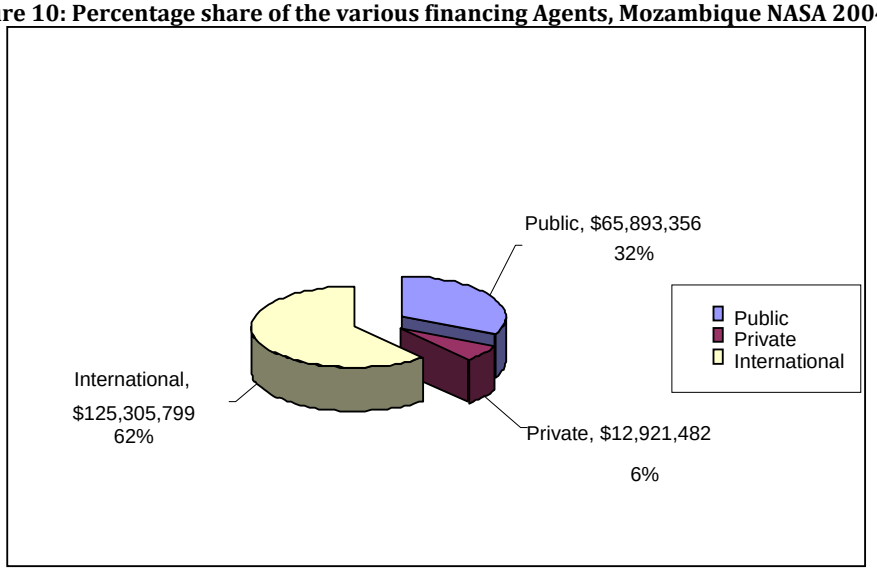


Table 17 and figure 10 show that funding to the HIV response flows essentially through international entities namely multilateral agencies and not-for- profit organizations.

4.2.3 HIV Service Providers

According to NASA classifications, HIV Service Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. They include government and other public entities, private for profit and non-profit organizations, corporate and non-corporate enterprises, self-employed persons whose activity falls within the NASA boundaries regardless of a formal or informal legal status. In Mozambique there are three categories of HIV service delivery providers, namely public sector organizations, bilateral and multilateral organizations, and private sector organisatons.

The results from the study (Table 18) show that the public organizations provide the majority of HIV and AIDS services in Mozambique. An estimated US$93,993,442 (46% of total expenditure) was spent by public service providers over the three year study period. The main public HIV service providers during the period under review were public general hospitals US$43,913,551(47%), public outpatient care centres US$19,541,561(21%) and CNCS US$16,911,879(18%) In 2004, public service providers spent 50% of the total HIV and AIDS

resources (US$48,503,886) mainly through public outpatient care centres US$7,653,298 (32%) and CNCS US$7,118,914 (29%). By 2006, public general hospitals accounted for 57% (US$26,183,697) of all public service spending on HIV and AIDS. The proportion of CNCS HIV and AIDS spending as a service provider had fallen to US$4,878,634 (11%) of total public service delivery in the same year.

Private sector HIV service providers mainly consist of for-profit and non-for profit organisations. The results from the NASA confirm the general trend that the provision of HIV and AIDS services has relied heavily on Private non-profit providers (NGOs). Many international NGOs and international FBOs are providing HIV and AIDS services, either with their own funding or project funds received from donors. The public-private partnership with the MOH, which acts as a "contractor" of services, enable HIV services to be delivered to those in need, and also integrate NGO activities and staff into government run facilities. Between 2004 and 2006, NGOs spent US$77,468,243 (38%) on HIV and AIDS. Total expenditure by NGO service providers has nearly doubled from US$ 17,619,655 in 2004 to US$32,335,725 in 2006. A significant number of these services are provided by NGOs and community based organizations (CBOs). Bilateral and multilaterals organizations spent US$19,905,542 (56% and 44% respectively) on the provision of various HIV and AIDS services during 2004 and 2006. Spending has remained even over the three years at around US$6.6 million per year. Between 2004 and 2006, bilateral and multilaterals share of HIV service provider spending decreased from 13% of total HIV service provider spending in 2004 to 7% in 2006. Private for-profit organisations HIV service providers in Mozambique comprise mainly of commercial pharmacies and a number of smaller privately run clinics, most with some emergency, obstetric and surgical facilities. Spending through these service providers increased exponentially from a reported US$37,000 in 2004 to US$1,724,233 in 2006. This mostly likely due to the establishment of workplace programmes and establishment of ART schemes in private companies

Figure 11: Expenditure by HIV Service Provider (US$), Mozambique NASA 2004-2006

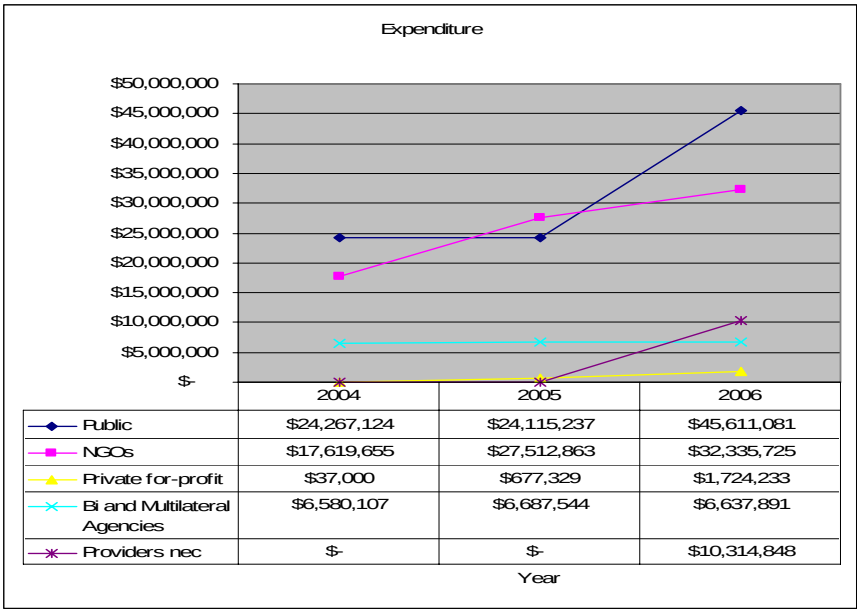


Table 18: Spending by Service Providers (US$), Mozambique NASA 2004-2006

		2004	2005	2006
PS.1	Public	24,267,124	24,115,237	45,611,081
PS.1.1.1	Public general hospitals	6,969,651	10,760,203	26,183,697
PS.1.1.2	Public specialty hospitals	0	22,082	0
PS.1.13.1	National AIDS Coordinating Authority (CNCS)	7,118,914	4,914,331	4,878,634
PS.1.13.2	Departments inside the Ministry of Health	1,088,090	1,109,656	2,544
PS.1.13.3	Departments inside the Ministry of Education	0	0	545,534
PS.1.13.6	Departments inside the Ministry of Finance	0	0	95,780
PS.1.13.7	Departments inside the Ministry of Labour	0	0	24,775
PS.1.13.99	Other Ministries or Public Administration entities n.e.c	1,198,528	1,629,948	6,403,786
PS.1.2.1	Public outpatient care centres	7,653,298	4,742,686	7,145,577
PS.1.3	Public nursing and residential care facilities	160,181	413,232	0
PS.1.8	Public enterprises	0	28,588	0
PS.1.9.3	Higher education	78,462	494,511	323,054
PS.1.99	Public providers not elsewhere classified	0	0	7,700
PS.2	Private non-profit: NGO's	17,619,655	27,512,863	32,335,725
PS.2.11	NGO and CBOs (other than PS.2.1 to PS.2.9)	15,894,653	27,512,863	32,297,033
PS.2.8.3	Private non-profit higher education	250,212	0	38,692
PS.2.99	Non-profit providers not elsewhere classified	1,474,790	0	0
PS.3	Private for-profit	37,000	677,329	1,724,233
PS.3.10	Corporations & Enterprises	0	581,329	188,051
PS.3.11.3	Private for profit higher education	0	0	12,170

PS.3.7	For profit pharmacies and medical goods retailers	0	0	519,890
PS.3.99	For profit providers not elsewhere classified	37,000	96,000	1,004,122
PS.4	Bi and Multilateral Agencies	6,580,107	6,687,544	6,637,891
PS.4.1	Bilateral Agencies	0	2,619,375	3,690,421
PS.4.2	Multilateral Agencies	6,580,107	4,068,169	2,947,470
PS.9	Providers not elsewhere classified	0	0	10,314,848
PS.99	Providers not elsewhere classified	0	0	10,314,848
	Total (US$)	48,503,886	58,992,973	96,623,778

Table 19: % Spending by Service Providers, (US$), Mozambique NASA 2004-2006

	2004	%	2005	%	2006	%	Total	%
Public	24,267,124	50%	24,115,237	41%	45,611,081	47%	93,993,442	46%
Private non-profit: NGO's	17,619,655	36%	27,512,863	47%	32,335,725	33%	77,468,243	38%
Private for-profit	37,000	0.1%	677,329	1%	1,724,233	2%	2,438,562	1%
Bi and Multilateral Agencies	6,580,107	14%	6,687,544	11%	6,637,891	7%	19,905,542	10%
Providers n.e.c	-	-	-	-	10,314,848	11%	10,314,848	5%
Total (US$)	48,503,886	24%	58,992,973	29%	96,623,778	47%	204,120,637	

Figure 12: Spending by Service Provider (US$), Mozambique NASA 2004-2006

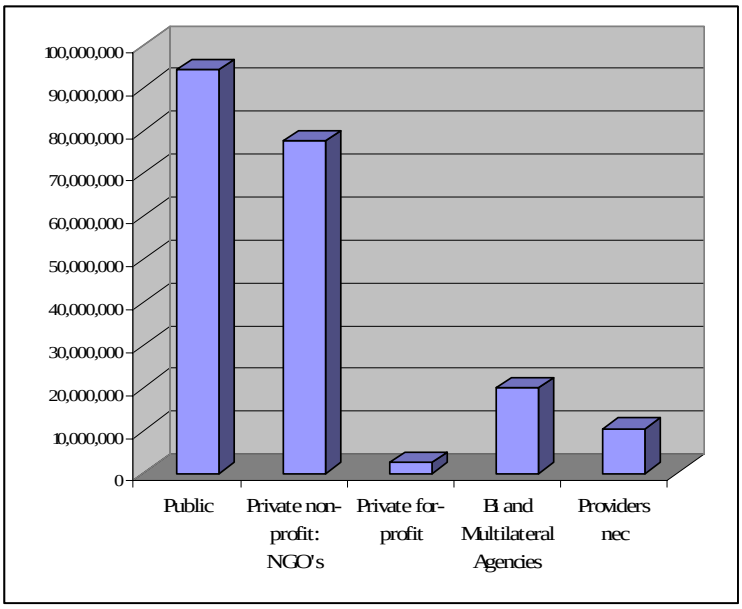
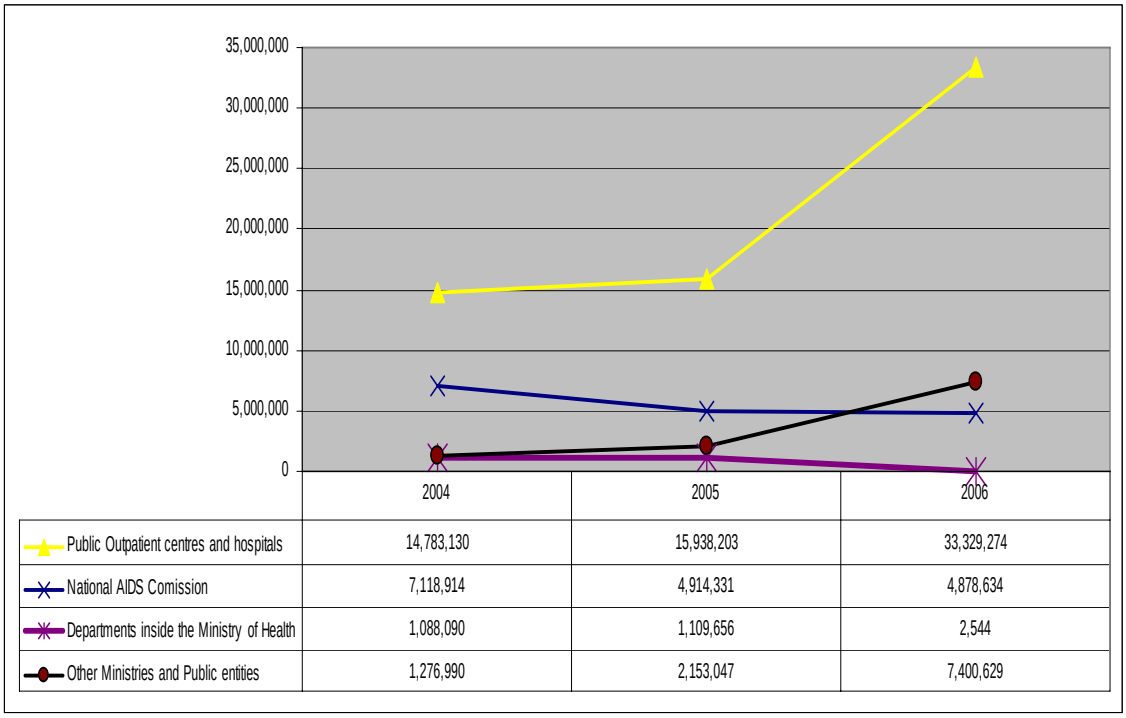


Figure 13: Financial trend in spending by the major Public HIV Service Providers (US$), Mozambique NASA 2004-2005



Service Providers by Key Intervention Areas

Table 20 shows service providers by key intervention areas from 2004 to 2006 respectively. In 2004 of the total services provided by public providers, 38% went into prevention programmes and 36% on the provision of treatment and care services; 11% on programme management and administrative strengthening and 11% on human resources. In 2005, the provision of treatment and care services services decreased to 30%, programme management services increased to 18% and prevention took up 42%. In 2006, a notable change was an increase in the provision of treatment and care which made up almost 50% of services provided from the public sector.

In the case of private non-profit, of the the total in 2004, prevention took up 61% with 16% on OVCs and 9% on treatment and care. In 2005 the share of prevention services reduced to 52%, treatment and care increased to 20%, programme management remained at 12% and 12% spent on OVCs. In 2006, the share of prevention services reduced further to 49%, treatment and care reduced to 12%, OVCs accounting for 15% of the total and services provided in the programme management category increasing to 18%.

There was minimal expenditure by private for-profit service providers on HIV and AIDS related programmes especially in 2004 and 2005. In 2004, 16% of the services provided by this group was spent in the area prevention with the majority spent on treatment and care. However, in 2005 and 2006, services provided in the area of prevention accounted for almost 90% with the remaining spent on treatment and care.

In 2004, bilaterals and multilaterals reported no provision of services in area of OVCs. Prevention programmes accounted for 51% of services provided in that year followed by services in the area of human resources recruitment & retention incentives (24%) and programme management services (23%). In 2005, programme managaement accounted for the greater share of services provided (43%) followed by prevention (20%); human resources recruitment & retention incentives (19%) and 5% on OVCs. In 2006, programme managaement still accounted for the greater share of services provided, increasing to almost 60 percent followed by services in the area of human resources recruitment & retention incentives (25%); prevention (15%); and nothing on OVCs.

Table 20: Expenditure by Service Providers by Key Intervention Areas (US$), Mozambique NASA 2004-2006 (US$ '000)

Code		Public			Private non-profit			Private for-profit			Bilateral and Multilaterals		
		2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
ASC.1	Prevention	9,268	10,086	14,006	10,746	14,315	15,836	6	596	1,560	3,346	1,366	969

ASC.2	Care and Treatment	8,730	7,226	22,553	1,575	5,439	3,815	32	82	150	-	274	9.107
ASC.3	OVC	804	400	1,253	2,818	3,438	4,911	-	-	-	11	336	1.193
ASC.4	Program Management & Adm. Strengthening	2,739	4,369	4,737	2,149	3,245	5,949	-	-	7	1,525	2,903	3,961
ASC.5	Human Resources Recruitment & Retention Incentives	2,582	1,711	2,500	293	903	681	-	-	-	1,587	1,284	1,647
ASC.6	Social Protection and Social Services	-	-	-	10	42	409	-	-	-	-	-	-
ASC.7	Enabling Environment & Community Dev.	78	322	535	29	131	735	-	-	-	64	20	76
ASC.8	HIV and AIDS related Research	65	-	-	-	-	-	-	-	7	47	505	-
	Total (US$)	24,267	24,115	45,611	17,620	27,513	32,336	38	678	1,724	6,580	6,688	6,663

Table 21: Percentage Expenditure by Service Providers by Key Intervention Areas, Mozambique NASA 2004-2006 (US$ '000)

		Public			Private non-profit			Private for-profit			Bilateral and Multilateral		
		2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
ASC.1	Prevention	38.2%	41.8%	30.7%	61.0%	52.0%	49.0%	14.9%	88.0%	90.5%	50.9%	20.4%	5.7%
ASC.2	Care and Treatment	36.0%	30.0%	49.4%	8.9%	19.8%	11.8%	85.1%	12.0%	8.7%	0.0%	4.1%	53.7%
ASC.3	Orphans & Vulnerable Children (OVC)	3.3%	1.7%	2.7%	16.0%	12.5%	15.2%	0.0%	0.0%	0.0%	0.2%	5.0%	7.0%
ASC.4	Program Management and Adm. Strengthening	11.3%	18.1%	10.4%	12.2%	11.8%	18.4%	0.0%	0.0%	0.4%	23.2%	43.4%	23.4%
ASC.5	Human Resources Recruitment & Retention Incentives	10.6%	7.1%	5.5%	1.7%	3.3%	2.1%	0.0%	0.0%	0.0%	24.1%	19.2%	9.7%
ASC.6	Social Protection and Social Services	0.0%	0.0%	0.0%	0.1%	0.2%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ASC.7	Enabling Environment and Community Development	0.3%	1.3%	1.2%	0.2%	0.5%	2.3%	0.0%	0.0%	0.0%	1.0%	0.3%	0.4%
ASC.8	HIV and AIDS related Research	0.3%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.7%	7.6%	0.0%

4.2 Composition of HIV and AIDS Spending

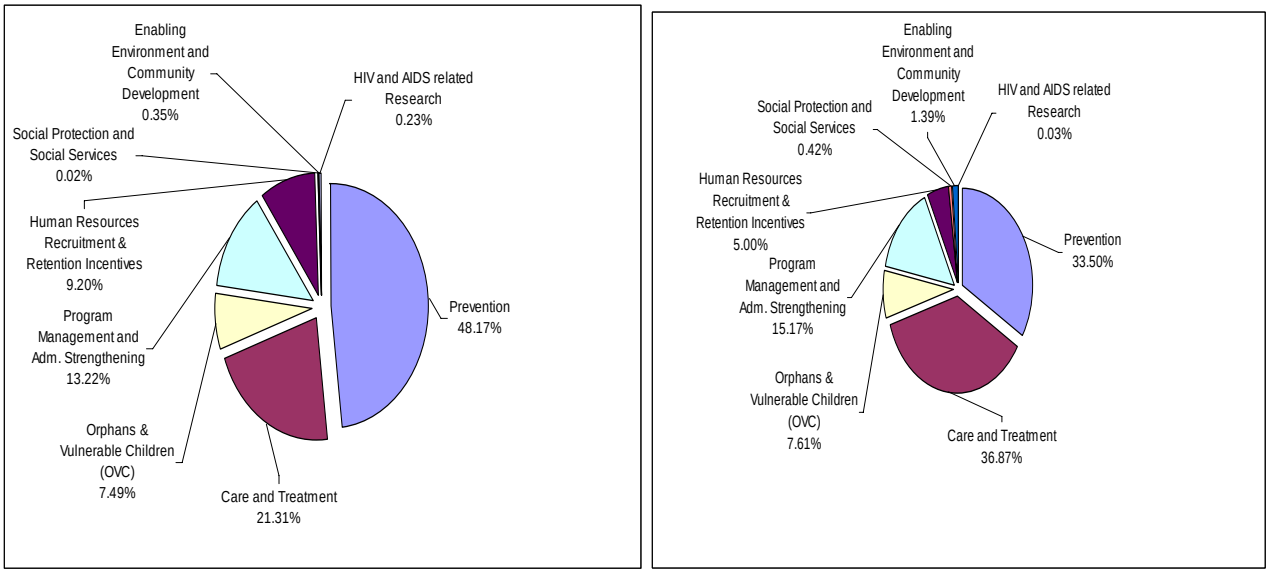
Overview of Total Spending for the period 2004-2006

The table 22 shows the total spending by year by the eight NASA AIDS Spending Categories (ASC). The key spending priorities for 2004-2006 have been on prevention (40%), treatment (29%) and programme management and administrative strengthening (15%).

Table 22: HIV and AIDS Expenditure by Key Areas of Intervention(US$), Mozambique NASA 2004-2006

Code	Areas of intervention	2004	2005	2006	Total	%
ASC.1	Prevention	23,365,806	26,362,729	32,370,805	82,099,340	40%
ASC.2	Care and Treatment	10,336,214	13,020,739	35,626,000	58,982,953	29%
ASC.3	Orphaned & Vulnerable Children (OVC)	3,633,405	4,174,460	7,356,543	15,164,408	7%
ASC.4	Program Management and Adm. Strengthening	6,413,186	10,517,023	14,653,954	31,584,163	15%
ASC.5	Human Resources Recruitment & Retention Incentives	4,461,730	3,897,851	4,827,748	13,187,329	6%
ASC.6	Social Protection and Social Services	9,841	41,794	408,929	460,564	0%
ASC.7	Enabling Environment and Community Development	171,606	473,134	1,346,255	1,990,995	1%
ASC.8	HIV and AIDS related Research	112,098	505,243	33,544	650,885	0%
	Total	48,503,886	58,992,973	96,623,778	204,120,637	

Figure 14: Percentage of HIV and AIDS Expenditure by Key Areas of Intervention, Mozambique NASA 2004 and 2006



Although in absolute terms there were an increase in all spending categories, but one (ASC 8) total expenditure on **prevention programmes** declined from 48% of total funding in 2004 to 34% in 2006; while expenditure on **treatment and care** increased from 21% of total spending in 2004 to 37% in 2006. Another important key intervention area where spending has being decreasing over the years is **human resources recruitment and retention incentives**. Spending fell from 9% of total spending in 2004 to a low 5% in 2006. Total spending on an **enabling environment and community development** increased during the reporting period from 0.4% in 2004 to around 1% in 2006. Total spending on **programme management and administrative strengthening** has remained stable from 2004 to 2006. Total spending on **Orphans and Vulnerable Children (OVC) and HIV and AIDS related research** remains low at 7% and 8% of total spending respectively between 2004 and 2006.

Table 23: Percentage of HIV and AIDS Expenditure by Key Area of Intervention, Mozambique NASA 2004-2006

Areas of intervention	2004	2005	2006	Total
Prevention	48%	45%	34%	40%
Care and Treatment	21%	22%	37%	29%
Orphans & Vulnerable Children (OVC)	7%	7%	8%	7%
Program Management and Adm. Strengthening	13%	18%	15%	15%
Human Resources Recruitment & Retention Incentives	9%	7%	5%	6%
Social Protection and Social Services	0%	0.1%	0.4%	0.4%
Enabling Environment and Community Development	0.4%	1%	1%	1%
HIV and AIDS related Research	0.2%	1%	0%	0.3%

Aids spending categories funded by type of funding source for the period 2004-2006 are presented in table 24.

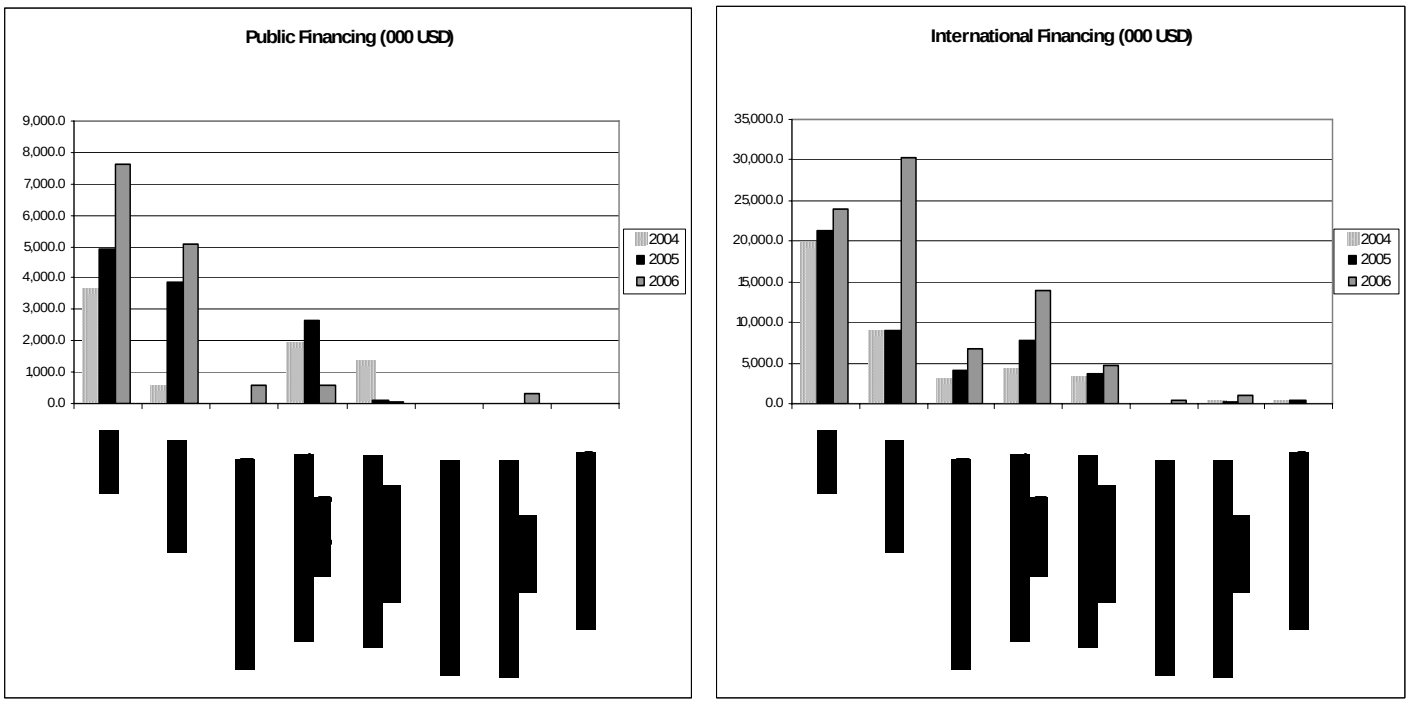
Table 24: Public, Private and External Financing Sources by Key Area of Intervention (US$), Mozambique NASA 2004-2006

Categories	Public			Private			International			Total		
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
Prevention	3,596	4,930	7,647	72	127	816	19,698	21,306	23,908	23,366	26,363	32,371
Care and Treatment	516	3,848	5,103	921	82	138	8,899	9,092	30,386	10,336	13,021	35,626
Orphans & Vulnerable Children (OVC)	3	5	604	825	74	84	2,806	4,096	6,669	3,633	4,175	7,357
Program Management and Administration Strengthening	1,898	2,641	588	359	8	81	4,156	7,868	13,985	6,413	10,517	14,654
Human Resources Recruitment & Retention Incentives	1,314	101	45	97	102	-	3,051	3,694	4,782	4,462	3,898	4,828
Social Protection and Social Services	-	-	4	-	20	-	10	22	405	10	42	409
Enabling Environment and Community Development	-	8	299	26	336	-	145	129	1,048	172	473	1,346
HIV and AIDS related Research	-	-	13	-	-	-	112	505	21	112	505	34
Total	7,326	11,533	14,302	2,301	747	1,118	38,876	46,712	81,204	48,504	58,993	96,624

In 2004, 49% of total public funds for HIV and AIDS were allocated to prevention programmes; about 26% was spent on Programme management and a further 18% percent on Human resources. In 2005, prevention activities took up 43% of total public funds with treatment and care making up 33% of the total from 7% of the total in 2004. In 2006 the analysis shows that the two majors pending categories were prevention (53%) and treatment and care (36%).

About 51% of the total spending by International financing sources was allocated to prevention activities in 2004, with 23% on treatment and care, 11% and 8% on programme management and human resources recruitment and retention incentives. In 2005, the share of prevention activities of the total spending by International organisations fell by 5 percentage points to 46%, further decreasing by about 17 percentage points to 29% in 2006. However, in 2006 the analysis shows that 37% of total spending was allocated to treatment and care.

Figure 15: Public and International Financing Sources expenditure by key intervention area (us$), Mozambique



NASA 2004-2006

Figure 15 indicates some success in ensuring even spread of resource allocation between prevention and treatment by public and international financing sources.

Area 1: Expenditure on HIV Prevention 2004-2006

The continued high levels of HIV prevalence and the limited successes in turning the tide of the epidemic in the region resulted in the calling of a special summit on HIV and AIDS by SADC Heads of State and Government in Maseru, in 2003. One of the outcomes of the summit, Maseru Declaration (Declaration on HIV and AIDS) provided the highest political commitment on HIV and AIDS in the region and articulates priority areas requiring urgent attention and action in various areas including prevention. The prioritisation of prevention was further given impetus by the Maputo Declaration of August 2005. This declaration adopted by 46 African Health Ministers at a WHO meeting held in Mozambique, resolved to accelerate HIV prevention and declared 2006 as the Year Acceleration of HIV Prevention in the African Region. The prevention agenda was further highlighted in the Brazzaville Commitment on Universal Access Initiative adopted in March 2006 by the African Union, UNAIDS and WHO. This initiative aims to ensure Universal Access to prevention, care and support and treatment by 2010.

Overall spending on prevention of HIV has increased by US$9,004,999 from US$23,365,806 in 2004 to US$32,370,805 in 2006. Table 25 presents preventative spending by component from 2004 to 2006.

Table 25: Total Expenditure by Expanded Prevention Categories (US$), Mozambique NASA 2004 - 2006

	Categories	2004	2005	2006
	Total	23,365,806	26,362,729	32,370,805
ASC.1.01.1	Communication for social and behavioral change programs targeting the health risks of HIV prevention campaigns	-	3,810	231,798
ASC.1.01.98	Communication for social and behavioral change not disaggregated according to the content as health or as non-health activities.	2,402,720	3,610,702	4,622,476
ASC.1.02	Community mobilization	2,458,139	450,158	3,169,382
ASC.1.03	Voluntary counseling and testing	2,014,378	2,177,090	2,529,906
ASC.1.04.1	VCT as part of programmes for vulnerable and special populations	-	11,422	-
ASC.1.04.2	Condom provision as part of programmes for vulnerable and special populations	-	-	111,000
ASC.1.04.98	Programmatic interventions for vulnerable and special populations	530,000	919,500	805,297
ASC.1.04.99	Other programmatic interventions for vulnerable and special population's n.e.c.).	-	28,322	1,173
ASC.1.05	Prevention - Youth in school	1,879,153	1,864,787	2,442,302
ASC.1.06	Prevention - Youth out-of-school	2,840,896	1,992,879	2,366,723
ASC.1.07	Prevention of HIV transmission aimed at persons living with HIV (PLHA)	42,038	50,000	137,781
ASC.1.08.3	STI prevention and treatment as part of programmes for sex workers and their clients	80,000	-	-
ASC.1.08.98	Programmatic interventions for sex workers and their clients not desegregated by type	-	100,000	140,000
ASC.1.09.99	Other programmatic interventions for men who have sex with men (MSM) (n.e.c.)	-	205,176	-
ASC.1.11	Prevention programs in the Workplace	72,800	341,488	1,481,482
ASC.1.12	Condom social marketing	2,623,936	2,488,400	2,257,100
ASC 1.13	Public and commercial sector condom provision	-	-	928,010
ASC.1.16	Prevention, diagnosis and treatment of Sexually Transmitted Infections (STI)	2,674,261	3,332,112	2,415,967
ASC.1.17.1	Pregnant women counseling and testing	226,810	654,422	727,461
ASC.1.17.2	Antiretroviral prophylaxis for HIV-infected pregnant women and newborns	69,086	113,126	249,575
ASC.1.17.98	PMTCT not-disaggregated by intervention	1,249,986	1,790,405	3,683,720
ASC.1.17.99	PMTCT activities not elsewhere classified	-	-	273,982
ASC.1.22	Universal precautions	-	521,703	118,231
ASC.1.99	Prevention activities not elsewhere classified	4,201,603	5,707,227	3,677,439

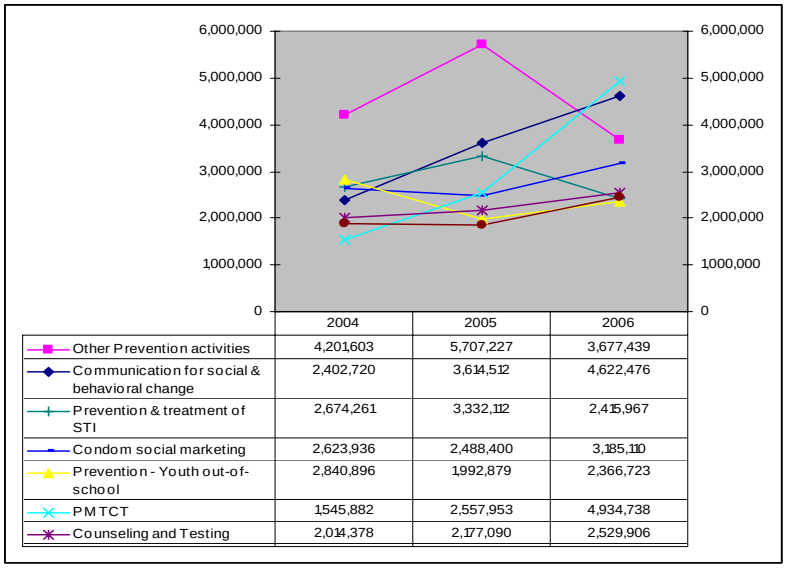
The results show (Table 26) that between 2004-2006, 96% of HIV prevention expenditure was spent on the following ten activities: communication for social and behavioral change (13%), prevention, diagnosis and treatment of STI (10%), condom social marketing (10%), PMTCT (11%), counseling and testing (8%), prevention for youth out-of-school (8%), prevention for youth in school (8%), community mobilization (7%), programmatic interventions for vulnerable populations (3%) and other Prevention activities (17%).

Table 26: Main HIV Preventive Spending Categories (US$), Mozambique NASA 2004 - 2006

Categories	2004	%	2005	%	2006		Total	%
Other Prevention activities	4,201,603	18%	5,707,227	22%	3,677,439	11%	13,586,269	17%
Communication for social and behavioral change	2,402,720	10%	3,614,512	14%	4,622,476	14%	10,639,708	13%
Prevention, Diagnosis and treatment of STI	2,674,261	11%	3,332,112	13%	2,415,967	7%	8,422,340	10%
Condom social marketing	2,623,936	11%	2,488,400	9%	3,185,110	10%	8,297,446	10%
Prevention - Youth out-of-school	2,840,896	12%	1,992,879	8%	2,366,723	7%	7,200,498	9%
PMTCT	1,545,882	7%	2,557,953	10%	4,934,738	15%	9,038,573	11%
Counseling and Testing	2,014,378	9%	2,177,090	8%	2,529,906	8%	6,721,374	8%
Prevention - Youth in school	1,879,153	8%	1,864,787	7%	2,442,302	8%	6,186,242	8%
Community mobilization	2,458,139	11%	450,158	2%	3,169,382	10%	6,077,679	7%

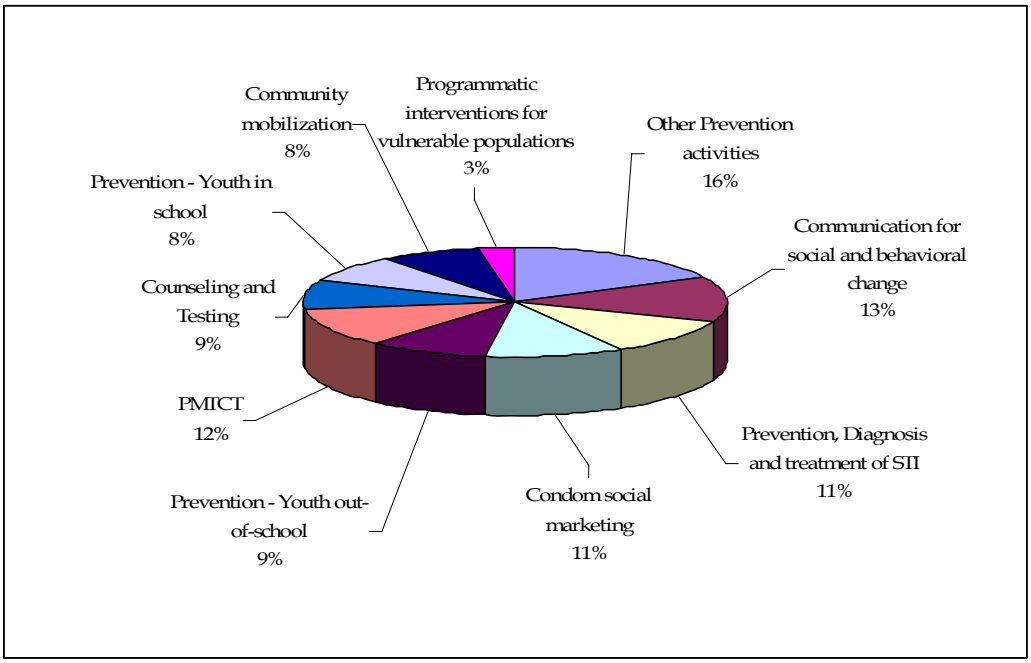
Programmatic interventions for vulnerable populations	530,000	2%	919,500	3%	805,297	2%	2,254,797	3%
Main activities spending US$	23,170,968		25,104,618		30,149,340		78,424,926	

Table 27: HIV Prevention Expenditure (US$), Mozambique NASA 2004-2006



	2004	2005	2006
Other Prevention activities	4,201,603	5,707,227	3,677,439
Communication for social & behavioral change	2,402,720	3,614,512	4,622,476
Prevention & treatment of STI	2,674,261	3,332,112	2,415,967
Condom social marketing	2,623,936	2,488,400	3,185,110
Prevention - Youth out-of-school	2,840,896	1,992,879	2,366,723
PMTCT	1,545,882	2,557,953	4,934,738
Counseling and Testing	2,014,378	2,177,090	2,529,906

Figure 16: Percentage HIV Prevention Expenditure, Mozambique NASA 2004-2006



In 2004, the main HIV prevention spending by public sources were prevention, diagnosis and treatment of STIs (73%), Counselling and Testing (17%) and prevention of mother-to-child transmissions (7%). In 2005, spending on prevention, diagnosis and treatment of STIs and Counselling and Testing dropped to 59% and 14% respectively while spending on prevention of mother-to-child transmissions increased to 10%. In 2006, the bulk of funds from public sources were spent to purchase services for prevention, diagnosis and treatment of STIs (31%), and interventions on communication for social behaviour change 31%. Spending on counselling and testing and PMTCT remained even at 17% and 9% respectively.

For private spending about 86% of the total spending in this category in 2004 and 2005 was on communication for social and behavioural change programmes. In 2006, 68% was spent on public and commercial sector condom provision, 10% on prevention programmes in workplaces and 14% on counselling and testing.

Overall, international funding is more evenly distributed among the sub-categories of prevention, revealing an attempt to address all major preventive activities. Proportionally voluntary counselling and testing decreased from 7% (2004) to 5% (2006). Same trend applies to Youth-Out-of-School from 14% to about 10% and to Condom Social Marketing from 13% to 9% respectively in 2004 and 2006. MTCT was the winner for the expenditures increased from around 7% to 17%.

Table 28: **Public, Private and International Expenditure on Prevention (US$), Mozambique NASA 2004-2006**

Spending Categories	2004			2005			2006		
	Public	Private	International	Public	Private	International	Public	Private	International
Mass media	-	-	-	-	-	3,810	-	-	231,798
Communication for social and behavioral change not disaggregated according to the content as health or as non-health activities.	-	62,121	2,340,599	67,455	20,589	3,522,658	2,340,331	43,215	2,238,930
Community mobilization	88,510	-	2,369,629	54,265	1,157	394,736	314,233	-	2,855,149
Voluntary counseling and testing	629,409	-	1,384,969	674,839	-	1,502,251	1,272,813	116,651	1,140,442
VCT as part of programmes for vulnerable and special populations	-	-	-	11,422	-	-	-	-	-
Condom provision as part of programmes for vulnerable and special populations	-	-	-	-	-	-	-	-	111,000
Programmatic interventions for vulnerable and special populations	-	-	530,000	-	14,500	905,000	-	14,297	791,000
Other programmatic interventions for vulnerable and special populations	-	-	-	28,322	-	-	1,173	-	-
Youth in school	-	-	1,879,153	-	-	1,864,787	130,912	-	2,311,390
Youth out-of-school	-	-	2,840,896	-	-	1,992,879	36,928	-	2,329,795
Prevention programs for PLHIV	-	2,038	40,000	-	-	50,000	27,158	-	110,623
STI prevention and treatment as part of programmes for sex workers and their clients	-	-	80,000	-	-	-	-	-	-
Programmatic interventions for sex workers and their clients	-	-	-	-	-	100,000	-	-	140,000
Other programmatic interventions for men who have sex with men (MSM)	-	-	-	25,546	-	179,630	-	-	-
Prevention programs in the Workplace	-	5,500	67,300	152,114	90,300	99,074	387,876	83,801	1,009,805
Condom social marketing	-	2,736	2,621,200	-	-	2,488,400	-	-	2,257,100
Public and commercial sector condom provision	-	-	-	-	-	-	27,320	558,290	342,400
Improving management of STIs	2,634,261	-	40,000	2,887,898	-	444,214	2,345,967	-	70,000
Prevention of mother-to-child transmission	243,657	-	1,302,225	495,809	-	2,062,144	656,510	-	4,278,228
Universal precautions	-	-	-	438,897	-	82,806	-	-	118,231
Others / Not elsewhere classified	-	-	4,201,603	93,873	-	5,613,354	105,614	-	3,571,825
Total	3,595,837	72,395	19,697,574	4,930,440	126,546	21,305,743	7,646,835	816,254	23,907,716

The general objective in the area of prevention as stated in PEN II is to reduce the number of new infections from the current level of 500 a day, among adults to 350 a day in 5 years and 150 a day in 10 years. The main prevention strategies revolve around promoting prevention through behavior change and the use of condoms; improving access to counseling and testing and STI diagnosis and testing as well as scaling up of PMTCT. The NASA reveals a correlation between the strategies for achieving the objectives stated in PEN II and expenditure on different HIV prevention interventions.

A1.1 Condoms

One of the strategies to reduce new infections especially in the 15-24 age group was to improve the distribution of condoms, making full use of the logistical capacity of all sectors and entities; promote the female condom and increase its availability at sale outlets (PEN II). Since 2006, the government has increased the number of male condoms distributed and has also started a female condom programme. The results of the NASA revealed that a total of US$8,408,446 (10% of total prevention spending) has been spent on Condoms between 2004and 2006. US$7,369,436 of total spending on condoms went to the condom social marketing programme. Analyses show that there was no expenditure on public and commercial sector condom provision in 2004 and 2005. In 2006, there was a reported spending of US$ 928,010.

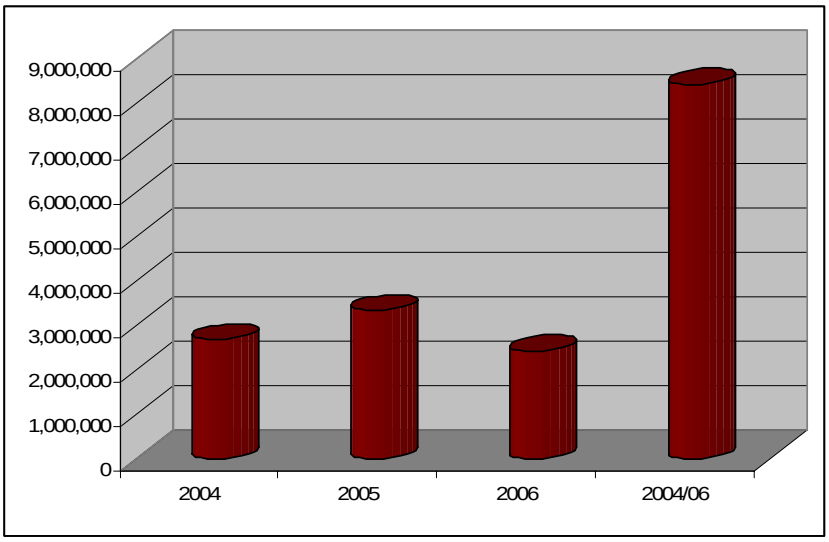
Table 29: Condom Expenditure by category (US$), Mozambique NASA 2004-2006

Category	2004		2005		2006		Total	
	US$	%	US$	%	US$	%	US$	%
Condom provision as part of programme for vulnerable & special populations	0	0%	0	0%	111,000	3%	111,000	1%
Condom social marketing	2,623,936	100%	2,488,400	100%	2,257,100	68%	7,369,436	88%
Public sector and commercial sector condom provision	0	0%	0	0%	928,010	28%	928,010	11%
Total	2,623,936		2,488,400		3,296,110		8,408,446	

A1.2 Sexually Transmitted Infection (STI)

Another objective set out in PEN II in the area of prevention is to increase the percentage of STI patients and their contacts treated in accordance with the Syndrome-related Protocol. Strategies to achieve this objective include building the capacity of health centres to treat STIs and IEC strategies to create more awareness of the disease to allow for early identification and encourage STI patients to bring in their contacts. The results of the assessment show that expenditure in this area of prevention has remained constant from 2004 and 2006 at an average of 10% of total spending on prevention programs with a slight increase in spending in 2005 to 13%.

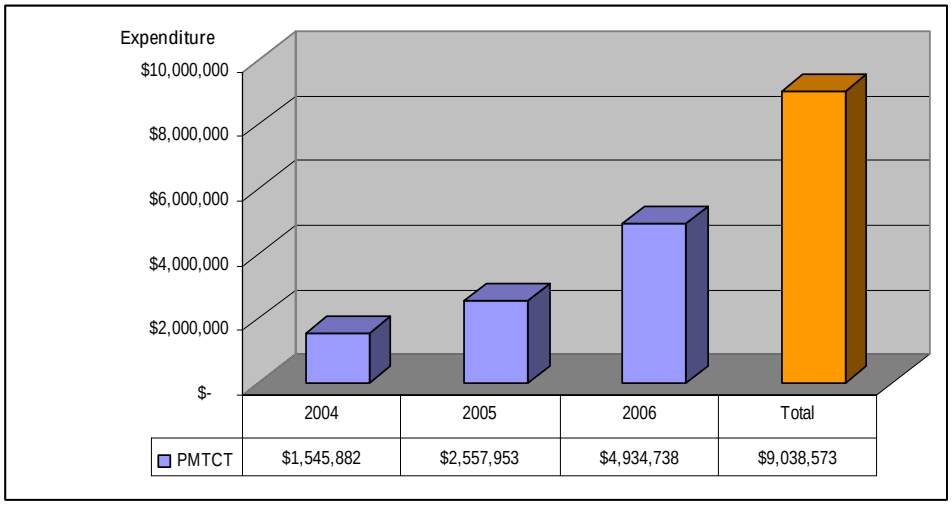
Figure 17: HIV Expenditure to prevent STI (US$), Mozambique NASA 2004-2006



A1.3 Prevention of Mother to Child Transmission (PMTCT)

In the area of PMTCT, the aim is to increase significantly the number of institutional childbirths, guarantee access to preventive treatment, and promote the education of pregnant women about the risks of mother-to-child transmission of HIV. The government has expanded PMTCT facilities throughout the country and this is reflected in the expenditure pattern revealed in the NASA (Figure 18). In 2004, PTMCT accounted for 7% of total spending on prevention, increasing to 10% in 2005 and 15 percent in 2006. In nominal terms, expenditure on PMTCT increased by about 93% from 2005 to 2006.

Figure 18: PMTCT Expenditure (US$), Mozambique NASA 2004-2006

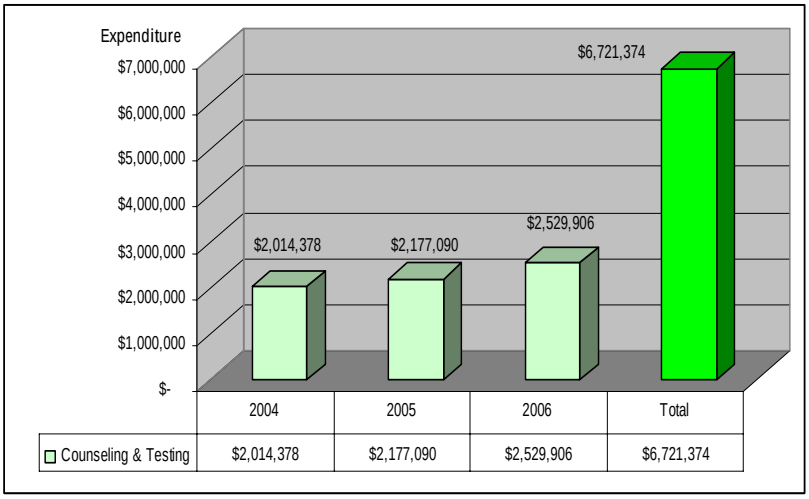


A1.4 Counselling and Testing (CT)

In recent years, Mozambique has expanded its Counseling and Testing (CT). This has led to the scaling up of treatment and the reduction of stigma. Although CT may not necessarily change the behaviour of those who test negative, it is believed to be an essential element of secondary prevention in those testing positive, given that

their viral loads is reduced whilst on treatment and the risk of transmission is also reduced significantly. This is reflected in the expenditure pattern revealed in the NASA (Figure 19). In 2004, counseling and testing accounted for US$ 2,014,378 (29%) of total spending on prevention, increasing to US$2,529,906 (38%) in 2006. Total expenditure on CT during the reporting period 2002-2006 was estimated at US$6,721,374.

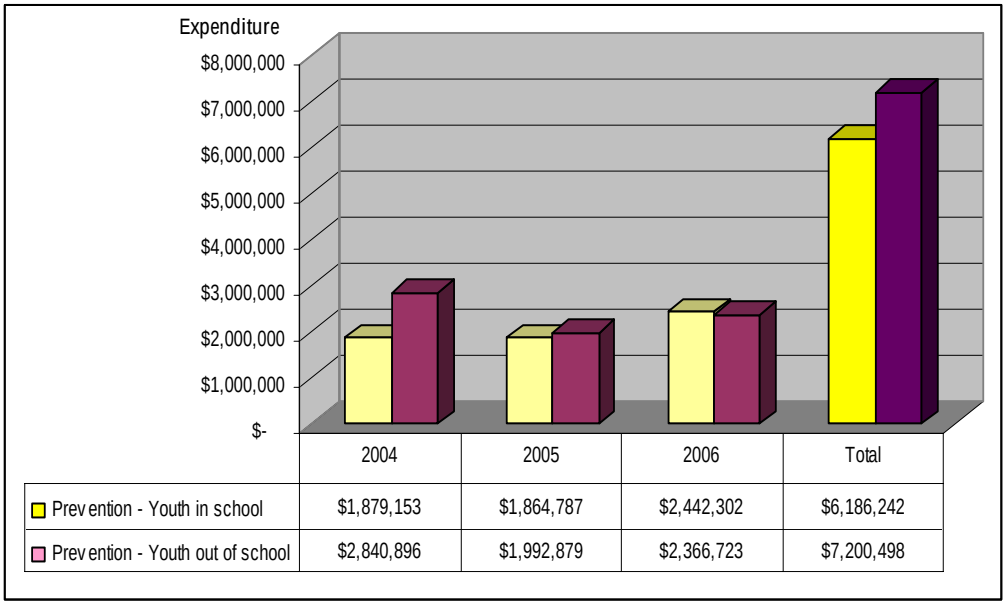
Figure 19: Counseling and Testing Expenditure (US$), Mozambique NASA 2004-2006



A1.5 Youth HIV prevention programmes

Youth HIV prevention programmes aim to support the development of psycho-social skills to prevent HIV infection among children and adolescents through life-skills sessions. The life-skills approach involves activities-including debates and interactive theatre work in school clubs- that enable children to identify and prevent. Youth HIV prevention programmes such as Geração Biz have reached over half a million youth in all provinces in Mozambique in the area of sexual and reproductive health. NASA estimates that a total of US$ 13,386,740 has been spent on youth HIV prevention programmes between 2004 and 2006. US$6,186,242 has been spent on prevention programmes for youth in-school while an estimated US$7,200,498 has supported programmes for youth out-of-school.

Figure 20: Expenditure on Youth HIV prevention programmes (US$), Mozambique NASA 2004-2006

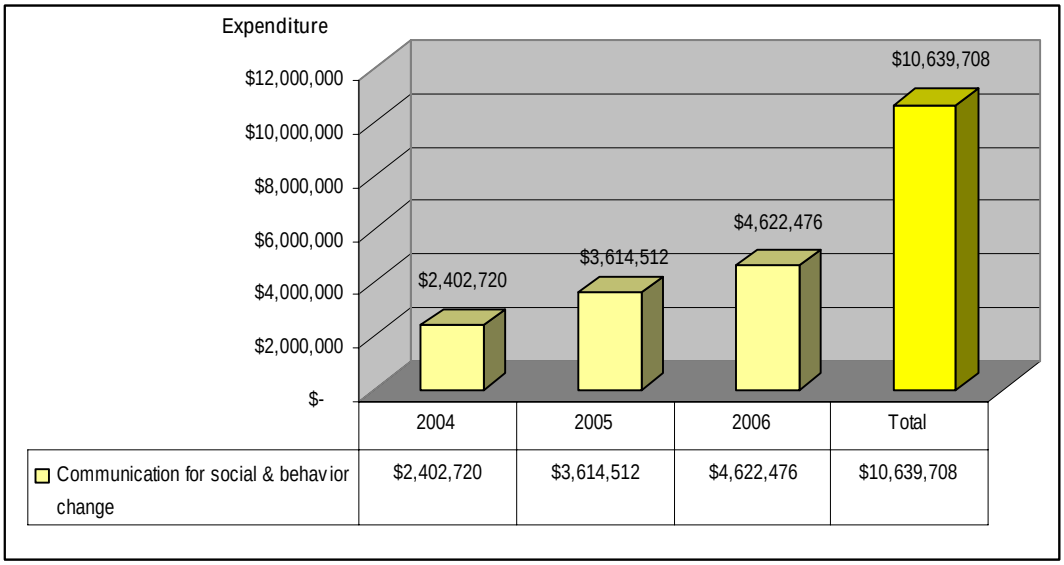


A1.6 Communication for Social Behavior change

Mozambique developed and launched a Communication Strategy for National HIV/AIDS Strategic Plan (PEN II) in 2006. Several programmes have been implemented since 2004. This is reflected in the expenditure pattern revealed in the NASA (Figure 21). Total expenditure on communication for social behaviour change during the reporting period 2002-2006 was estimated at US$10, 639,708. In 2004, spending on communication for social behaviour change accounted for US$ 2,402,720 of total HIV preventative spending, increasing to US$4,622,476 in 2006.

In 2004, private and international sources of funding spent an estimated US$62,121 (3% of total spending) and US$2,340,599 (97% of total spending) respectively on HIV communication change initiatives. By 2006, the bulk of funds spent on communication initiatives came from public sources US$2,340,331 (51% of total spending) and international sources US$2,238,930 (49%)

Figure 21: Expenditure on Communication for Social Behavior change (US$), Mozambique NASA 2004-2006



Area 2: Care and Treatment

The total spending on care and treatment from 2004 to 2006 was US$58,982,953. In 2004, total spending on treatment and care programmes was US$10,336,214 with about 64% of this total spent on ART and 17% on Opportunistic infections' (OI) treatment. By 2006, this configuration on spending had changed. Although ART remained the main treatment spending category at US$19,522,780, the share of Home Based Care (HBC) expenditure increased nearly ten-fold from US$ 1,068,880 in 2004 to US$ 9,681,318. Other spending categories such as Nutritional support associated to ARV therapy also constituted a major share of the total expenditure at US$3,166,111.

Table 30: Total HIV and AIDS Expenditure on Care and Treatment (US$), Mozambique NASA 2004 - 2006

Code	Category	2004	2005	2006
ASC.2.1.01	Provider initiated testing and counseling	171,610	244,451	84,756
ASC.2.1.02	Opportunistic infection (OI) prophylaxis	0	0	61,843
ASC.2.1.03.1.98	Adult antiretroviral therapy not-disaggregated by line	3,839,596	3,404,774	661,061
ASC.2.1.03.98	Antiretroviral therapy not-disaggregated age or line of treatment	2,820,262	3,365,999	18,861,719
ASC.2.1.04	Nutritional support associated to ARV therapy	137,899	573,408	3,166,111
ASC.2.1.05	Specific HIV-related laboratory monitoring	39,556	194,292	759,507
ASC.2.1.06	Dental care and services for People Living with HIV	0	0	139,716
ASC.2.1.07	Psychological treatment and support services	0	0	4,479
ASC 2.1.08	Palliative care	0	96,096	198,941
ASC.2.1.09.1	Home-based medical care	0	736,331	0
ASC.2.1.09.2	Home-based non medical /non-health care	853,422	0	0
ASC.2.1.09.98	Home-based care not-disaggregated	215,458	3,498,698	9,681,318
ASC.2.1.10	Alternative and informal care and treatment services	445,961	475,128	97,369
ASC.2.1.99	Outpatient Care services Not elsewhere classified	0	45,857	156,100
ASC.2.2.1	Opportunistic infections' (OI) treatment	1,800,700	385,705	1,733,080
ASC.2.99	Care and treatment services not elsewhere classified	11,750	0	20,000
	Total (US$)	10,336,214	13,020,739	35,626,000

The main treatment spending categories during the NASA reporting period are: ART US$32,953,411 (56%), Home Based Care (HBC) US$14,985,227 (26%), nutritional support associated to ARV US$3,877,418 (7%), and treatment of opportunistic infections US$3,919,485 (7%).

Table 31: Main Treatment Spending categories (US$), Mozambique NASA 2004-2006

Category	2004		2005	%	2006		Total	%
Antiretroviral therapy	6,659,858	64%	6,770,773	52%	19,522,780	55%	32,953,411	56%
Nutritional support associated to ARV therapy	137,899	1%	573,408	4%	3,166,111	9%	3,877,418	7%
Specific HIV-related laboratory monitoring	39,556	0%	194,292	1%	759,507	2%	993,355	2%
Home-based care	1,068,880	10%	4,235,029	33%	9,681,318	27%	14,985,227	25%
Alternative and informal care and treatment services	445,961	4%	475,128	4%	97,369	0.3%	1,018,458	2%
Opportunistic infections' (OI) treatment	1,800,700	17%	385,705	3%	1,733,080	5%	3,919,485	7%
Total (US$)	10,152,854		12,634,335		34,960,165		57,747,354	

Figure 22: Percentage of Treatment Spending Categories Mozambique NASA 2004 - 2006

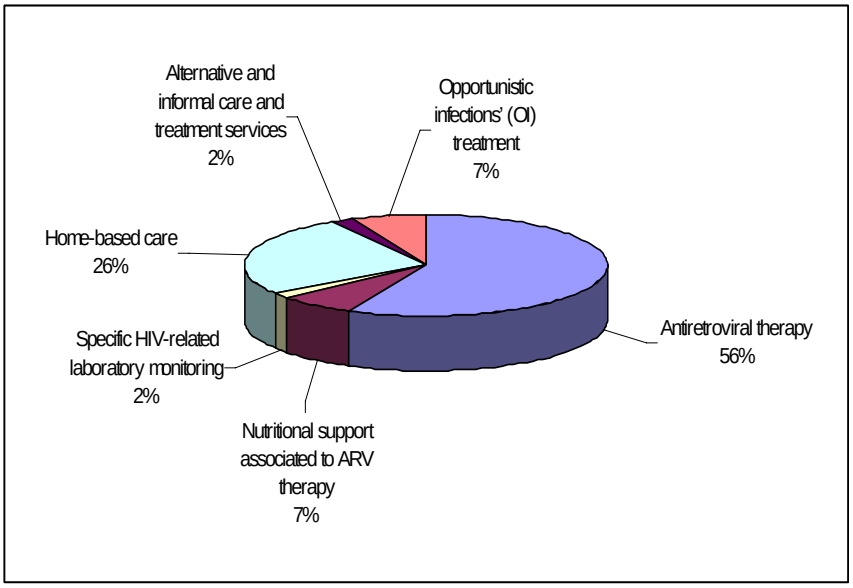
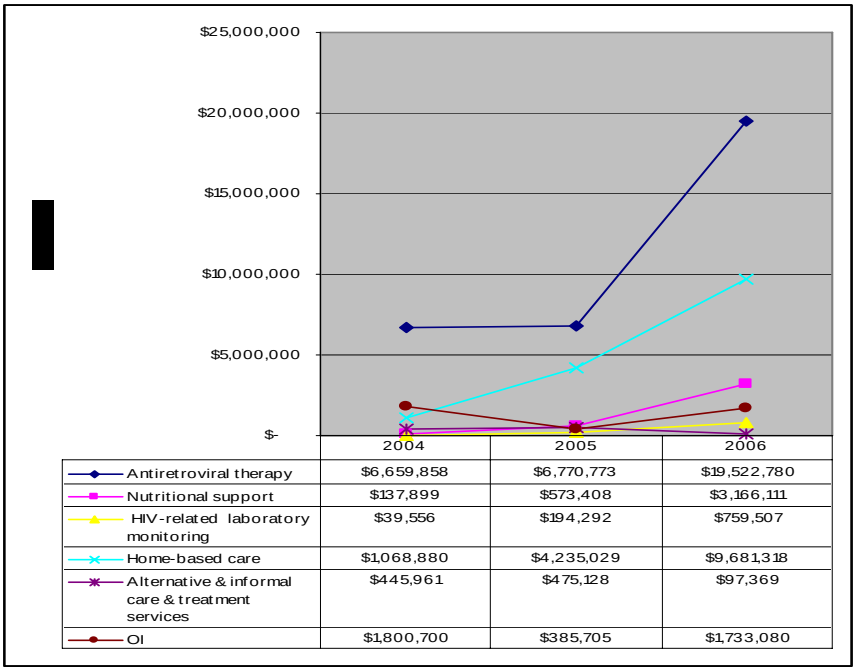


Figure 23: HIV and AIDS Treatment Expenditure (US$), Mozambique NASA 2004-2006



In 2006, the public share of total spending in treatment and care decreased to about 15% and as in previous years, the bulk of the funds (91%) were spent on ART. Private spending accounted for 11% of the total spending on treatment and care in 2004 with all the funds also spent on ART. In 2005, there was no record of private spending in this category and private spending in 2006 was also very minimal (0.4% of the total). International Organisations accounted for 82% of total spending in this category in 2004, 63% in 2005 and 85% in 2006. Majority of the spending was on ART although this has been declining over the three years under the study (87% in 2004, 53% in 2005 and 50% in 2006).

Table 32: Public, Private and International Expenditure on Treatment Programmes (US$), Mozambique NASA 2004-2006

Spending Categories	2004			2005			2006			Total		
	Public	Private	International	Public	Private	International	Public	Private	International	2004	2005	2006
Provider initiated testing and counseling	140,942	0	30,668	236,149	0	8,302	64,749	0	20,007	171,610	244,451	84,756
Opportunistic infection prophylaxis	0	0	0	0	0	0	0	0	61,843	0	0	61,843
Adult antiretroviral therapy	324,973	909,680	5,425,205	3,352,274	52,500	3,365,999	4,688,907	100,500	14,795,216	6,659,858	6,770,773	19,584,623
Nutritional support associated to ARV therapy	0	0	137,899	0	0	573,408	57,664	0	3,108,447	137,899	573,408	3,166,111
HIV-related laboratory monitoring	39,556	0	0	184,292	10,000	0	164,586	17,000	577,921	39,556	194,292	759,507
Dental care and services for PLWHIV	0	0	0	0	0	0	0	0	139,716	0	0	139,716
Psychological treatment and support services	0	0	0	0	0	0	0	0	4,479	0	0	4,479
Palliative care	0	0	0	0	0	96,096	0	0	198,941	0	96,096	198,941
Home-Based Care	10,314	0	1,058,566	48,085	0	4,186,944	118,498	0	9,562,820	1,068,880	4,235,029	9,681,318
Alternative and informal care and treatment services	0	0	445,961	0	0	475,128	8,162	0	89,207	445,961	475,128	97,369
Outpatient Care services (nec)	0	0	0	26,857	19,000	0	0	0	156,100	0	45,857	156,100
Opportunistic infections' treatment	0	0	1,800,700	0	0	385,705	0	0	1,733,080	1,800,700	385,705	1,733,080
Care and treatment services (nec)	0	11,750	-	-	-	-	-	20,000	-	11,750	0	20,000

Total (US$)	515,785	921,430	8,898,999	3,847,657	81,500	9,091,582	5,102,566	137,500	30,385,934	10,336,214	13,020,739	35,626,000

A 2.1: Antiretroviral Treatment

Mozambique spent an estimated US$32,953,411 on Antiretroviral therapy between 2004 and 2006. In 2004 estimated expenditure was US$6,659,858. This figure grew to US$19,522,780 by 2006.

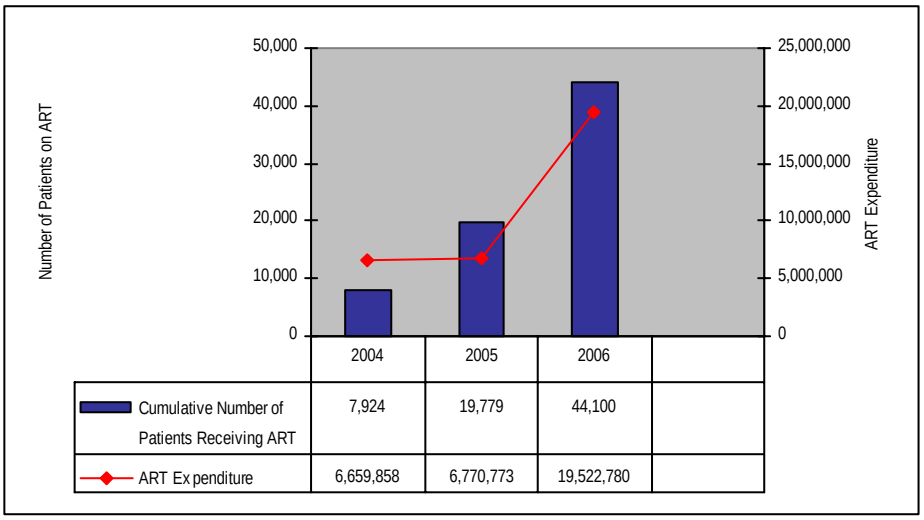
Expenditure on treatment was used to purchase several services including: (i) provision of test kits and medications; (ii) strengthening clinical laboratories; (iii) strengthening blood safety and bio-security; (iv) health sector staff sensitization; (v) health waste management; (vi) research into traditional medicines; and (vii) capacity building. However, most of the funds were spent on Antiretroviral Therapy (ART) in all three years of the study; about 64% in 2004, 52% in 2005 and 55% in 2006.

In 2002 ARV treatment was being provided to less than 2000 people in Mozambique, mainly through private services. Treatment began on the basis that all anti-retroviral drugs would be financed through the public system only for the prevention of parent-to-child-transmission and as post-exposure prophylaxis for health workers who are occupationally exposed to HIV. With the expectation of substantial donor financing, coupled with the reduction of drug prices and growing experience with treatment protocols, this policy has been revised to expand treatment to all eligible PLWH on a first come first served basis from mid 2004.

Since implementation of the MOH National HIV and AIDS strategy began in 2003, tremendous progress has been made in the provision of services. The number of people on ARVs by the end of December 2006 was 44,100. The number of sites now offering antiretroviral treatment has increased from 38 in 2005 to in 2006.

Given the increasing focus on expanding rural access and decentralisation of services, previous geographical inequities are now being addressed and all districts in the country currently have at least one treatment site. However, much remains to be done with respect to expanding further access as estimates show that approximately 50% of those in need of treatment have access in the southern region, 15% in the centre, and only 5% in the north. The current aim of the government is to scale up ART, particularly the expansion of ART sites and activities supporting ART such as Home-based care as well as nutrition counseling and supplementation.

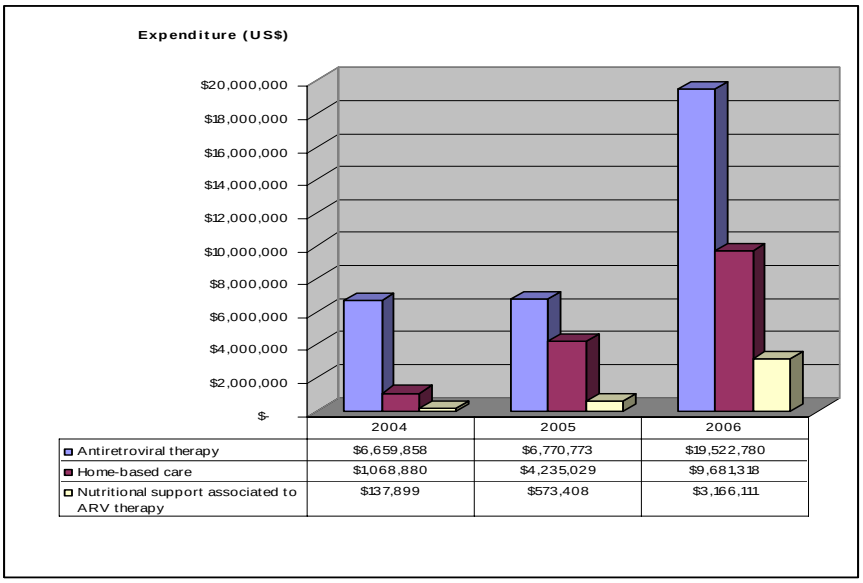
Figure 24: Number of patients on ART and ART Expenditure 2004-2006, Mozambique NASA 2004-2006



A2.2 Home Based Care

The assessment reveals that expenditure on Home-Based Care (HBC) and nutrition is increasing as more people are put on ART (Figure 25). Nutritional support for people on ARV and other vulnerable groups is viewed as a key component for a successful treatment program. Funding was used to (i) supply nutritional support (ii) Strengthen capacity to manage the distribution of food (iii) support local production of fortified foods. During the reporting period there was also a noticeable increase in spending on HBC which increased ten-fold from 10% in 2004 to 27% in 2006.

Figure 25: Total Spending on ART, HBC and Nutritional Support (US$), Mozambique NASA 2004-2006



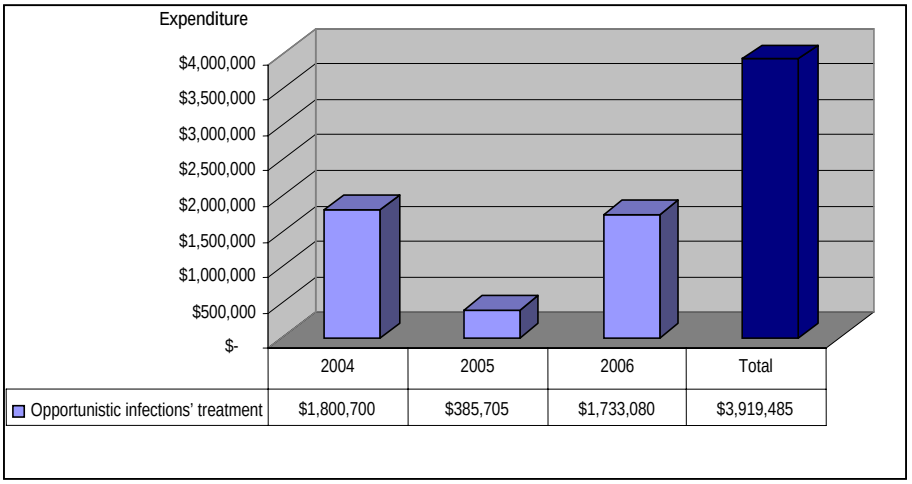
	2004	2005	2006
Antiretroviral therapy	$6,659,858	$6,770,773	$19,522,780
Home-based care	$1,068,880	$4,235,029	$9,681,318
Nutritional support associated to ARV therapy	$137,899	$573,408	$3,166,111

A2.3 Opportunistic Infections

The general objective of the National HIV Strategy is to provide effective treatment and care to patients with HIV and AIDS opportunistic infections. According to the National TB strategy, TB is the most frequent opportunistic infection and the most frequent cause of death in AIDS patients. Initiatives focus on strengthening health workers' skills and the provision of health services in order to guarantee the identification, prophylaxis and treatment of the more common OIs; ensuring early screening and referral, including adherence, prophylaxis and treatment of opportunistic infections; and strengthening the link between the Communicable Diseases Control Programme and the PEN National AIDS Control Programme.

Total expenditure on initiatives to prevent Opportunistic Infections (OIs) during the reporting period 2002-2006 was estimated at US$3,919,485, spending on treatment of OIs. According to the assessment, the main funding source for treatment of OI was international organizations which spent an estimated US$1,800,700, US$385,705 and US$ 1,733,080 in 2004, 2005 and 2006.

Figure 26: HIV Expenditure to Prevent Opportunistic Infections (US$), Mozambique NASA 2004-2006



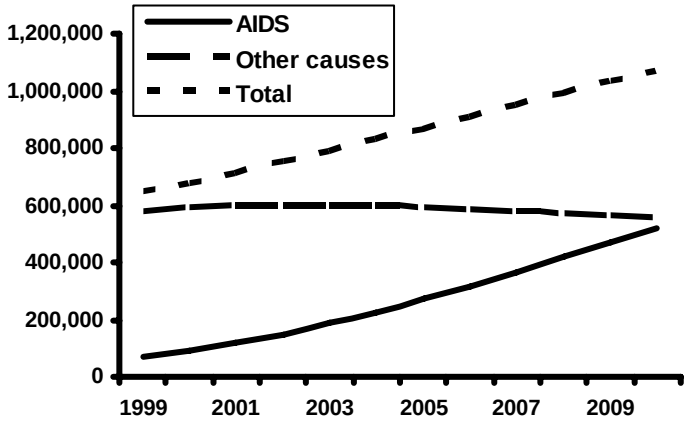
	2004	2005	2006	Total
Opportunistic infections' treatment	$1,800,700	$385,705	$1,733,080	$3,919,485

Area 3: Care and Support

A3.1 Orphans and Vulnerable Children (OVC)

Government of Mozambique defines orphans as children having lost one or both parents, and there are twelve categories of children identified as vulnerable and in need of protection and support[13]. In 2006, approximately 1.6 million children less than 18 years of age were orphaned (12% to 16% of the total population)[14]. Of these children, projections estimate that 380,000 (more than 20% of the total of orphaned children) have lost their parents due to AIDS and this number is estimated to reach 630,000 by 2010[15]. The number of orphans is highest in areas with high HIV prevalence.

Figure 27: Projected Orphans (cumulative 0-17 years), Mozambique - 1999-2010



[Source: Impacto Demografico do HIV/SIDA em Mocambique, 2002]

A costed multi-sectoral Action Plan (from 2005 to 2010) to address the situation of OVCs approved. In 2006, 1.2 million OVC were targeted by the Plan, costed at US$ 71 million[16]. By the end of 2006, 24% of OVC identified in the OVC Action Plan (or over 280,000) had gained access to at least 3 basic services, reaching about 120% of the 2006 PARPA annual target. Under the Social Action section of the BdPES (Balance of Economic and Social Plan), it is reported that 62,918 OVCs were reached with at least three basic services (or 5.2% of the target of 1.2 million set out in the OVC Action Plan for the year 2006)[17]. In addition, through support provided to Civil Society Organisations by various bi-laterals, multi-laterals and governmental and non-governmental institutions, more than 220,000 OVC were reached[18].

Table 33 gives a summary of OVC spending areas from 2004 to 2006. Total spending on OVC increased slightly from almost $3million in 2004 to $4.2 in 2005 and increased further to $7.4 million in 2006. In 2004, 41% of the total spending on OVCs was on unspecified services, 22% on administrative costs, 19% on community support, 12% on basic health care and 6% on education. In 2005, 5% of the total spending on OVCs was on unspecified services, 12% on administrative costs, 36% on community support. There was no reported spending on basic health care and education for OVCs.

[13] In Mozambique, vulnerable children are defined as: i) Children affected by HIV/AIDS, or infected by HIV/AIDS; ii) Children living in households headed by other children, youth, women or elderly persons; iii) Children living in households headed by a chronically ill adult; iv) Children living on the street; v) Children living in institutions (orphanages, prisons, mental health institutions); vi) Children in conflict with the law (children being prosecuted under law for minor crimes); vii) Children with disabilities; viii) Child victims of violence; ix) Children who are the victims of sexual exploitation; x) Child who are victims of trafficking; xi) Children married before the legal age; xii) Child refugees or children who have been internally displaced.

[14] UNICEF, Childhood Poverty in Mozambique. A Situation and Trends Analysis, 2006.
[15] Instituto Nacional de Estatística (INE), Ministério da Saúde (MISAU), Ministério do Plano e Finanças (MPF), Centro de Estudos de População da Universidade Eduardo Mondlane (CEP) - UEM, Conselho Nacional de Combate ao HIV/SIDA (CNCS), Faculdade de Medicina – UEM, 'Impacto Demográfico do HIV/SIDA em Moçambique - Actualização Ronda de Vigilância Epidemiológica 2002', Maputo, Maio de 2004
[16] GOM/PAP, HIV Joint Annual Review 2007
[17] Ibid.
[18] Ibid

Table 33: Total HIV and AIDS Expenditure on OVC (US$), Mozambique NASA 2004 – 2006

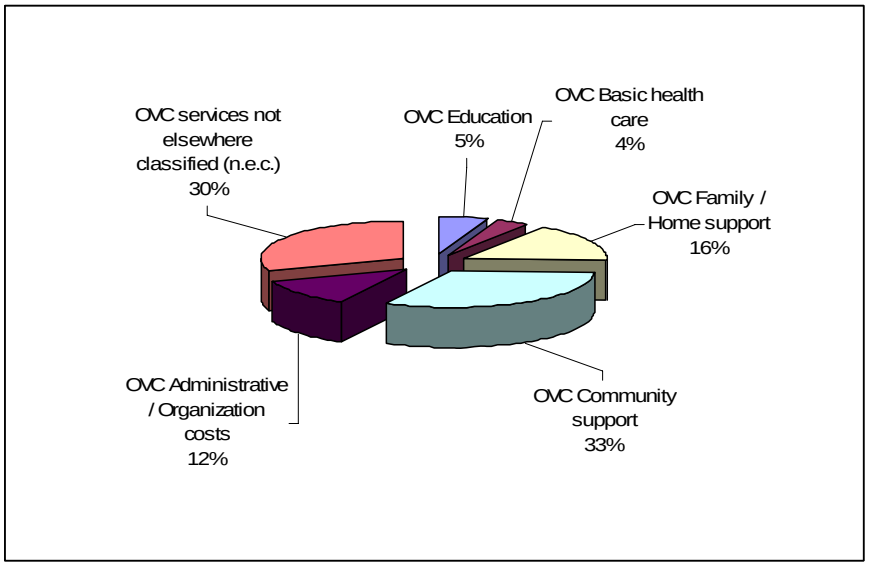
		2004	2005	2006
ASC.3.1	OVC Education	192,299	-	639,371
ASC.3.2	OVC Basic health care	349,853	-	206,237
ASC.3.3	OVC Family / Home support	-	109,740	2,375,738
ASC.3.4	OVC Community support	820,786	1,644,384	2,394,989
ASC.3.5	OVC Administrative / Organization costs	648,666	244,846	929,707
ASC.3.99	OVC services not elsewhere classified (n.e.c.)	1,621,801	2,175,490	810,501
	Total (US$)	3,633,405	4,174,460	7,356,543

In 2006, the pattern of spending on OVCs in 2004 and 2005 changed. Most of the spending was now on OVC family/home support (16%) and OVC community support (32%). OVC spending on unspecified sources fell drastically in 2006 to 11% from a high of 50% in 2005. Generally, there was more targeted spending in 2006 than in 2004 and 2005. The lack of a more disaggregated data on OVC spending makes it quite difficult to make any detailed analysis but generally provision for OVCs have been scaled up since 2004.

Table 34: Percentage of HIV and AIDS Expenditure on OVC (US$), Mozambique NASA 2004 – 2006

	2004	2005	2006	Total
OVC Education	5%	-	9%	5%
OVC Basic health care	10%	-	3%	4%
OVC Family / Home support	-	3%	32%	16%
OVC Community support	23%	39%	33%	32%
OVC Administrative / Organization costs	18%	6%	13%	12%
Other OVC services	45%	52%	11%	30%

Figure 28: Percentage HIV and AIDS Expenditure on OVC, Mozambique NASA 2004 – 2006



A3.2 Social Protection and Social Services

The spending on social protection and social services from 2004 to 2006 is shown in Table 35. The bulk of the expenditure in all three years was spent on HIV-specific income generations projects, even though the share in total spending has been decreasing over the same period. In 2006, about 21% of the share in total spending went to unspecified social services. The data was not disaggregated enough to determine which groups of people are receiving social protection and other social services. Estimated HIV and AIDS prevalence rates in Mozambique indicate that more women than men aged 20-24 were HIV positive which meant that there was an urgent need to address gender inequalities and other social norms which made women more susceptible to HIV infection.

Table 35: HIV and AIDS Expenditure on Social Protection and Social Services (US$), Mozambique NASA 2004 – 2006

Code	Category	2004	2005	2006

ASC.6.1	Social protection through monetary benefits	-	328	-
ASC.6.4	HIV-specific income generation projects	9,841	41,466	322,467
ASC.6.99	Social protection services and social services not elsewhere classified n.e.c	-	-	86,462
	Total (US$)	9,841	41,794	408,929

Area 4: Programme Management and Administrative Strengthening

Resources for the national response to HIV and AIDS have contributed to the improvement of infrastructure, procurement and distribution, upgrading of laboratory facilities and blood banks, nutrition, and logistics management. Table 36 presents the spending on programme management and administrative strengthening activities for 2004 to 2006. Total spending in this category has increased by 64% from year 2004 to 2005 and by 39% from 2005 to 2006. On average over 85% of total spending for this category was on administrative, planning and coordinating activities for all the years under study. Share of spending on monitoring and evaluation was 12% for each year between 2004 and 2006. This generally shows the government's commitment to strengthen the coordinating and monitoring capabilities of CNCS as the one coordinating body in accordance with the "Three Ones" principles.

Table 36: HIV and AIDS Expenditure on Programme Management and Administrative Strengthening Activities (US$), Mozambique NASA 2004 – 2006

Code	Category	2004	2005	2006
ASC.4.01.	Program Administration	2,762,088	4,433,861	5,869,088
ASC.4.02	Planning and coordination	2,534,271	4,364,787	4,772,672
ASC.4.03	Monitoring and Evaluation	778,278	1,263,871	1,861,811
ASC.4.04	Operations Research	-	224,172	205,420
ASC.4.05	Serological-surveillance (Serosurveillance)	-	10,850	-
ASC.4.07	Drug supply systems	2,711	-	-
ASC.4.08	Information technology	-	-	77,993
ASC.4.09	Supervision of personnel and patient tracking	-	1,463	8,455
ASC.4.10.1	Upgrading laboratory infrastructure & new equipment	132,593	52,362	1,822,792
ASC.4.10.2	Construction of new health centres	122,544	165,657	35,723
ASC.4.10.99	Upgrading and construction of infrastructure n.e.c	80,701	-	-
	Total (US$)	6,413,186	10,517,023	14,653,954

Area 5: Human Resources and Retention Incentives – Human Capital

An insufficient number of trained and retained public sector health personnel constitute a major constraint in scaling up HIV and AIDS care and treatment in Mozambique. This covers the entire gamut of health professionals, including doctors, nurses, midwives, counselors, laboratory technicians, and pharmacists. HIV and AIDS resources have been used to purchase services to build technical and management capacity of health workers in the management and care of HIV infected persons.

Table 37 shows the spending on human resources and retention incentives, from 2004 to 2006. In all three years, most of the spending went into training with the rest into monetary incentives for other staff on HIV and AIDS related activities. The share of training in total spending on human resources and retention incentives has been decreasing over the period under study while that of monetary incentives for other staff has being increasing. The share of training decreased from 98% in 2004 to 96% in 2005 and then to 86% in 2006. On the other hand monetary incentives for other staff increased from 1.4% in 2004 to 4% in 2005 and then to 14% in 2006. Human capacity constraints cannot be overlooked. Currently, there are a limited number of personnel to plan, manage and implement the many initiatives to the national response outlined in the PEN II.

Table 37: HIV and AIDS –related Human Resources and Retention Incentives Expenditure (US$), Mozambique NASA 2004 – 2006

Code	Category	2004	2005	2006
ASC.5.3	Monetary incentives for other staff	63,270	155,310	657,329
ASC.5.5	Training	4,398,460	3,742,541	4,170,419
	Total (US$)	4,461,730	3,897,851	4,827,748

Area 6: Enabling Environment and Community development

The main spending activities in this category mainly involved programmes on advocacy and strategic communication, human rights, and AIDS-specific programmes focused on women and institutional development. Given the feminisation of HIV and AIDS in Mozambique, relatively small amount of money are spent on AIDS-specific programmes focused on women as shown in Table 38. The development of appropriate, specific and targeted programming for women is essential and therefore must reflect in the expenditure patterns.

Table 38: Spending on Enabling Environment and Community Development Activities (US$), Mozambique NASA 2004 – 2006

Code	Category	2004	2005	2006
ASC.7.1	Advocacy and strategic communication	89,534	355,047	791,171
ASC.7.2	Human rights	3,520	3,395	278,024
ASC 7.3	AIDS-specific Institutional Development	21,127	102,663	151,406
ASC.7.4	AIDS-specific programs focused on women	57,425	12,029	125,654
	Total (US$)	171,606	473,134	1,346,255

Area 7: HIV and AIDS Related Research

Table 39 presents a summary of HIV and AIDS-related research spending (excluding operations research) from 2004 to 2006. Generally, the amounts reported spent on HIV and AIDS related research are very low compared to the other spending categories. In 2004, total spending in this category went into social science research. In 2005 about 96% of total spending went into social science research with 4% in behavioural research. In 2006, 83% of total spending went into biomedical research and 17% on social services research. There was a general decrease in spending on social science research between 2004 and 2006. Biomedical research which had no spending in 2004 and 2005 had US$27,912 in 2006 thus forming about 83% of total spending on research in 2006.

Table 39: HIV and AIDS-related Research Spending (US$), Mozambique NASA 2004 – 2006

Code	Category	2004	2005	2006
ASC.8.1	Biomedical research	-	-	27,912
ASC.8.4	Social Science research	112,098	484,642	5,632
ASC.8.5	Behavioural research	-	20,601	-
	Total (US$)	112,098	505,243	33,544

4.4 Beneficiaries of HIV and AIDS Spending

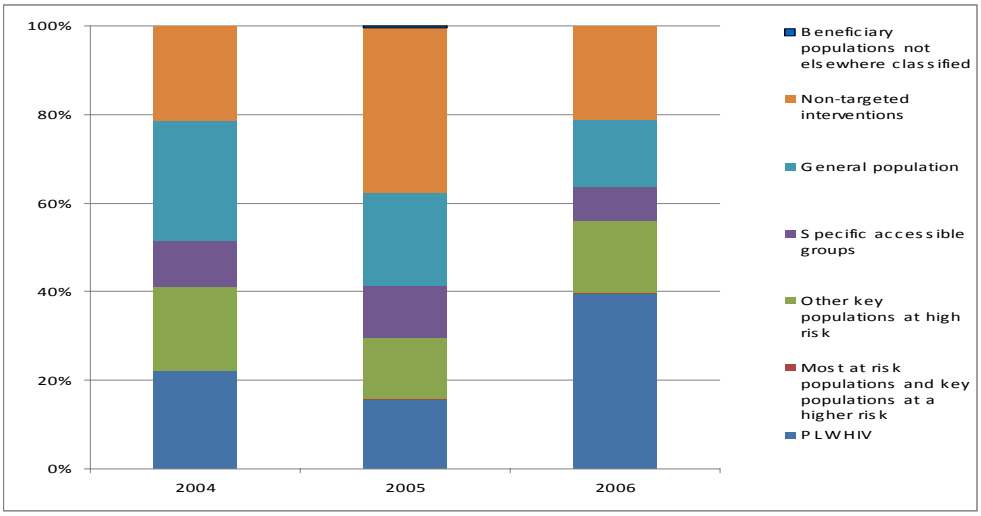
There are six sub groupings of beneficiary populations in the NASA model (explained in detail in Section 3). A further disaggregation of the data provides the various sub category groups of populations that have benefited from spending on HIV and AIDS programmes in 2004, 2005 and 2006. The two main beneficiary groups during the assessment period were the General Population: US$ 93,086,523 (46%) and People Living with HIV: US$ 58,177,430 (29%). This is presented in Table 40. In 2004 and 2005, the results show that most of the programmes were targeted to the general population followed by Orphaned and Vulnerable Children (OVC) and other youth groups. In 2006, People Living with HIV (PLWH) retained the highest share of total expenditure, followed by the general population and OVC.

Table 40: HIV and AIDS-related Spending by Beneficiary Population (US$), Mozambique NASA 2004-2006

Beneficiary Population	2004	2005	2006	Total
People living with HIV	10,678,690	9,147,918	38,350,822	58,177,430
Sellers of sexual services (SW) and their clients	80,000	111,422	140,000	331,422
Orphaned and vulnerable children	4,273,206	3,575,553	7,716,275	15,565,034
Children born or to be born to HIV mothers	1,519,200	2,175,270	4,934,738	8,629,208
Internally displaced populations (because of an emergency)	-	50,000	-	50,000
Migrants / Mobile Populations	90,000	160,000	316,449	566,449
Refugees, displaced persons and people separated from their families	-	-	70,000	70,000
Prisoners and other institutionalized persons	4,476	-	-	4,476
Truck drivers / Transport workers & commercial drivers	-	148,322	282,122	430,444
Children and youth out of the school	2,840,896	1,993,936	2,366,723	7,201,555
Partners of persons living with HIV	440,000	50,000	78,634	568,634
People attending STI clinics	2,634,261	2,887,898	2,415,967	7,938,126
Children in school	36,445	399,624	1,314,457	1,750,526
Youth in school	2,383,232	1,464,106	1,580,158	5,427,496
University students	-	313,812	234,537	548,349
Women attending reproductive health clinics	-	707,683	-	707,683
Health care workers	-	571,703	70,000	641,703
Military	-	75,000	210,000	285,000
Police and other uniformed services (other than the military)	-	75,000	-	75,000
Factory Employees	72,800	511,298	1,481,482	2,065,580
General population	23,450,680	34,574,428	35,061,414	93,075,672
Total (US$)	48,503,886	58,992,973	96,623,778	204,120,637

On the basis of the six NASA beneficiary populations the results show that in 2004, 27% of the total spending benefited the general population, with about 22% spent on PLWH, 21% on non-targeted interventions 19% on other key populations at high risk and 11 percent on specific accessible groups which include the youth, uniformed groups and factory workers. In 2005, 37% of total spending was spent on non-targeted interventions, 21% on the general population and about 16 percent on PLWH, 14% on other key populations at high risk and 12 %on specific accessible groups. In 2006 spending on PLWH increased to 40% of the total spending from 16% in the previous year; 21% was spent on non-targeted interventions while 15%, 16% and 8% was spent on the general population, other key populations at high risk and specific accessible groups respectively.

Figure 29: Percentage of HIV and AIDS spending by Beneficiary Popuçation, Mozambique NASA 2004-2006



Figures 30, 31 and 32 show a breakdown of spending categories by beneficiary groups for 2004, 2005 and 2006 respectively. In all the three years under the study, spending on PLWH was mainly on treatment and care. All the other beneficiary subgroups benefited mostly from prevention programmes however, in 2005 there was some

amount of spending on treatment and care for non-targeted populations. In 2006, PLWH also benefited from prevention programmes and social protection and social services although the share of these other programmes was minimal compared to what was spent on them for treatment and care.

Figure 30: HIV and AIDS Spending Categories by Beneficiary Population in 2004(US$), Mozambique NASA 2004-2006

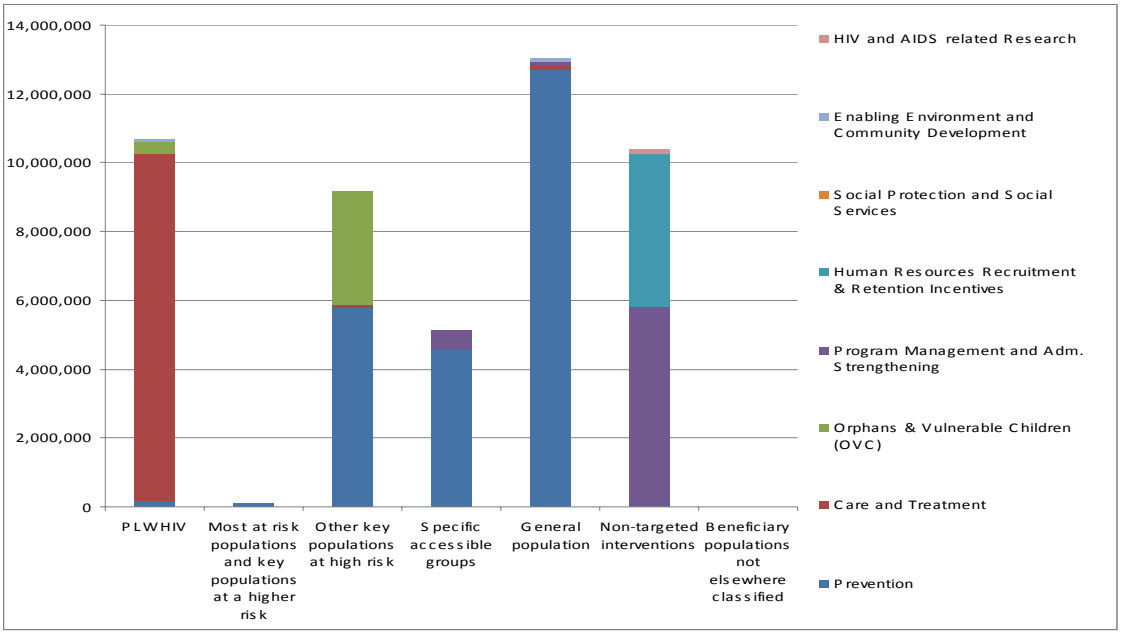


Figure 31: HIV and AIDS Spending Categories by Beneficiary Population in 2005 (US$), Mozambique NASA 2004-2006

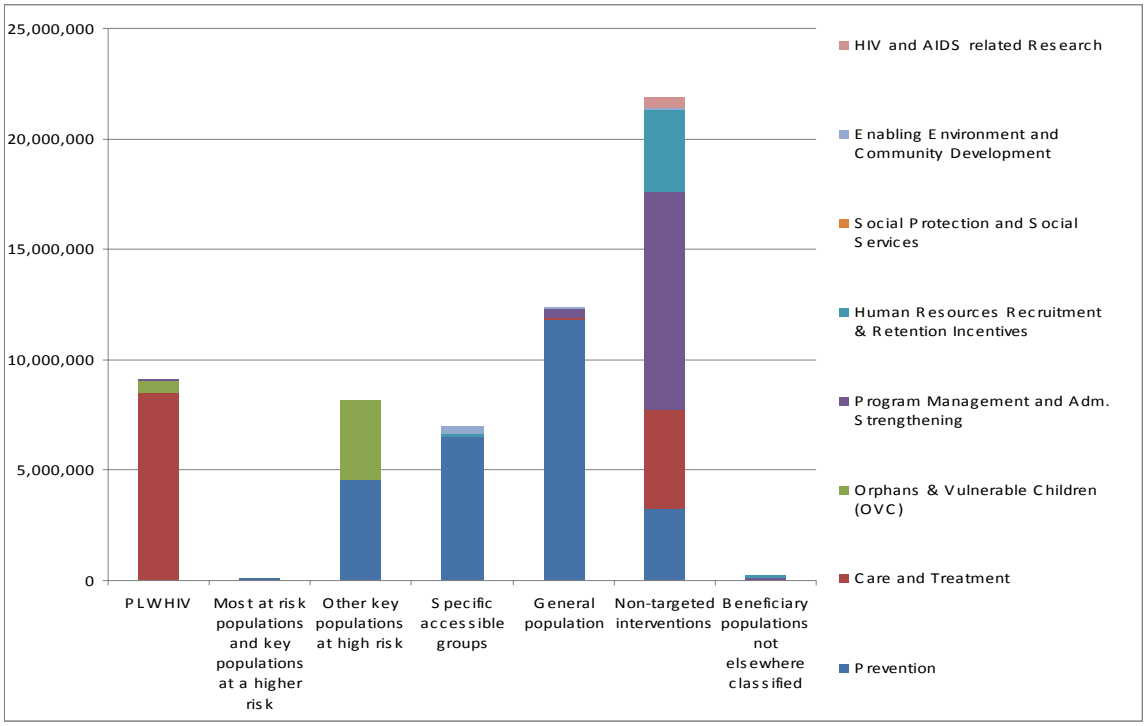
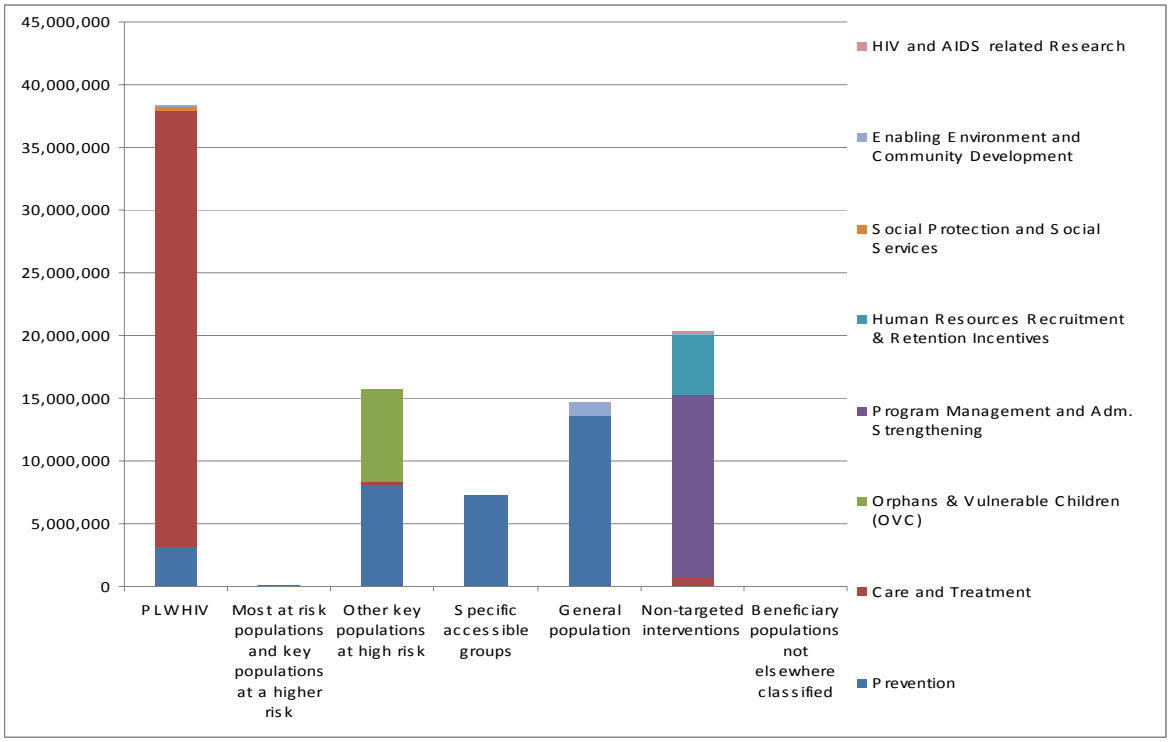


Figure 32: HIV and AIDS Spending categories by Beneficiary Population in 2006 (US$), Mozambique NASA 2004-2006



5 Section: Conclusions and Recommendations

The Government of Mozambique has initiated a comprehensive prevention, treatment, and care and support response to reduce future transmission of HIV and meet the growing demand for HIV services. Substantial amounts of resources have been invested in prevention, treatment and care, and the growth in funding for HIV and AIDS prevention and care has outpaced that for most other public health programmes. Given the unabated rise in HIV prevalence and the absence of a mechanism to track HIV and AIDS spending, it was important for an assessment to be carried out to identify what services are being purchased with HIV and AIDS funding, and who is benefiting from these resources.

	Key Message	Detail
1.	Funding for HIV and AIDS programmes has doubled from 2004 to 2006.	Overall total expenditure on national HIV and AIDS response is estimated at $204,120,637. Between 2004 and 2006 HIV and AIDS expenditure has doubled in size from US$48,503,886 in 2004 to US$96,623,778 in 2006. There is however, no clear evidence to correlate between epidemiologic information and expenditure in most-at-risk and vulnerable populations
2.	Support of Mozambique's development partners is essential in ensuring that the in-flow of funds is translated into more and better, HIV and AIDS-specific services.	The substantial increase in funding is a real test to the capacity of public sector management mechanisms in Mozambique, and has a particular bearing on the performance of ministries like the Ministry of Finance and the Ministry of Health. Budget execution rates at the Ministry of Health in 2004, while varying according to the funding source, are generally low. Similarly, the National AIDS Council (CNCS) has had difficulties ensuring that it is able to execute its budget, particularly in the allocation of funds to NGOs and local associations. As a result, this is a priority area in which the Mozambican government requires strong support from its development partners. It is crucial that this challenge be met to ensure that funding mechanisms function efficiently and that more money really does mean an increase in the quality and quantity of services.
3.	Heavy reliance on external international sources of financing for the national response to HIV and AIDS.	In all the three years, International organizations were the largest source of funding. However, in terms of funding of HIV and AIDS related activities there is a move towards harmonisation and alignment of donor support centered on supporting PARPA implementation, together with an interrelated shift from isolated projects towards more flexible aid modalities such as sector Common Funds and from Budget Payment Support (BPS) to General Budget Support (GBS).
4.	Size of off-budget flows for HIV and AIDS is substantive	A substantial amount of external assistance for HIV and AIDS is disbursed and reported through vertical projects and is therefore not captured in government accounts. Most donors are likely to continue using a broad range of aid modalities to balance different interests and hedge against risk. To ensure achievement of programmatic results towards Universal Access to HIV services rather than duplication of efforts and inefficient use of resources more efforts are needed to bring these different funding flows on plan and expenditure figures reported meaningfully.
5.	Total expenditure on prevention programmes has been on the decline	A sharper increase in treatment may have led to a moderate decrease in HIV prevention spending. Whilst expenditure on treatment increased from 21% in 2004 to 38% in 2006, funding towards HIV prevention has decreased from 48% in 2004 to 34% in 2006. The decrease in spending on prevention programmes and the increase in spending for treatment components during the reporting period could be attributed to increased funding for treatment from international sources or due to a Government push to scale up access to ART.
6.	Spending on treatment has increased substantially indicating the Government's commitment to provide Universal Access to ART	In the area of treatment, most of the funds were spent on high cost Antiretroviral Therapy (ART) programme in all three years of the study
7.	Less than 5% of all HIV and AIDS spending over the reporting period was used on human resources recruitment and retention incentives	Despite Human resource challenges in Mozambique, the assessment revealed that less that 5% of all HIV and AIDS spending over the reporting period was used on human resources recruitment and retention incentives. Moreover, total HIV and AIDS spending in this area fell from 7.5% in 2004 to as low 4.4% in 2006. This has implications for the delivery of Primary Health Care services including HIV and AIDS related services. It is unclear why so little is spent in this programmatic area, however it may be as a result of either declining human resources or reduced payments.

	Key Message	Detail
8.	Spending on OVC not commensurate to the problem.	Total expenditure on Orphans and Vulnerable Children (OVC) decreased from US$2,998,003 in 2004 to US$2,099,647 in 2005 but there was a slight increase in 2006, where spending on OVCs increased to US$7,370,390. The correlation between the number of OVC and per capita expenditure aggregated at the national level, corroborate existing evidence of inequity in the distribution of HIV resources among beneficiary populations
9.	Lack of reliable and consistent disaggregated data on spending by gender	The assessment revealed that there is a lack of reliable and consistent disaggregated data on spending by gender. This makes it very difficult to assess whether the strategies and programme interventions targeting women/girls and men/boys are well resourced. It also raises further questions about how effectively the expansion of gender equality and equity in national HIV programmes particularly in efforts to scale up towards universal access to prevention, treatment, care and support has occurred. Given the feminization of the HIV epidemic in Mozambique it is important to be able to assess whether issues regarding gender inequalities and other social norms which made women more susceptible to HIV infection were being addressed.
10	Public-Private partnerships deliver a lot of the HIV services to those in need	Over the reporting period, NGOs have been the second largest provider of HIV services after public service providers. In many cases, they have been contracted by MOH to support the provision of services in government facilities. These results confirm the general trend that the provision of HIV and AIDS services has relied heavily on non-public providers.

5.2 Key recommendations

(i) **In order to have an impact on HIV incidence and prevalence match resources to the priorities of the national HIV response:** The Government needs to identify, select and fund those HIV prevention measures that are most appropriate and effective for the country in relation to its specific epidemic scenario(s) and settings. The findings of this assessment reveal that the Government and its development partners have been successful in matching the prevention priorities in the National Strategic Plan (PEN II) to HIV expenditure. However, this has not resulted in a reduction in HIV prevalence. This may be an indication that the resources that are allocated for HIV and AIDS are not being efficiently used to purchase the correct HIV services.

(ii) **Cost Sectoral HIV Plans to ensure a needs-based resource allocation formula:** Resource mobilisation is an important element for a scaled-up response to HIV. Given the gaps that exist between commitments and needs to reach Universal Access, on the one hand, and actual expenditures and requirements, on the other, increased financial flows to support response interventions are especially critical. The sectoral HIV plans play a very important role in resource mobilisation, both domestically and internationally. It is therefore critical to cost, and comprehensively link sectoral HIV plans to the overall national planning and budgetary process for resource allocation.

(iii) **Increase national budgetary allocations for HIV and AIDS programmes to reflect the priority status given by the Government to the National Response to HIV:** The internal budget allocation to the CNCS has sharply decreased for the third consecutive years, both in absolute and proportional terms (US$ 4.3 million in 2004 or 18% of total budget, US$ 3.5 million in 2005 or 15% of total budget, and US$ 2.5 million in 2006 or 9% of total budget). While this decrease is proportional to the increase in the external component, this situation is of concern. Furthermore, the donor portfolio composition of the CNCS is limited, with over 60% of the external component depending on one donor only (the World Bank). The allocation of adequate State resources for CNCS Secretariat at national and provincial level is needed to signal political commitment to the national response and ensure its sustainability. Within the framework of the 2008-2010 MTEF exercise, the CNCS Secretariat has forecasted an overall decrease of external financial assistance and has concurrently requested an increase in the internal allocation (US$ 3.5 million in 2008, US$ 3.75 million in 2009 and US$ 4 million in 2010).

(iv) **Undertake a comprehensive assessment of out-of-pocket (OOP) expenditure on HIV** to establish if OOP constitutes a large or small portion of total HIV and AIDS expenditure it is recommended that some questions related to HIV spending are incorporated into existing household surveys. This will enable the government to establish the proportion of households with catastrophic HIV and AIDS expenditure in Mozambique.

(v) **Provide reliable and consistent disaggregated data on spending by gender:** Gender inequality is a critical barrier to access and utilization of care and treatment services. GOM confirmed its commitment to mainstream equity including gender equity in care and treatment health services. There was agreement to disaggregate data to monitor access and use of services by women; train health workers on gender issues;

conduct research to analyze gender power relations; work with other relevant ministries and sectors to address human and reproductive health rights and legal measures to protect against domestic violence. Improving the status of women is a long-term goal. The average figures provided in the assessment conceal a lot of useful information which is necessary to evaluate the response in terms of equity implications. Concrete actions are needed to obtain dissagregated data on the percentage of spending on HIV interventions that benefit women, girls, men and boys and/or aim to challenge harmful gender norms and change in percentage over time. Dissagregaton by other measures such as socioeconomic status (e.g. income quintile, education, area of residence) of beneficiary populations may also provide a better picture.

(vi) **Strengthen public financial management**: It was difficult to accurately estimate the level of resources mobilised and allocated for HIV and AIDS over the reporting period either in terms of actual public expenditure (recurrent and capital) or support received. Consequently, to avoid the lack of accountability, many donors channel HIV and AIDS funds directly to/through NGOs, CBOs or other private sector based institutions. Ultimately this practice compromises a host government's ability to fully capture and account for claimed assistance being provided by donors - oftentimes leading to the inability of policy makers and planners to determine the actual levels of resource gaps that exist in their respective sectors. To obtain good estimates of HIV expenditure there is a need to strengthen the capacity of the CNCS and sector ministries to track expenditure; and to develop standardized reporting formats. Budgetary classifications of public spending should be disaggregated to facilitate monitoring of sector spending on HIV and AIDS and efforts should be made to explore how SISTAFE can be tailored to the needs of NASA-type classifiers.

(vii) Finally, there is the need to **institutionalize the NASA process in Mozambique** for ease of data collection and also reporting on HIV and AIDS spending. The key issues that need to be addressed are (i) greater advocacy to all Ministries, Departments and Agencies, beneficiaries and the international organisations; (ii) streamlining of financial disbursement and reporting mechanisms; and (iii) the CNCS coordinating mandate has to be enforced - that is a suitable mechanism has to be introduced that will track HIV and AIDS from source to provider in Mozambique.

6 Appendices

Appendix 1: References

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Appendix 2: Definition of Key Terms

Beneficiary Population: The beneficiary population is not an expected target — as accountants and model-builders have used in projecting resource needs — but people that actually have benefited or served from the spending on HIV and AIDS goods and services. Beneficiaries are the actual number of people covered representing an outcome from the resources spent, regardless of the effectiveness of the use of resources (effective coverage).

Capital expenditure: Records the value of non-financial assets that are acquired, disposed of or have experienced a change in value during the period under study. The assets held by the health system include new acquisitions, and major renovation and maintenance of tangible and intangible assets that are used repeatedly or continuously in production processes of health care, over periods of time longer than one year. The main categories of the classification features are buildings, capital equipment and capital transfers. These categories may include major renovation, reconstruction or enlargement of existing fixed assets, as these interventions can improve and extend the previously expected service life of the asset.
Capital transfers to providers: Are considered as a governmental provision of assets without receiving in return any form of good, asset or service.

Civil Society Organization (CSO): The formal and informal networks and organizations that are active in the public sphere between the state and family. They include a wider range of associate forms such as trade Unions, churches, cooperatives, professional associations and informal community-based groups

Consumption of fixed capital. The consumption of fixed capital represents the reduction in the value of the fixed assets used in the production process during the accounting period, resulting from physical deterioration, normal obsolescence or damage. It measures the decline in the usefulness of a fixed asset for purposes of production. Measurement is frequently an assumed regular rate of decline of their efficiency in production over time, based on an average service life of the asset.

Current Expenditures: Refers to the total value of the resources in cash or in kind, payable to a health provider by a financing agent on behalf of the final consumer of health services in return for services performed (including the delivery of goods) during the year of the assessment.

Direct bilateral contributions: Allocations as grant or non-reimbursable financial cooperation that higher per capita income countries provide to recipient countries directly, either as earmarked contributions or non-earmarked contributions, e.g. budget support directly to the treasury of recipient countries.

Fiduciary Risk: are the risks that public resources are not used for the intended purposes, are not properly accounted for or do not achieve value for money

Financing Agent: entities that pool financial resources collected from different financing sources and transfer them to pay for or to purchase health care or other services or goods. These entities finance programmes or provision of services and goods used in the satisfaction of a need. Financing agents may pool resources that pay directly for resources they consume (principally households) and comprise entities that buy on behalf of specific beneficiaries (mainly intermediaries such as insurers or donors).

Financing Sources: entities that provide money to financing agents to be pooled and distributed[19]. An analysis of financing sources may be of particular interest in countries where funding for the HIV and AIDS response is heavily dependant on international sources of financing or when there are pooled sources through few management entities.

Foreign for-profit entities: For-profit entities whose home base or headquarters are located outside of the country where the services, or goods, are being provided, including among others, multinational pharmaceutical and biotechnology companies.

General Budget Support (GBS): A form of programme aid in which official development assistance (ODA) that is not linked to specific project activities is channeled directly to partner governments using their own allocation, procurement and accounting systems.

General Common Fund (PROSAUDE): This is a new fund, aiming to provide general support to the PESS and health sector activities set out in the Annual Operational Plans (POA). In 2003 a transitional common fund was set up. In January 2004, the FCG was created using government funding flow systems. This means that the donors will transfer their contributions to the Ministry of Finance (MPF), who will merge the funds together with the Government of Mozambique (GoM) contribution and transfer the funds to the PROSAUDE account.

General Provincial Fund: This fund has been operating for several years, providing support to provinces for recurrent expenditure of the public health system. The FCP was previously called Fundo Comum dos Gastos Correntes and managed by an individual donor (Swiss Development Cooperation). In early 2004, management was transferred to the MISAU DAG department. In order to ensure maximum continuity, the FCP will remain off-budget (off-Treasury) for the time being, which means that the fund will be managed as a separate fund by MISAU, outside the GoM's payment system, with donors transferring their contributions directly to the FCP bank account at MISAU, without passing through the MPF. Management of the FCP is expected to shift to on-Treasury in the medium term.

General Drugs Fund: This fund has been operating for several years, previously managed by an individual donor (Swiss Development Cooperation). The FCM aims to coordinate joint purchasing of drugs and medical supplies. Management of the FCM was transferred to the MISAU DNS department, drugs unit, in early 2004. In order to ensure funding continuity, the FCM will remain off-budget for the time being.

Interest: Interest payments accruing to loans made by different entities are not negligible. Interest is defined as payment on top of the amount of the principal borrowed, that has to be paid to the creditor by the debtor over a given period of time without reducing the outstanding amount. Interest may be a predetermined sum of money or a percentage of the outstanding principal. Interest is added to the principal. When government units pay interest on debts on behalf of another unit, as the government incurring the debt as the primary obligor (debtor), the existing debt of another unit should be recorded as a subsidy (when the other unit is an enterprise), or transfer (if it is a government unit).

International Funds: Resources originating from outside the country and executed in the current year. Bilateral and multilateral international grants as well as funds contributed by institutions and individuals outside the country are included to the extent that they are used in the current period. The terminology used by the specialists of NHA is "Rest of the world".

Multilateral Agencies: International Public or public/private organizations, institutions or Agencies which receive contributions from donor countries and from other sources, thus multilateral funding is a mechanism whereby assistance investments are pooled by different donors and granted in not necessarily one-to-one relationships between donor and recipient countries. This usually occurs via international agencies within the UN system, development banks, the GFATM is a private/public multilateral organization

Non-Governmental Organization (NGO): Organizations separate from the state that usually value-based, non-profit and established to benefit others.

Non-wage labour income: Includes honoraria towards self-employed providers of care and other services contributing to the *National Response to HIV and AIDS*, gratuities, and diverse forms of compensating services rendered

Provider: Entities or persons that engage directly in the production or provision of services and are responsible for a final product or the subcontracting of a complex process involving several units of production that may require the hiring of personnel and the acquisition of inputs, materials and services towards the final object sought. A provider is usually accountable to the beneficiary for the delivery and the quality of the service rendered though the provision does not entail a positive or desirable outcome. Providers include government and other public entities, private for-profit and non-profit organizations, corporate and non-corporate enterprises.

Public Funds: All bodies of territorial governments, i.e. departments and establishments—central, state or local—that engage in a wide range of activities such as administration, defence, health, education and other social services, promotion of economic growth and welfare, and technological development.

Sector Budget Support: Earmarked support to a particular sector within the government budget

Social contributions: Includes social contributions received by health personnel. Exceptions include employers' social contributions, in-kind payments of supplies and services required for work, and payments made to non-active workers.

Subsidies: Subsidies to medical producers are current unrequited payments that government units make to health services producers on the basis of the level of their production activities or the values of the goods or services that they produce, sell or import. Subsidies are payable per unit of good or service specific products or on production in general to producers only and not to final consumers. They constitute current transfers and not capital transfers. The payment may involve an amount by each unit of product or be calculated as the difference between a specific target price and the market price actually paid by a buyer. Subsidies may cover losses when they are a result of a deliberate government policy, as in the case of health services provided in prices under the average production cost. That an entity engages in these transfers or subsidies is an indication that it should be treated as a financing agent (perhaps in addition to its activity as a provider).

Supplies and services: Consists of all goods and subcontracted services used as inputs in production of health services. This category includes goods that are entirely used up when they are fed into the production process, during which they deteriorate or are lost, accidentally damaged or pilfered. Such goods include inexpensive durable goods, for example hand tools, and goods that are cheaper than machinery and equipment. The category also includes tools used exclusively or mainly at work, for example clothing or footwear worn exclusively or mainly at work (such as protective clothes and uniforms). One of the most important types of supplies is pharmaceuticals. Donations of materials and supplies should be treated to reflect real values, so the amounts recorded should be at market prices and net of subsidies minus indirect taxes.

Transfers: Transfers to households are transactions by which government units reimburse households all or part of the cost of purchasing goods, services or durables without counterpart. These are mostly cash transfers related to health care goods and services, the bulk of the services and goods dispensed without payment being accounted for through the entries above.

Wages: Includes all kinds of wages, salaries, and other forms of compensation, including extra payments of any nature, such as payments for overtime or night work, bonuses, various allowances and annual holidays. In-kind payments include meals, drinks, travel, special clothing, transportation to and from work, car parking, day-care for children, and the value of interest forgone when loans are provided at nil—or reduced—interest rate. Also included are payments to recruit or retain workers (health or else) in providing HIV or AIDS services.

Appendix 3: Targeted / Intended-Beneficiary Populations (BP)

NASA code	Label and abridged content description
BP.1 People living with HIV *(regardless of having a diagnosis of AIDS)*	
BP.1.1	Male adults (25 years of age and over)
BP.1.2	Female adults (> 25 years and over)
BP.1.3	Young men (15-24)
BP.1.4	Young women (15-24)
BP.1.5	Boys (5-14)
BP.1.6	Girls (5-14)
BP.1.7	Infants (under 5)
BP.1.98	People living with HIV not-desegregated by age or gender
BP.2 Most at risk populations and key populations at higher risk	
BP.2.1	Injecting (IDU) and other drug users and their sexual partners
BP.2.2	Sex workers (SW) and their clients
BP.2.3	Men who have sex with men (MSM)
BP.2.99	"Most at risk populations" not elsewhere classified (n.e.c.)
BP.3 Other key populations at high risk	
BP.3.01	Orphans and vulnerable children (OVC)
BP.3.02	Children born or to be born to HIV mothers
BP.3.03	Refugees (externally displaced)
BP.3.04	Internally displaced populations (because of an emergency)
BP.3.05	Migrants / Mobile Populations
BP.3.06	Indigenous groups
BP.3.07	Prisoners and other institutionalized persons
BP.3.08	Truck drivers / Transport workers and commercial drivers
BP.3.09	People affected by trafficking and violence
BP.3.10	Youth at social risk
BP.3.11	Children and youth living in the street
BP.3.12	Children and youth gang members
BP.3.13	Children and youth out of the school
BP.3.14	Institutionalized children and youth
BP.3.15	Partners of persons living with HIV
BP.3.99	"Populations at high risk" not elsewhere classified n.e.c.)
BP.4 Specific "accessible" populations	
BP.4.01	People attending STI clinics
BP.4.02	Children in school
BP.4.03	Youth at school
BP.4.04	University students
BP.4.05	Women attending reproductive health clinics
BP.4.06	Health care workers
BP.4.07	Sailors
BP.4.08	Military
BP.4.09	Police and other uniformed services (other than the military
BP.4.10	Ex-combatants and other armed non-uniformed groups
BP.4.11	Factory Employees
BP.4.99	"Accessible populations" not elsewhere classified (n.e.c.)
BP.5 General population	
BP.5.1	General Adult population (above 24)
BP.5.1.1	Male adult population
BP.5.1.2	Female adult population
BP.5.1.98	General Adult population (above 24) not discriminated by gender
BP.5.2	Children (under 15)
BP.5.2.1	Boys
BP.5.2.2	Girls
BP.5.2.98	Children (under 15) not discriminated by gender
BP.5.3	Youth (age 15 to 24)
BP.5.3.1	Young men
BP.5.3.2	Young females
BP.5.3.98	Youth (age 15 to 24) not discriminated by gender
BP.5.98	General population not desegregated by age or gender.
BP.6 Non-targeted interventions	
BP.99 Beneficiary populations not elsewhere classified (n.e.c)	

Appendix 4: Questionnaire

This information is confidential

Country:

Year of the estimation: ***Date:***

This Form should be used to obtain information from Financial Sources.

1.-

Name of the Institution:	
Contact (Name and Title):	
Address	**E-mail:**
Telephone:	**Fax:**

2.- Legal Status

Indicate with an **x** your legal status

	National	***International***
Public		
Private		
Profit		
Non profit (NGO)		
Bilateral Agencies		
Multilateral Agencies		

3.- Transference of funds

In the next Table please indicate

Na Institution that received funds from other organizations to undertake HIV and AIDS activties?	Yes (complete part 2)
An institution that uses your own funds to finance or implement HIV and AIDS related activities?	Yes (Complete line 10 and part 2)
Institution that transfered funds to other institutions that finance or implement HIV and AIDS related activities?	Yes (Complete part 3)
Na institution that produces HIV and AIDS related services	Yes (complete part 2, and 3 first columns)

Indicate with an x if all the expenses are expressed in local money:	
Other currency, specify:	

2. Origin of the Funds Received

Indicate:

- Name of the entity that received the funds in the year of the estimation.
- O montante gasto no ano, desagregado por cada fonte financeira.

Name of Insitutions	**Amount Received**	***Amount spent in your organization***	***Amount transfered to other organizations***
OF [1]			
OF [2]			
OF [3]			
OF [4]			
OF [5]			
OF [6]			
OF [7]			
OF [8]			

Name of Insitutions	**Amount Received**	***Amount spent in your organization***	***Amount transfered to other organizations***
OF [9]			
OF [10]			
TOTAL			

Se indicou ter a organização utilizado recursos, preencha as Parte 4 e 5 para cada um dos fundos utilizados.

3. Destination of Funds:

Indique:

- O nome das entidades para as quais enviou fundos no ano da estimativa e
- O montante reportado como gasto no ano por cada entidade.

Nome da Instituição que recebeu fundos	**Valor transferido**	***Valor reportado como gasto***
DF [1]		
DF [2]		
DF [3]		
DF [4]		
DF [5]		
DF [6]		
DF [7]		
DF [8]		
TOTAL		

a) Se preencheu ambas as partes 2 e 3, a soma do Valor Transferido calculado na parte 3, deverá em princípio igualar a soma do Valor Transferido a Outras Organizações calculado na parte 2. Se assim não for indique as causas da diferença.

b) Para cada uma das instituições que utilizaram recursos, Valor reportado como gasto pelas Organizações, referidas na Parte 3, preencha as Parte 4 e 5.

Nome do Inquiridor: _____

Appendix 5: Questionnaire 2 Detalhes da utilização dos recursos por Fundo (fonte financeira)

Nome da Instituição que utilizou os recursos:

Nome da Instituição que forneceu a informação:

Para cada um dos Fundos indicados como utilizados na Parte 2, e **se possui os dados requeridos,** providencie a seguinte informação:

- O valor da despesa por cada Actividade realizada, conforme classificação do MEGAS. O total apurado deve ser igual ao valor registado como utilizado na parte 2.
- Se não possui os dados exactos para desagregar as despesas por Tipo de Despesa, por favor faça uma estimativa dos valores usando toda informação disponível ou a sua experiencia profissional. Assinale com um asterisco (*) o dado que foi estimado.
- Indique quais as fontes ou as suposições que foram feitas para fazer tal estimativa e registe-as neste formulário.
- Se não for possível fazer qualquer estimativa para as despesas realizadas desagregadas por tipo de despesa, então favor indicar "não disponível" (N/D).

APLICAÇÃO DOS FUNDOS RECEBIDOS DE OF [3]:DANIDA

4.1. Despesa por Tipo de Actividade e por fonte financeira

Actividade	Código MEGAS	Nome da Actividade	TOTAL
A1	ASC 4.1	Programme Management –translation, printing, dissemination	$38,710
A2	ASC 4.2	Planning and Coordination	
A3			
A4			
A5			
Total			

4.2. Despesa por tipo de Actividade e População Beneficiada

Indique:

- O valor da despesa por cada Actividade, conforme registado na tabela 4.1., discriminada por grupos alvos do programa, conforme classificação do MEGAS.
- Se não possui os dados exactos para desagregar as despesas por Grupo Alvo, por favor faça uma estimativa dos valores usando toda informação disponível ou a sua experiencia profissional. Assinale com um asterisco (*) o dado que foi estimado.

População Beneficiária	A1-OF[1]	A2-OF[2]	A3-OF[3]
BP 1.1.1. Adultos Sexo Masculino. PVVS			
BP 1.1.2. Adultos do Sexo Feminino PVVS			
BP 1.1.2.1. Mulheres grávidas PVVS			
BP 1.1.3.1. Rapazes PVVS			
PF 1.1.3. 1. Meninas PVVS			
BP 2.1. Utilizadores de drogas injectáveis e seus parceiros sexuais			
BP 2.2. Jovens utilizadores de drogas injectáveis (15-18)			
BP 2.3. Trabalhadores de sexo e seus clientes			

População Beneficiária	A1-OF[1]	A2-OF[2]	A3-OF[3]
BP 2.4. Trabalhadores do sexo jovens (15-18)			
BP 2.5. Homens que fazem sexo com homens			
BP 2.6. Homens jovens que fazem sexo com homens (15-18)			
BP 3.1. Orfãos e Crianças Vulneráveis			
BP 3.2. Criaças a nascer cuja mãe vive com com HIV			
BP 3.3. Migrantes, refugiados e pessoas deslocadas			
BP 3.4. Prisioneiros e outras pessoas "internadas"			
BP 3.5. Homens e Mulheres separadas das suas famílias			
BP 3.6. Mulheres e crianças afectadas por tráfico e violência			
BP 3.7. Crianças de rua ou membros de gangs			
BP 3.8. Jovens fora da escola			
BP 3.9. Jovens internados em centros para menores			
BP 3.10. Parceiros de pessoas vivendo com HIV			
BP 4.1.1. Homens pacientes de ITS			
BP 4.1.2. Mulheres pacientes de ITS			
BP 4.2. Crianças na escola (menos de 18 anos de idade)			
BP 4.3. Jovens na escola / universidade (18-24)			
BP 4.4. Trabalhadores Migrantes			
BP 4.5. Motoristas de longo curso			
BP 4.6. Mulheres que frequentam serviços de atenção reprodutiva			
BP 4.7. Militares, policias e marinheiros			
BP 4.8. Motoristas de viaturas pesadas			
BP 4.9. Trabalhadores que prestam cuidados de saúde			
BP 5.1.1. Homens – População em geral			
BP 5.1.2. Mulheres– População em geral			
BP 5.2. Outras actividades que não sejam direccionadas a uma população específica pela sua natureza			
Total gasto com a actividade			

(Os totais de cada coluna deverão igualar o montante registado na tabela de aplicação dos fundos por tipo de actividade 4.1)

4.3. Despesas por tipo de Actividades e factores de produção

Indique:

- O valor da despesa por cada Actividade, conforme registado na tabela 4.1., discriminada pelos factores de produção utilizados (consumidos), conforme classificação do MEGAS.
- Se não possui os dados exactos para desagregar as despesas por Grupo Alvo, por favor faça uma estimativa dos valores usando toda informação disponível ou a sua experiencia profissional. Assinale com um asterisco (*) o dado que foi estimado.

Despesas consoante a sua natureza	**A1-OF[ ]**	**A2-OF[ ]**	**A3-OF[ ]**
PF 1.1.Remuneração de empregados e proprietários.			
PF 1.2. Bens de consumo.			
PF 1.2.1. Anti-retrovirais			
PF 1.2.2. Outros medicamentos (excluindo ARV)			
PF 1.2.3. Artigos medicos e cirurgicos			
PF 1.2.4. Preservativos			
PF 1.2.5. Reagentes e materiais			
PF 1.2.6. Alimentos			
PF 1.6.7. Outros bens de consumo			
PF 1.3. Serviços.			
PF 1.3.1. Serviços Administrativos			
PF 1.3.2. Manutenção e Reparação			
PF 1.3.3. Formação de pessoal			
PF 1.3.4. Pesquisa de mercado			
PF 1.3.5. Serviços de Consultoria			
PF 1.3.6. Gastos de transporte e viagens			
PF 1.3.7. Acomodação			
PF 1.3.8. Refeições e bebidas			
PF 1.3.9. Outros serviços			
PF 1.4. Consumo de capital fixo (amortização)			
PF 1.5. Juros			
PF 1.6. Subsidios aos provedores			
PF 1.7. Transferências as familias			
PF 1.8. Outros gastos correntes			
PF 2. Despesa de capital (investimento)			
PF 2.1. Instalações			
PF 2.2. Equipamento			
PF 2.2.1. Veículos			
PF 2.2.2. Tecnologias de Informação (hard & software)			
PF 2.2.3. Outro			
TOTAL			

DRAFT

(Os totais de cada coluna deverão igualar o montante registado na tabela de aplicação dos fundos por tipo de actividade 4.1)

Appendix 6: List of Institutions and Status of HIV and AIDS Expenditure Information

Public Organizatons	2004	2005	2006
Ministry of Health			
DAF/DPC	Ⓟ	Ⓟ	Ⓟ
ATS	✓	✓	Ⓟ
PTV	✓	✓	✓
ITS	✓	✓	✓
CMAM /DAM : TARV	✓	✓	✓
GACOPI (MAP/TAP)	Ⓟ	Ⓟ	Ⓟ
National AIDS Council (CNCS)	Ⓟ	Ⓟ	Ⓟ
Ministry of Science & Technology	⃠	⃠	×
Ministry of Administration	⃠	⃠	⃠
Ministry of Finance	⃠	⃠	✓
Ministry of MDN	×	×	×
Ministry of MIC	⃠	⃠	✓
Ministry of Agriculture	⃠	⃠	✓
Ministry of Education and Culture	⃠	⃠	✓
Ministry of Interior	✓	Ⓟ	Ⓟ
Ministry of MIREME	⃠	⃠	✓
Ministry of Works	×	×	✓
Ministry of Tourism	⃠	⃠	✓
Ministry of Youth and Sports	×	×	×
Ministry of Justice	⃠	⃠	×
Ministry of Women Affairs & Social Action	×	×	✓
Ministry of Foreign Affairs	⃠	⃠	✓
Ministry of Public Works	⃠	⃠	✓
Ministry of Planning & Development	⃠	⃠	⃠
INE	✓	✓	✓
ICS	✓	Ⓟ	Ⓟ
IMAP	⃠	⃠	⃠
ISCTEM	⃠	⃠	✓
ISPU	⃠	⃠	✓
UCM	×	×	×
UDM	×	×	×
UEM	✓	✓	✓
UP	×	×	✓
Private. Organisations	**2004**	**2005**	**2006**
PRESERVATIVOS PRIVADOS	Ⓟ	Ⓟ	Ⓟ
UGC	⃠	⃠	⃠
9 TV	×	×	Ⓟ
BP	×	×	×
CDM	✓	✓	✓
CETA	⃠	⃠	×
CFM	×	×	✓
CocaCola	⃠	⃠	✓
Crown Agents	⃠	⃠	⃠
EDM	⃠	⃠	✓
JFS	×	×	×
LAM	⃠	⃠	✓
MARAGRA	×	×	×
MCEL	×	×	×
MIRAMAR	×	×	×
MOZAL	×	×	✓
Mozambique Leaf Tobacco	⃠	⃠	⃠
NOTÍCIAS	⃠	⃠	✓
PRETOMOC	×	×	×
Salao Cló	×	✓	×
SAVANA	⃠	⃠	⃠
TDM	✓	✓	✓
TOTAL	⃠	⃠	✓
TVM	⃠	⃠	✓
VODACOM	⃠	✓	✓
International Organizations	**2004**	**2005**	**2006**
French Cooperation	Ⓟ	Ⓟ	Ⓟ
AUSAiD (Australia)	✓	✓	✓
Canada (CIDA)	Ⓟ	Ⓟ	Ⓟ
CDC	©	©	©
Italian Cooperation	×	×	✓
Swiss Development Cooperation (SDC)	Ⓟ	Ⓟ	×
DFID - United Kingdom	Ⓟ	Ⓟ	Ⓟ
Denmark (DANIDA)	×	×	Ⓟ
Finland	×	×	✓
Flanders International Cooperation Agency	Ⓟ	Ⓟ	Ⓟ
Holland	⃠	Ⓟ	Ⓟ
Irish Aid (DCI)	Ⓟ	Ⓟ	✓
Norway	×	×	✓
Swedish Int. Dev. Coop. Agency	Ⓟ	Ⓟ	✓
USAID	✓	✓	✓
GTZ	✓	✓	✓
JICA	×	✓	×
African Development Bank	×	×	×
European Union	Ⓟ	Ⓟ	Ⓟ
Global Fund	×	×	×
World Bank	Ⓟ	Ⓟ	Ⓟ
FNUAP	✓	✓	✓
OMS (WHO)	✓	✓	✓
ONUSIDA	✓	✓	✓
PAM (WFP)	✓	✓	✓
PNUD	✓	✓	✓
FAO	×	✓	×
UNESCO	⃠	✓	✓
ILO	⃠	⃠	✓
UNICEF	✓	✓	✓
NGOs	**2004**	**2005**	**2006**
AMODEFA	✓	✓	✓
Associação de Enfermeiros de Moçambique	×	×	×
Aro Moçambique	×	×	✓
Associação Kindlimuka	✓	✓	✓
Conselho Cristao de Mocambique	×	×	×
Conselho Islâmico de Moçambique	×	×	Ⓟ
CVM	×	×	×
ECOSIDA	×	×	Ⓟ
FDC	✓	✓	✓
Forum Mulher	×	×	×
KULIMA	×	✓	✓
KUYAKANA	×	×	Ⓟ
MONASO	✓	✓	✓
Muleide	×	×	✓
NAIMA	×	×	×
OJM	×	×	✓
OMM	⃠	⃠	⃠
ORAM	✓	✓	×
Rede Crista contra HIV-SIDA	×	×	✓
RENSIDA	✓	✓	✓
SNP - Sindicato Nacional de Professores	×	×	✓
UTOMI	⃠	⃠	⃠

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ADPP	×	×	×
Africare	×	×	×
American International Health Alliance	×	×	×
Association of Public Health Laboratories	×	×	×
CARE International	Ⓟ	Ⓟ	✓
CARITAS	×	×	✓
Columbia University	✓	✓	✓
Concern Internacional	×	×	×
Dolour sans Frontiere	✓	✓	✓
Elizabeth Glaser Pediatric AIDS Foundation	×	×	×
FHI - Family Health International	Ⓟ	✓	×
Food for the Hungry	×	×	×
Fundacao Clinton	Ⓟ	Ⓟ	Ⓟ
GOAL	⃠	⃠	⃠
HAI	✓	✓	✓
Help Age International	×	×	✓
HELVETAS	×	×	✓
JHPIEGO	×	×	✓
John Snow, Inc.	×	×	✓
Johns Hopkins University	×	×	×
Medicus del Mundo	✓	✓	✓

Medicus do Mundo	Ⓟ	Ⓟ	✓
MSF Belgica	⃠	⃠	⃠
MSF Luxemburg	✓	✓	✓
MSF Suica	✓	✓	✓
Opportunity International	×	×	×
OXFAM Australia	×	×	Ⓟ
OXFAM GB	⃠	⃠	⃠
Pathfinder	✓	✓	✓
Project HOPE	×	×	×
PSI Jeito	✓	✓	✓
Samaritan's Purse	×	×	✓
SANTO EGIDIO	×	Ⓟ	Ⓟ
SAT Southern Africa Aids Trust	✓	✓	✓
SAVE THE CHILDREN	×	×	✓
N'Weti (Soul City)	✓	✓	✓
TROCARE	Ⓟ	Ⓟ	Ⓟ
Tulane University	×	×	×
World Relief Corporation	✓	✓	✓
World Vision (Visão Mundial)	✓	✓	×

Key

☑ Complete expenditure data was captured

ⓅPartial expenditure data was captured

© Budget data was available but not captured to avoid double-counting

☒ Expenditure data was unavailable

⃠ No HIV and AIDS activities

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Appendix 7: List of Organizations visited and contact persons

1. CNCS
   Pascoa Temba
   pascoa.themba@cncs.org.mz

2. CMAM - MISAU/DAM : TARV
   827116560 / 823120760

3. MCT

4. MAE
   Abel Saul

5. MdF
   Alferdina Moiana / Pena Vasco
   829085110 / 828009440
   alferdina_moiana@yahoo.com.br
   (penavasco@yahoo.com.br)

6. MDN
   Elias Paulo Mataruca / Francisco Tauzene (Manuel Dinis)
   823153380 / 825323271 (823183030)
   matarucaelias@yahoo.com /
   ftauzene@yahoo.com.br

7. MIC
   Verónica
   825446084

8. MINAG
   Albertina Alaje

9. MEC
   Ana Sousa Chiau, Gestão de fundos CNCS

16. MPD
    Madalena Cristina Monteiro / Sata Senaia
    DNAdj Adm. RRHH
    824383390 / 21495473
    humonteiro@yahoo.com.br
    /sarasenai@dnpo.gov.mz

17. INE
    Paula Jamboce
    paula.jamboce@ine.gov.mz

18. ICS
    Figueiredo
    8289425590

    Sofia Momade Abdula
    823080220
    826441770
    achiau@mec.gov.mz

10. MINT
    Ana Sendela (Dino / Abreu)
    823007820 / 823964960
    Abreu: 827073000

11. MITRAB
    Sr. Macuácua
    824640780

12. MITUR
    Aurélio Chume, Técnico Turismo
    823998140
    chumeau@yahoo.com

13. MJD
    Edson Semedo Mussa (Rui Albasini / Dulce)
    842834570
    edimussa@yahoo.com.br

14. MMAS
    José Maria Jone, Técnico
    825954920
    zeusreich@yahoo.com

15. MNEC
    Lídia Soares/ Amélia, Jurista
    843177350 / 823831120
    isoares@ind.gov.mz
    Bernardete Sitão / Armindo Filipe Pedro
    sabdul@isctem.qc.mz

19. ISPU
    Celso Sitoe (ANDREA Sara)
    827982810

20. UCM
    Conselho Episcopal

21. UEM
    Rita Manuel Mapie
    Contabilista
    823153930
    ritamapie@yahoo.com.br

22. UEM - CEA
    Ilda
    21490828

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23. UEM - CEP
    Natercia
    823220160

24. UP
    Dr Júlio Gonsalves
    Coordenador Geral
    21400033 / 843012700
    dr_goncalves@yahoo.com

25. AMODEFA
    Marcelo Rufino Kantu

26. Director de Programas Interino
    21 405107/9 / 82 3031649
    mkantu@amodefa.or.mz,
    marcelokantu@hotmail.com

27. Associação de Enfermeiros de Moçambique (ANEMO)
    21324642

28. Aro Moçambique
    Policarpo Tamele

29. Associação Kindlimuka
    André
    846540250

30. Conselho Cristao de Mocambique
    Rev. Mascane
    825937930

31. Conselho Islâmico de Moçambique
    Mamede
    828912550

32. CVM
    Alberto
    21497721 / 823012251-2

33. ECOSIDA
    Dr. Balane
    823851840

34. FDC
    Renato Carrilho
    Gestor de Subvencões
    21355300
    rcarrilho@fdc.org.mz

35. Forum Mulher
    Anibal Muendane
    829572730
    anibal@forummulher.org.mz

36. KUYAKANA
    Sergio
    21407128

37. MONASO
    Hélder T. Gune
    824545770
    helgune@hotmail.com

38. Muleide
    Rafa Valente Machava
    21325831

39. NAIMA
    Dra Linda
    823013902

40. OJM
    Rui Mapatse
    828547970

41. OMM - Organização da Mulher Moçambicana
    Amalia
    21492665

42. ORAM
    Tacano (Macia)

43. Rede Crista contra HIV-SIDA
    Octávio Mabunda
    823067910

44. RENSIDA
    Egas Mucanhane / Eugénio José Banze / Júlio Ramos Mujojo
    Assistente Administrativo
    823020035 / 828017060 / 823979738
    rensida@tvcabo.co.mz /
    eugeniobanze@yahoo.com.br /
    rensida@tvcabo.co.mz

45. SNP - Sindicato Nacional de Professores
    Rosalina
    21490400 / 823080450

46. UTOMI - Associação Moçambicana de Combate Ao SIDA
    21417187

47. 9 TV
    H. José
    824833770 / 843986410

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48. BP
    Teofilo F. Nhangumele
    Corporate Affairs Manager
    823175140
    TEOFILO.NHANGUMELE@MZ.BP.COM

49. CDM
    Elisio / Elisabeth Sousa, 21352313
50. CETA
    Dr Mauro
    21355600

51. CFM
    Francisco Cabo
    21427746

52. CocaCola
    Faruk
    843762880

53. EDM
    Dra Teresa
    21326020

54. MARAGRA
    Sra Joana
    828341180

55. MCEL
    Assucena Paulo

56. MIRAMAR
    D. Matabele

57. MOZAL
    Sofia Jambane
    21735000
    sofia.jambane@bhpbilliton.com

58. NOTÍCIAS
    Dra Lúcia
    Chefe dos Rec. Humanos
    21320119

59. PRETOMOC
    Salao Cló

60. TDM
    Dr Batista
    823085030

61. TVM
    Délio Ernesto Massingue
    21308117/9/ 829808310
    tvm@tvm.co.mz

62. VODACOM
    Hanifa Hassangy
    HR Manager
    840900000/840901783/
    840900113/849901853
    hanifa.hassangy@vm.co.mz

63. AFD - Coop Francesa
    Geneviéve Verdelhan-Cayre / Caroline Blan
    823007016 / 21304300/2
    verdelhan-cayre@groupe-afd.org

64. AUSAiD (Australia)
    Stacey Walker
    (823250260) 21491143 / 21497328
    stacey.walker@ausaidmoz.org

65. Canada (CIDA)
    Luc Pincine/Daniel Taillon
    Primeiro Secretário
    21492623
    823283670
    pincine@international.gc.ca

66. CDC
    Lisa Nelson
    Director
    21314747 / 8 (82 3097210)
    NelsonL@mz.cdc.gov

67. Cooperacao Italiana
    Fabrizio Falcone
    827240670 / 21495739
    paolo.barduagni.esp@esteri.it

68. Cooperacao Suica (SDC)
    Giorgio Dimas

69. DFID - United Kingdom
    Levi
    847322487
    irwh@zebra.uem.mz / d-reves@dfid.gov.uk

70. Dinamarca (DANIDA)
    Bert Schroeder
    astper@um.dk
71. Finlandia
    Ritva Patviainen
    Programme Manager
    21482405 / 21491662

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72. Flanders International Cooperation Agency
    Laurence Hendrickx
    824797740 / 21485544
    lhendrickx@tvcabo.co.mz

73. Holanda
    Annie Vestjens
    Primeira Secretária Saúde e HIV/SIDA
    21484218 / 21484248
    Annie.Vestjens@minbuza.nl

74. Irlanda (DCI)
    Doris Uane/Caroline Forkin
    Assessora para a Area de HIV multisectorial
    21483529 / 824840320
    Doris.Uane@dfa.ie

75. Noruega (NORAD)
    Clarice Barbosa
    82 3006650
    clarisse.barbosa@mfa.no

76. SIDA - Swedish Int. Dev. Coop. Agency
    Maria de Lourdes Aguiar
    21480300
    maria.aguiar@sida.se

77. USAID
    Nena Lentini
    Oficial de Programas para HIV/SIDA
    823025019
    nlentini@usaid.gov

78. Banco Mundial - MAP
    Dr. Humberto Cossa
    hcossa@worldbank.org
    Banco Mundial - TAP
    Dr. Humberto Cossa
    hcossa@worldbank.org

79. FNUAP
    Petra Lantz / Marta Bazima/Shadit Murgay
    Representante / Oficial Prog
    21494469
    lantz@unfpa.org / bazima@unfpa.org

80. Fundo Global
    Via DFID

81. OMS (WHO)
    Dr. Sandra Muchanga
    muchangas@mz.afro.who.int

82. ONUSIDA
    Eva Kiwango
    Kiwangoe@unaids.org

83. PAM (WFP)
    Francesca Erdelmann/Cerlso Bila/Deolinda
    Chefe de Programa
    823016299 / 21482252
    francesca.erdelmann@wfp.org

84. PNUD
    Stella Pinto
    stella.pinto@undp.org

85. FAO
    Hanise Sumbane

86. UNESCO
    Zulmira Rodriguez

87. ILO
    Paulo Romao

88. Uniao Europeia
    Doulgas Hamilton
    843102790 / 21481000
    douglas.hamilton@cec.eu.int

89. UNICEF
    Jean Dupraz / Maaike Arts
    825617251

90. CARE International
    Jamisse
    pjamisse@care.org.mz
    CARITAS
    Pde Francisco / Sra Fernanda

91. COLUMBIA UNIVERSITY
    Mie Okamura
    823172710
    mieokamura@columbia.org.mz

92. Concern Internacional
    Anibal Machava / Ana Maria Machaieia
    21417948 / 21419146

93. FHI - Family Health International
    Silvia Gurrola Bonilla
    Country Director
    826127230
    sgurrola@fhimoz.org

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94. Fundacao Clinton
Claire Bader
823014343

95. Health Alliance International (HAI)
Kenneth Gimbel-Sherr / Carolina B. Honwana / Monica Rodriguez / Else Contabilista
824638070 / 823015875
chonwana@hotmail.com / moroga@gmail.com

96. Help Age International
Rosalia Mutisse
rosaliamutisse@tvcabo.co.mz

97. HELVETAS
Mabote
824429610

98. JHPIEGO
Karula

99. John Snow, Inc.
Mario Marrengula
8230112075

100. Johns Hopkins University Center for Communication Programs
Sozinho Guerra
Fin&Adm Manager
825904660
sguerra@jhuccp.org.mz

101. Medicus del Mundo
Dr. Pablo

102. Medicus do Mundo
Joaquim Samuel / Cláudia Paixão / Vasco Coelho
21 493852

103. MSF Belgica
MSF Luxemburg
Ellie Ford-Kamara
Finance Coordinator
21 307946/7 / 82 558 0960
msfl-maputo-fin@luxembourg.msf.org

104. MSF Suica
Natia Nerasitsverida
Financial Controller
827769960
MSFCH-Maputo-Finco@geneva.msf.org

105. OXFAM Australia
Omar Mangueira
21488716

106. OXFAM GB
José M. Rueda

107. Pathfinder
Ana Jacinto
Oficial de M&A
828788240
ajacinto@pathfind.org

108. Project HOPE
Dr. Armanda Chuva
21314700

109. PSI Jeito
Brian Smith / Luisa Alcinda (marketing)
Representante
21485025
bsmith@psi.org.mz

110. Samaritan's Purse
César/Joana
823277850/823227930

111. SANTO EGIDIO
Máximo Magnano (Ivete)
823291220

112. SAT Southern Africa Aids Trust
Lucrécia Wamba

113. SAVE THE CHILDREN
Júlio Machava
825146274

114. N'Weti (Soul City)
Denise Namburete / Leovigildo

115. TROCARE
Belmira Seuane / Ian Dolan
21415616 / 21414338
bseuane@trocaire.org.mz / trocaire@trocaire.org.mz

116. World Relief Corporation
Bembele
21488813/5

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117.	World Vision (Visão Mundial)	Dorca Hele / Omo Olupona (Dr. Bandão) 824542080 dorca-elewvi@org

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Appendix 8: Flow of HIV and AIDS Funds from Financing Sources and Financing Agents

Example of Public Flow of HIV and AIDS Funding

Figure 33: CNCS HIV and AIDS Financial Flows, Mozambique NASA 2004-2006

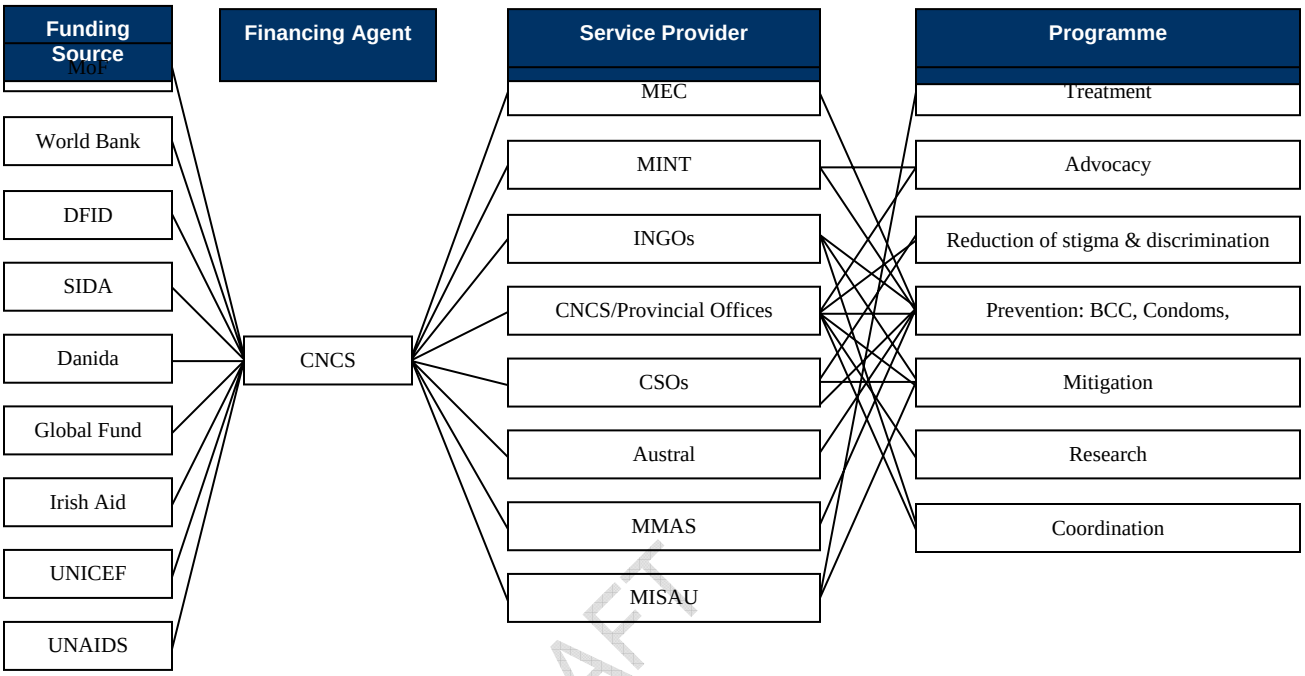

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Figure 34: Health Sector HIV and AIDS Financial Flows, Mozambique NASA 2004-2006

Financing Sources		
Public	**International**	**Private**
Ministry of Finance	(1) World Bank (2) DFID (3) SIDA (4) Danida (5) Global Fund (6) Norway (7) SDC (8) CIDA (9) Denmark (10) EU (11) AFD (12) Netherlands (13) AECI (14) Finland (15) Catalunya (16) Irish Aid (17)UNFPA	

Financial Agents		
Public	**International**	**Private**
	(1) HAI (2) Santa Egidio (3) MONASO (4) Medicus Mundi (5) Others	

Service Providers		
Public	**International**	**Private**
(1)Provincial Health Centres (2) District health services	(1) HAI (2) Santa Egidio	

AIDS Spending Categories
(1) C&T (2) PMTCT (3) Diagnosis & treatment of STIs (4) Treatment of OIs (5) HBC (6) Promotion & distribution of Condoms (7) Biosecurity (8) Nutrition (9) HAART (10) IEC (11) Monitoring & Evaluation (12) Programme Management (13) Technical

A: Example of Flow of External HIV and AIDS Funding

Figure 35: DCI HIV and AIDS Funding Flows, Mozambique NASA 2004-2006

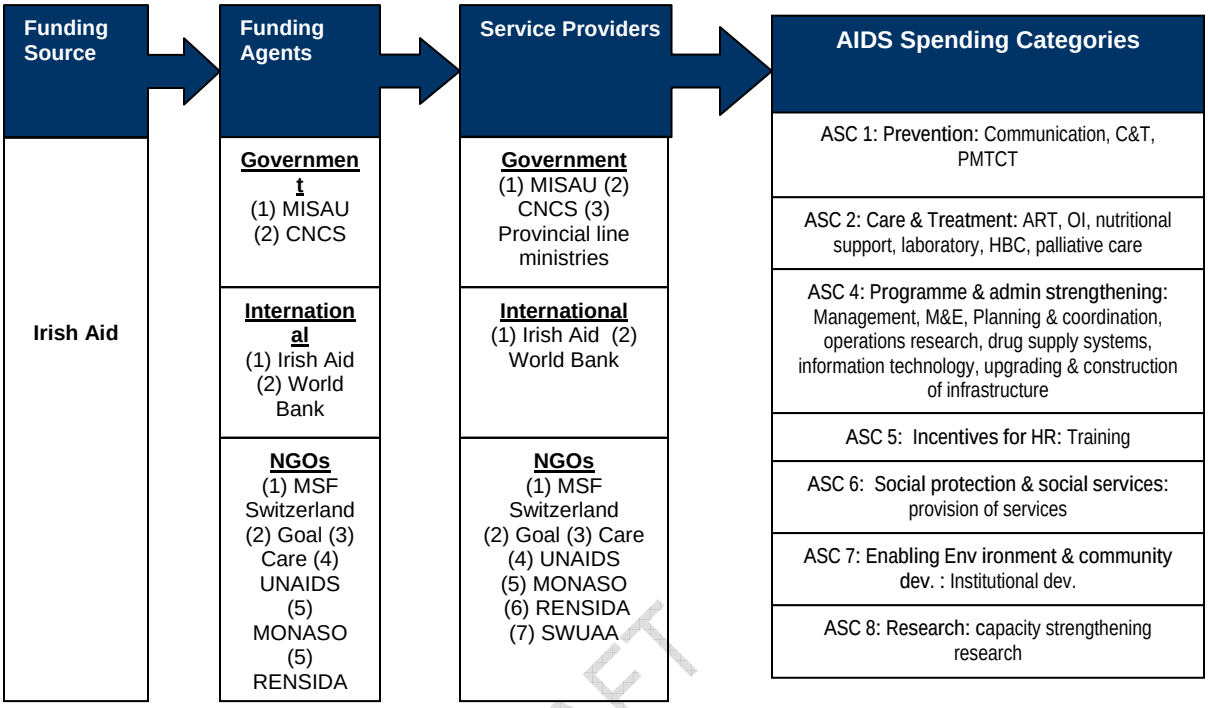

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Figure 36: CDC HIV and AIDS Funding Flows, Mozambique NASA 2004-2006

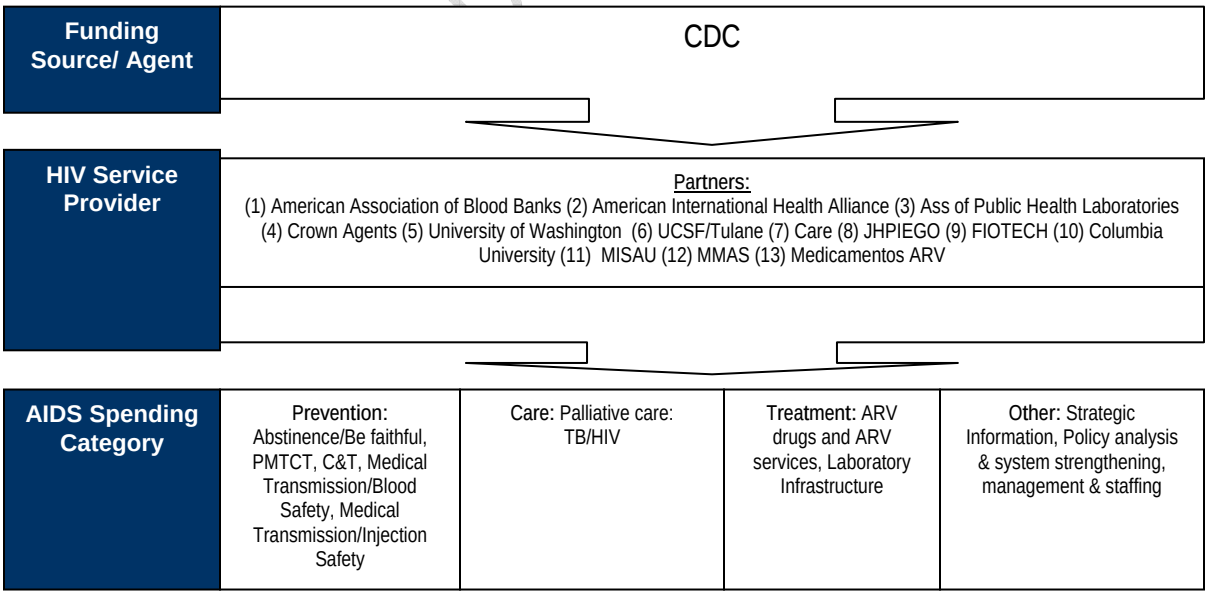


Figure 37: USAID HIV and AIDS financing flows, Mozambique NASA 2004-2006

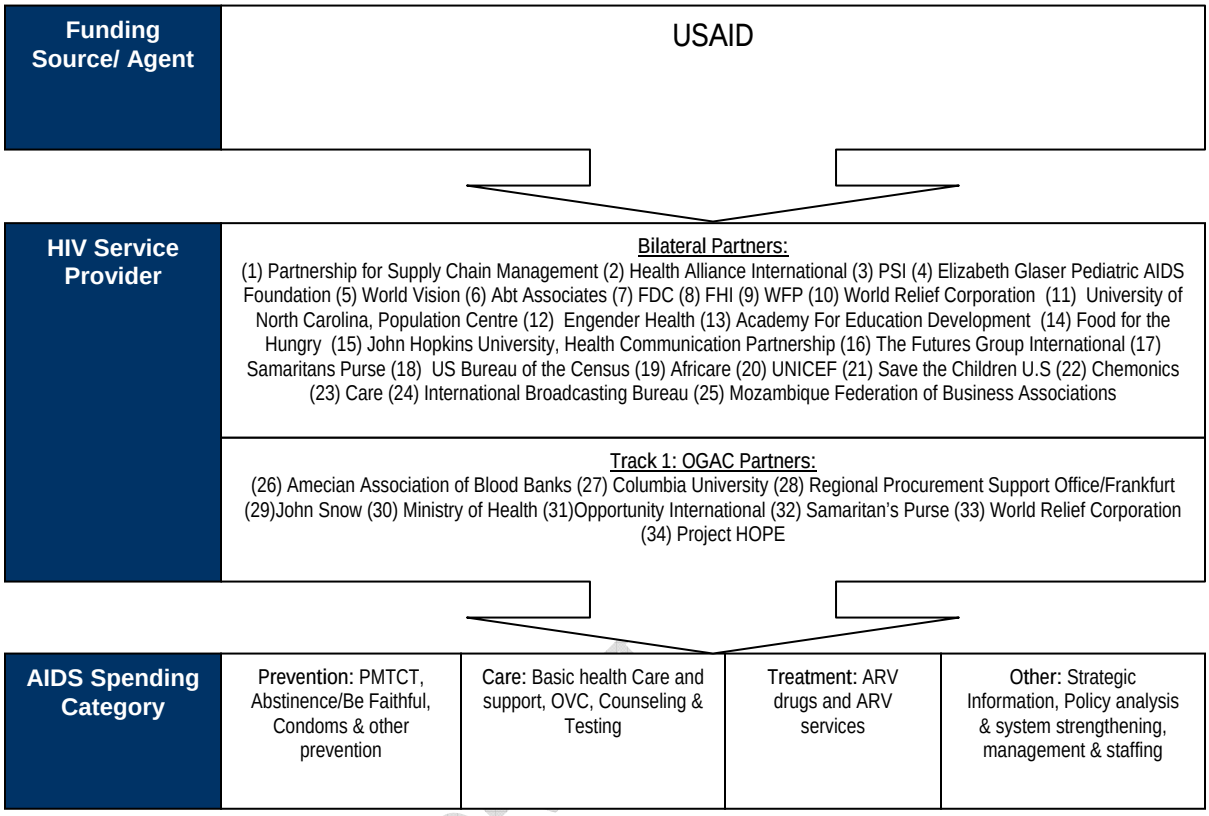


Figure 38: UNICEF HIV and AIDS financing flows, Mozambique NASA 2004-2006

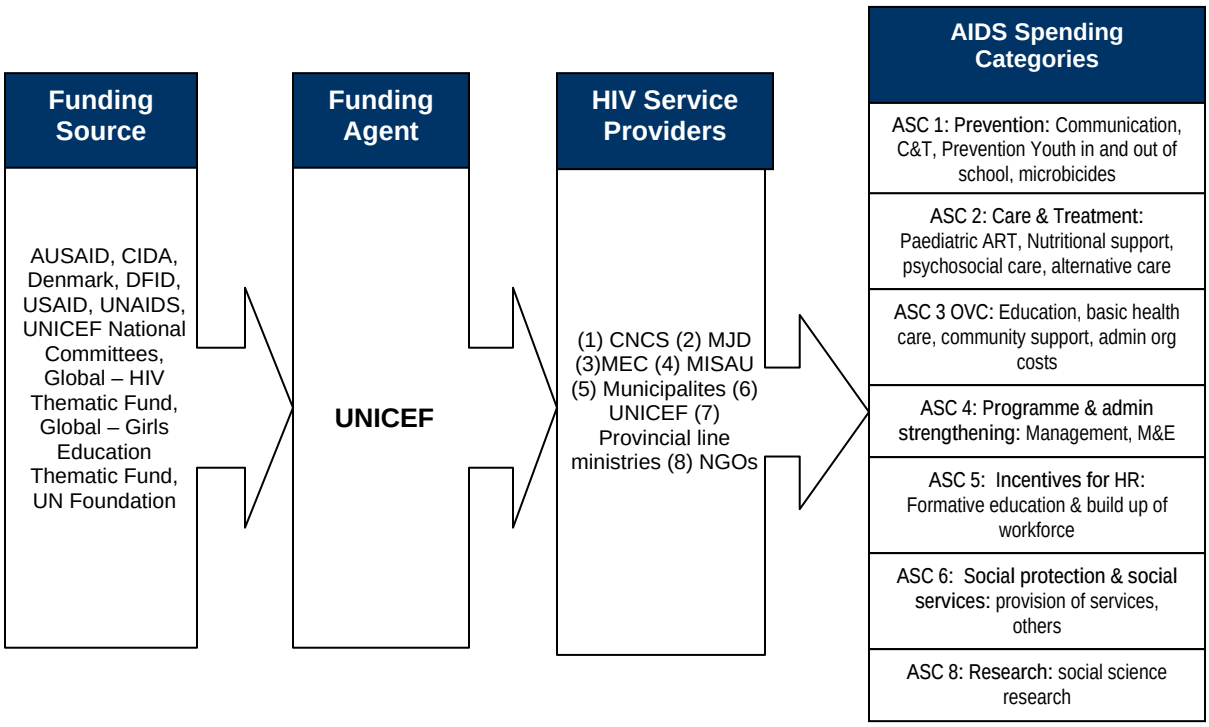
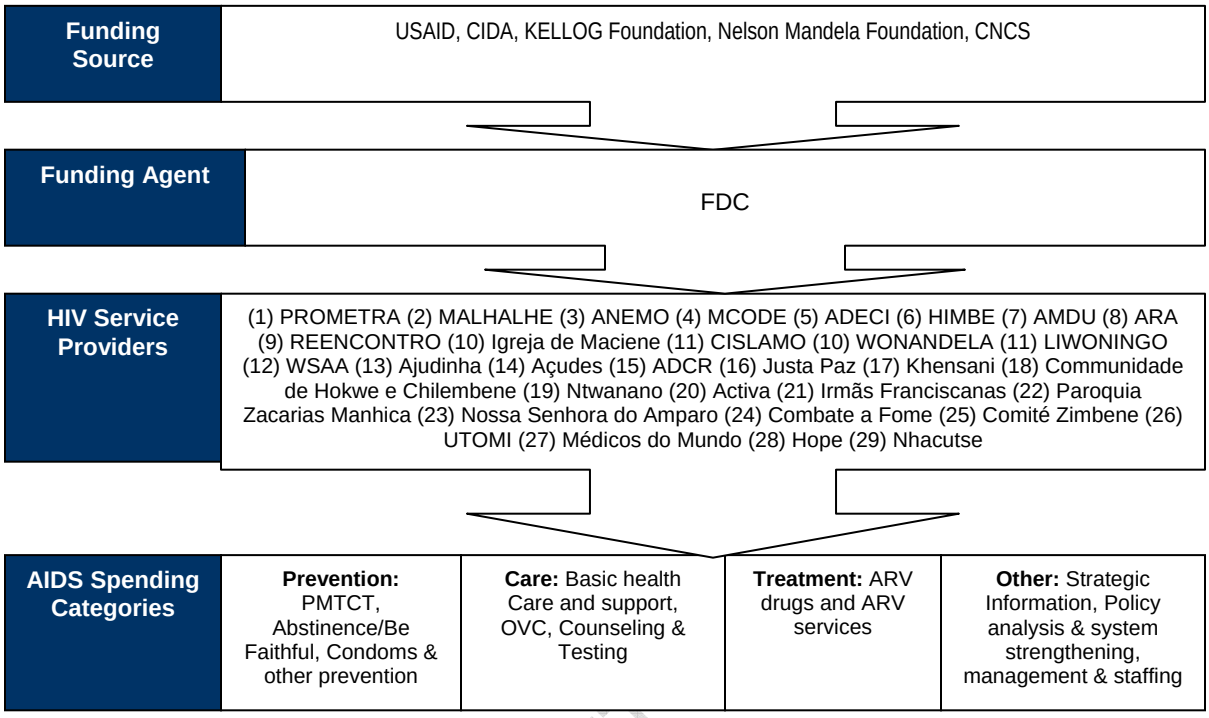


Figure 39: FDC HIV and AIDS Financial Flows, Mozambique NASA 2004-2006



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Appendix 9: Mozambique Financing Source - Service Provider, 2004

	Funding Source												
Provider	FS.1.1.1.1	FS.1.1.1.10	FS.1.1.1.99	FS.1.4	FS.1.99	FS.2.2	FS.2.3	FS.2.4	FS.2.99	FS.3.1.	FS.3.2.	FS.3.3.	Grand Total
PS.1.1.1:	210,079	0	0	0	0	0	0	0	889,930	4,475,189	153,154	997,642	6,725,994
PS.1.13.	3,648,269	0	3,177,622	0	0	0	0	0	0	2,636,014	4,977,196	2,708,936	17,148,037
PS.1.2.1	154,450	0	0	0	0	0	0	0	0	0	0	0	154,450
PS.1.3	0	0	0	0	0	0	0	0	0	160,181	0	0	160,181
PS.1.9.3	0	0	0	0	0	0	0	0	0	0	0	78,462	78,462
PS.2.11	0	128,608	0	0	0	0	0	0	950,986	10,736,641	2,562,464	1,515,954	15,894,653
PS.2.8.3	0	0	7,269	0	0	0	0	0	242,943	0	0	0	250,212
PS.2.99	0	0	0	0	0	0	0	0	0	1,474,790	0	0	1,474,790
PS.3.99	0	0	0	0	0	0	0	0	37,000	0	0	0	37,000
PS.4.2	0	0	0	0	0	0	0	0	180,368	1,936,283	4,463,456	0	6,580,107
Total	4,012,798	128,608	3,184,891	0	0	0	0	0	2,301,227	21,419,098	12,156,270	5,300,994	48,503,886

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Appendix 10:Mozambique Financing Source - Service Provider, 2005

	Funding Source												
Provider	FS.1.1.1.1	FS.1.1.1.10	FS.1.1.1.99	FS.1.4	FS.1.99	FS.2.2	FS.2.3	FS.2.4	FS.2.99	FS.3.1.	FS.3.2.	FS.3.3.	Grand Total
PS.1.1.1:	4,032,375	0	438,897	0	0	0	0	0	0	3,432,085	1,386,216	1,470,630	10,760,203
PS.1.13.	0	0	0	0	0	0	0	0	0	22,082	0	0	22,082
PS.1.2.1	3,798,886	0	2,636,797	0	0	0	0	0	0	2,178,205	2,838,933	0	11,452,821
PS.1.3	0	0	0	0	0	0	0	0	0	943,800	0	0	943,800
PS.1.9.3	0	0	0	0	0	0	0	0	0	0	413,232	0	413,232
PS.2.11	0	0	0	28,588	0	0	0	0	0	0	0	0	28,588
PS.2.8.3	0	0	15,699	0	0	0	0	0	313,812	165,000	0	0	494,511
PS.2.99	0	407,594	174,598	0	0	0	126,202	0	120,861	13,551,817	10,109,555	3,022,236	27,512,863
PS.3.99	0	0	0	0	0	0	0	90,300	0	0	491,029	0	581,329
PS.4.2	0	0	0	0	0	0	0	96,000	0	0	0	0	96,000
PS.1.1.1:	0	0	0	0	0	0	0	0	0	2,619,375	0	0	2,619,375
PS.1.13.	0	0	0	0	0	0	0	0	0	1,285,905	2,782,264	0	4,068,169
Total	7,831,261	407,594	3,265,991	28,588	0	0	126,202	186,300	434,673	24,198,269	18,021,229	4,492,866	58,992,973

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Appendix 11: Mozambique Financing Source - Service Provider, 2006

	Funding Source												
Provider	FS.1.1.1.1	FS.1.1.1.10	FS.1.1.1.99	FS.1.4	FS.1.99	FS.2.2	FS.2.3	FS.2.4	FS.2.99	FS.3.1.	FS.3.2.	FS.3.3.	Grand Total
PS.1.1.1	3,259,998	30,489	0	0	0	0	0	0	0	13,753,999	5,454,564	3,215,109	25,714,159
PS.1.13.	0	1,271,137	17,255	0	36,238	0	0	0	0	7,628,798	3,326,871	140,292	12,420,591
PS.1.2.1	5,893,292	0	0	0	0	0	0	0	0	294,008	929,328	28,949	7,145,577
PS.1.9.3	0	76,924	3,585	0	0	0	0	0	0	0	242,545	0	323,054
PS.1.99	0	0	0	0	0	0	0	0	0	7,700	0	0	7,700
PS.2.11	0	3,557,582	0	0	0	0	168,821	14,625	0	19,012,617	7,053,624	2,489,764	32,297,033
PS.2.8.3	0	38,692	0	0	0	0	0	0	0	0	0	0	38,692
PS.3.10	0	0	0	0	0	0	0	188,051	0	0	0	0	188,051
PS.3.11.3	0	12,170	0	0	0	0	0	0	0	0	0	0	12,170
PS.3.7	0	0	0	0	0	519,890	0	0	0	0	0	0	519,890
PS.3.99	0	104,158	0	0	0	0	0	55,140	171,901	13,500	659,423	0	1,004,122
PS.4.1	0	0	0	0	0	0	0	0	0	3,690,421	0	0	3,690,421
PS.4.2	0	0	0	0	0	0	0	0	0	297,402	2,638,999	11,069	2,947,470
PS.99	0	0	0	0	0	0	0	0	0	16,085	10,298,763	0	10,314,848
	9,153,290	5,091,152	20,840	0	36,238	519,890	168,821	257,816	171,901	44,714,530	30,604,117	5,885,183	96,623,778

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Appendix 12: Mozambique Financing Agents - Service Provider, 2004

	Financing Agent													
HIV Service Provider	FA.1.1.1.1	FA.1.1.1.10	FA.1.1.1.99	FA.1.4	FA.1.99	FA.2.4	FA.2.5	FA.2.6	FA.2.99	FA.3.1.	FA.3.2.	FA.3.3.	FA.3.99	Grand Total
PS.1.1.1	210,079	0	0	0	0	0	0	0	889,930	0	146,829	2,997,464	2,481,692	6,725,994
PS.1.13.	4,309,270	6,904,685	0	0	0	0	0	0	0	4,476	1,835,370	4,094,236	0	17,148,037
PS.1.2.1	154,450	0	0	0	0	0	0	0	0	0	0	0	0	154,450
PS.1.3	0	0	0	0	0	0	0	0	0	0	160,181	0	0	160,181
PS.1.9.3	0	0	78,462	0	0	0	0	0	0	0	0	0	0	78,462
PS.2.11	0	1,919,265	0	0	0	0	2,418,025	0	958,798	136,557	2,752,860	7,692,111	17,037	15,894,653
PS.2.8.3	0	0	7,269	0	242,943	0	0	0	0	0	0	0	0	250,212
PS.2.99	0	0	0	0	0	0	0	0	0	0	1,474,790	0	0	1,474,790
PS.3.99	0	0	0	0	0	0	0	0	37,000	0	0	0	0	37,000
PS.4.2	0	0	0	0	0	0	0	0	0	0	6,580,107	0	0	6,580,107
	4,673,799	8,823,950	85,731	0	242,943	0	2,418,025	0	1,885,728	141,033	12,950,137	14,783,811	2,498,729	48,503,886

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Appendix 13: Mozambique Financing Agents - Service Provider, 2005

	Financing Agent													
HIV Service Provider	FA.1.1.1.1	FA.1.1.1.10	FA.1.1.1.99	FA.1.4	FA.1.99	FA.2.4	FA.2.5	FA.2.6	FA.2.99	FA.3.1.	FA.3.2.	FA.3.3.	FA.3.99	Grand Total
PS.1.1.1	4,032,375	499,621	0	0	0	0	0	0	0	0	123,080	6,105,127	0	10,760,203
PS.1.1.2	0	22,082	0	0	0	0	0	0	0	0	0	0	0	22,082
PS.1.13.	4,167,332	4,814,707	123,526	0	0	0	0	0	0	165,930	2,181,326	0	0	11,452,821
PS.1.2.1	0	0	0	0	0	0	0	0	0	0	0	943,800	0	943,800
PS.1.3	0	0	0	0	0	0	0	0	0	0	413,232	0	0	413,232
PS.1.8	0	0	0	28,588	0	0	0	0	0	0	0	0	0	28,588
PS.1.9.3	0	0	313,812	0	180,699	0	0	0	0	0	0	0	0	494,511
PS.2.11	0	7,304,731	0	0	0	0	1,835,762	0	775,873	63,625	7,803,174	9,729,698	0	27,512,863
PS.3.10	0	491,029	0	0	0	0	0	0	90,300	0	0	0	0	581,329
PS.3.99	0	0	0	0	0	0	0	0	96,000	0	0	0	0	96,000
PS.4.1	0	0	0	0	0	0	0	0	0	1,920,000	699,375	0	0	2,619,375
PS.4.2	0	0	0	0	0	0	0	0	0	0	4,068,169	0	0	4,068,169
Total	8,199,707	13,132,170	437,338	28,588	180,699	0	1,835,762	0	962,173	2,149,555	15,288,356	16,778,625	0	58,992,973

Appendix 14: Mozambique Financing Agents - Service Provider, 2006

	Financing Agent													
HIV Service Provider	FA.1.1.1.1	FA.1.1.1.10	FA.1.1.1.99	FA.1.4	FA.1.99	FA.2.4	FA.2.5	FA.2.6	FA.2.99	FA.3.1.	FA.3.2.	FA.3.3.	FA.3.99	Grand Total
PS.1.1.1	5,926,942	30,489	0	0	0	0	0	0	0	4,453,760	2,543,331	12,759,637	0	25,714,159
PS.1.13.	0	6,149,771	72,195	0	0	0	0	0	36,238	0	5,584,773	577,614	0	12,420,591
PS.1.2.1	6,916,362	0	0	0	0	0	0	0	0	0	0	229,215	0	7,145,577
PS.1.9.3	0	76,924	246,130	0	0	0	0	0	0	0	0	0	0	323,054
PS.1.99	0	0	0	0	0	0	0	7,700	0	0	0	0	0	7,700
PS.2.11	656,831	9,213,255	0	0	0	0	4,812,463	0	0	0	2,764,300	14,850,184	0	32,297,033
PS.2.8.3	0	38,692	0	0	0	0	0	0	0	0	0	0	0	38,692
PS.3.10	0	0	0	0	0	0	0	0	188,051	0	0	0	0	188,051
PS.3.11.3	0	12,170	0	0	0	0	0	0	0	0	0	0	0	12,170
PS.3.7	0	0	0	0	0	519,890	0	0	0	0	0	0	0	519,890
PS.3.99	0	748,670	0	0	0	0	0	0	255,452	0	0	0	0	1,004,122
PS.4.1	0	0	0	0	0	0	0	0	0	3,690,421	0	0	0	3,690,421
PS.4.2	0	0	0	0	0	0	0	0	0	0	2,947,470	0	0	2,947,470
PS.99	0	0	0	0	0	0	0	0	0	0	10,298,763	0	16,085	10,314,848
	13,500,135	16,269,971	318,325	0	0	519,890	4,812,463	7,700	479,741	8,144,181	24,138,637	28,416,650	16,085	96,623,778

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Appendix 15: Mozambique Beneficiary - Function, 2004

	Prevention	Care and Treatment	Orphans & Vulnerable Children (OVC)	Program Management & Adm. Strengthening	Human Resources Recruitment & Retention Incentives	Social Protection & Social Services	Enabling Environment & Community Dev	HIV and AIDS related Research	Total
People living with HIV	172,111	10,089,460	349,853	0	0	9,841	57,425	0	10,678,690
Sellers of sexual services (SW) and their clients	80,000	0	0	0	0	0	0	0	80,000
Orphans and vulnerable children (OVC)	883,842	105,812	3,283,552	0	0	0	0	0	4,273,206
Children born or to be born to HIV mothers	1,519,200	0	0	0	0	0	0	0	1,519,200
Migrants / Mobile Populations	90,000	0	0	0	0	0	0	0	90,000
Prisoners and other institutionalized persons	4,476	0	0	0	0	0	0	0	4,476
Children and youth out of the school	2,840,896	0	0	0	0	0	0	0	2,840,896
Partners of persons living with HIV	440,000	0	0	0	0	0	0	0	440,000
People attending STI clinics	2,634,261	0	0	0	0	0	0	0	2,634,261
Children in school	36,445	0	0	0	0	0	0	0	36,445
Youth at school	1,845,444	0	0	537,788	0	0	0	0	2,383,232
Factory Employees	72,800	0	0	0	0	0	0	0	72,800
General population	12,706,331	140,942	0	105,520	0	0	93,054	0	13,045,847
Not targeted interventions	40,000	0	0	5,769,878	4,461,730	0	21,127	112,098	10,404,833
Total	23,365,806	10,336,214	3,633,405	6,413,186	4,461,730	9,841	171,606	112,098	48,503,886

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Appendix 16: Mozambique Beneficiary - Function, 2005

	Prevention	Care and Treatment	Orphans & Vulnerable Children (OVC)	Program Management & Adm. Strengthening	Human Resources Recruitment & Retention Incentives	Social Protection & Social Services	Enabling Environment & Community Dev	HIV and AIDS related Research	Total
Male adults (25 years of age and over)	0	0	0	10,850	0	0	0	0	10,850
People living with HIV not-disaggregated by age or gender	50,151	8,468,833	587,140	0	0	41,794	0	0	9,147,918
Sellers of sexual services (SW) and their clients	111,422	0	0	0	0	0	0	0	111,422
Orphans and vulnerable children (OVC)	0	0	3,575,553	0	0	0	0	0	3,575,553
Children born or to be born to HIV mothers	2,175,270	0	0	0	0	0	0	0	2,175,270
Internally displaced populations (because of an emergency)	50,000	0	0	0	0	0	0	0	50,000
Migrants / Mobile Populations	160,000	0	0	0	0	0	0	0	160,000
Truck drivers / Transport workers & commercial drivers	148,322	0	0	0	0	0	0	0	148,322
Children and youth out of the school	1,993,936	0	0	0	0	0	0	0	1,993,936
Partners of persons living with HIV	50,000	0	0	0	0	0	0	0	50,000
People attending STI clinics	2,887,898	0	0	0	0	0	0	0	2,887,898
Children in school	399,624	0	0	0	0	0	0	0	399,624
Youth at school	1,464,106	0	0	0	0	0	0	0	1,464,106
University students	0	0	0	0	0	0	313,812	0	313,812
Women attending reproductive health clinics	707,683	0	0	0	0	0	0	0	707,683
Health care workers	571,703	0	0	0	0	0	0	0	571,703
Military	75,000	0	0	0	0	0	0	0	75,000
Police and other uniformed services (other than the military)	75,000	0	0	0	0	0	0	0	75,000
Factory Employees	355,988	0	0	0	155,310	0	0	0	511,298
General population not disaggregated by age or gender.	11,829,564	59,695	0	448,505	0	0	63,837	0	12,401,601
Not targeted interventions	3,257,062	4,492,211	11,767	9,884,099	3,660,301	0	95,485	505,243	21,906,168
Beneficiary populations not elsewhere classified	0	0	0	173,569	82,240	0	0	0	255,809
Total	26,362,729	13,020,739	4,174,460	10,517,023	3,897,851	41,794	473,134	505,243	58,992,973

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Appendix 17: Mozambique Beneficiary - Function, 2006

	Prevention	Care and Treatment	Orphans & Vulnerable Children (OVC)	Program Management & Adm. Strengthening	Human Resources Recruitment & Retention Incentives	Social Protection & Social Services	Enabling Environment and Community Dev	HIV & AIDS related Research	Total
People living with HIV not-disaggregated by age or gender	3,171,418	34,682,322	0	0	0	407,322	89,760	0	38,350,822
Sellers of sexual services (SW) and their clients	140,000	0	0	0	0	0	0	0	140,000
Orphans and vulnerable children (OVC)	0	359,732	7,356,543	0	0	0	0	0	7,716,275
Children born or to be born to HIV mothers	4,934,738	0	0	0	0	0	0	0	4,934,738
Migrants / Mobile Populations	316,449	0	0	0	0	0	0	0	316,449
Refugees, displaced persons and people separated from their families	70,000	0	0	0	0	0	0	0	70,000
Truck drivers / Transport workers & commercial drivers	282,122	0	0	0	0	0	0	0	282,122
Children and youth out of the school	2,366,723	0	0	0	0	0	0	0	2,366,723
Partners of persons living with HIV	78,634	0	0	0	0	0	0	0	78,634
People attending STI clinics	2,415,967	0	0	0	0	0	0	0	2,415,967
Children in school	1,314,457	0	0	0	0	0	0	0	1,314,457
Youth at school	1,580,158	0	0	0	0	0	0	0	1,580,158
University students	214,291	0	0	20,246	0	0	0	0	234,537
Health care workers	70,000	0	0	0	0	0	0	0	70,000
Military	210,000	0	0	0	0	0	0	0	210,000
Factory Employees	1,481,482	0	0	0	0	0	0	0	1,481,482
General Adult population (above 24) not discriminated by gender	173,361	0	0	0	0	0	0	0	173,361
General population not disaggregated by age or gender.	13,432,774	74,548	0	0	0	0	1,019,486	0	14,526,808
Not targeted interventions	118,231	509,398	0	14,633,708	4,827,748	1,607	237,009	33,544	20,361,245
Total	32,370,805	35,626,000	7,356,543	14,653,954	4,827,748	408,929	1,346,255	33,544	96,623,778

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Appendix 18: Mozambique Beneficiary – Service Provider, 2004

	Public Providers	Private non-profit: NGO's providers	Private for-profit providers	Bilateral and Multilateral providers	Total
People living with HIV not-disaggregated by age or gender	8,715,471	1,900,626	31,500	31,093	10,678,690
Sellers of sexual services (SW) and their clients	0	80,000	0	0	80,000
Orphans and vulnerable children (OVC)	804,232	3,457,788	0	11,186	4,273,206
Children born or to be born to HIV mothers	1,325,440	193,760	0	0	1,519,200
Migrants / Mobile Populations	0	90,000	0	0	90,000
Prisoners and other institutionalized persons	4,476	0	0	0	4,476
Children and youth out of the school	555,329	481,723	0	1,803,844	2,840,896
Partners of persons living with HIV	0	440,000	0	0	440,000
People attending STI clinics	2,634,261	0	0	0	2,634,261
Children in school	0	36,445	0	0	36,445
Youth at school	252,889	1,289,358	0	840,985	2,383,232
Factory Employees	0	67,300	5,500	0	72,800
General population not disaggregated by age or gender.	4,588,121	7,744,097	0	713,629	13,045,847
Not targeted interventions	5,386,905	1,838,558	0	3,179,370	10,404,833
	24,267,124	17,619,655	37,000	6,580,107	48,503,886

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Appendix 19: Mozambique Beneficiary – Service Provider, 2005

	Public Providers	Private non-profit: NGO's providers	Private for-profit providers	Bilateral and Multilateral providers	Total
Male adults (25 years of age and over)	0	0	0	10,850	10,850
People living with HIV not-disaggregated by age or gender	3,445,105	5,347,625	81,500	273,688	9,147,918
Sellers of sexual services (SW) and their clients	0	111,422	0	0	111,422
Orphans and vulnerable children (OVC)	400,465	2,846,588	0	328,500	3,575,553
Children born or to be born to HIV mothers	1,767,226	408,044	0	0	2,175,270
Internally displaced populations (because of an emergency)	0	50,000	0	0	50,000
Migrants / Mobile Populations	0	160,000	0	0	160,000
Truck drivers / Transport workers & commercial drivers	0	148,322	0	0	148,322
Children and youth out of the school	571,216	531,242	0	891,478	1,993,936
Partners of persons living with HIV	0	50,000	0	0	50,000
People attending STI clinics	2,887,898	0	0	0	2,887,898
Children in school	0	338,307	0	61,317	399,624
Youth at school	662,179	594,275	0	207,652	1,464,106
University students	313,812	0	0	0	313,812
Women attending reproductive health clinics	382,683	325,000	0	0	707,683
Health care workers	521,703	50,000	0	0	571,703
Military	0	75,000	0	0	75,000
Police and other uniformed services (other than the military)	0	75,000	0	0	75,000
Factory Employees	168,984	237,514	104,800	0	511,298
General population not disaggregated by age or gender.	2,571,802	9,143,085	491,029	195,685	12,401,601
Not targeted interventions	10,422,164	6,765,630	0	4,718,374	21,906,168
Beneficiary populations not elsewhere classified	0	255,809	0	0	255,809
Total	24,115,237	27,512,863	677,329	6,687,544	58,992,973

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Appendix 20: Mozambique Beneficiary – Service Provider, 2006

	Public Providers	Private non-profit: NGO's providers	Private for-profit providers	Bilateral and Multilateral providers	Providers not elsewhere classified	Total
People living with HIV not-disaggregated by age or gender	22,957,869	6,151,976	133,745	1,168	9,106,064	38,350,822
Sellers of sexual services (SW) and their clients	0	140,000	0	0	0	140,000
Orphans and vulnerable children (OVC)	1,613,019	4,910,557	0	0	1,192,699	7,716,275
Children born or to be born to HIV mothers	4,890,508	44,230	0	0	0	4,934,738
Migrants / Mobile Populations	0	316,449	0	0	0	316,449
Refugees, displaced persons and people separated from their families	0	70,000	0	0	0	70,000
Truck drivers / Transport workers & commercial drivers	104,111	178,011	0	0	0	282,122
Children and youth out of the school	1,677,443	689,280	0	0	0	2,366,723
Partners of persons living with HIV	0	73,010	5,624	0	0	78,634
People attending STI clinics	2,345,967	70,000	0	0	0	2,415,967
Children in school	540,880	773,577	0	0	0	1,314,457
Youth at school	515,401	1,034,757	0	30,000	0	1,580,158
University students	192,950	38,692	2,895	0	0	234,537
Health care workers	0	70,000	0	0	0	70,000
Military	0	210,000	0	0	0	210,000
Factory Employees	314,912	336,595	816,975	13,000	0	1,481,482
General Adult population (above 24) not discriminated by gender	0	173,361	0	0	0	173,361
General population not disaggregated by age or gender.	2,717,370	10,146,957	733,784	912,612	16,085	14,526,808
Not targeted interventions	7,740,651	6,908,273	31,210	5,681,111	0	20,361,245
Total	45,611,081	32,335,725	1,724,233	6,637,891	10,314,848	96,623,778

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Appendix 21: Mozambique Beneficiary – Service Provider - Function, 2004

Beneficiary populations and Service providers	Prevention	Care and Treatment	Orphans & Vulnerable Children (OVC)	Program Management and Adm. Strengthening	Human Resources Recruitment & Retention Incentives	Social Protection and Social Services	Enabling Environment and Community Development	HIV and AIDS related Research	Total
People living with HIV (regardless of having a diagnosis of AIDS)	172,111	10,089,460	349,853	0	0	9,841	57,425	0	10,678,690
Public providers	126,677	8,588,794	0	0	0	0	0	0	8,715,471
Private non-profit: NGO	45,434	1,469,166	349,853	0	0	9,841	26,332	0	1,900,626
Private for-profit	0	31,500	0	0	0	0	0	0	31,500
Bilaterals and Multilateral providers	0	0	0	0	0	0	31,093	0	31,093
Most at risk populations and key populations at higher risk	80,000	0	0	0	0	0	0	0	80,000
Private non-profit: NGO	80,000	0	0	0	0	0	0	0	80,000
Other key populations at high risk	5,778,414	105,812	3,283,552	0	0	0	0	0	9,167,778
Public providers	1,885,245	0	804,232	0	0	0	0	0	2,689,477
Private non-profit: NGO	2,089,325	105,812	2,468,134	0	0	0	0	0	4,663,271
Bilaterals and Multilateral providers	1,803,844	0	11,186	0	0	0	0	0	1,815,030
Specific “accessible” populations	4,588,950	0	0	537,788	0	0	0	0	5,126,738
Public providers	2,887,150	0	0	0	0	0	0	0	2,887,150
Private non-profit: NGO	855,315	0	0	537,788	0	0	0	0	1,393,103
Private for-profit	5,500	0	0	0	0	0	0	0	5,500
Bilaterals and Multilateral providers	840,985	0	0	0	0	0	0	0	840,985
General population	12,706,331	140,942	0	105,520	0	0	93,054	0	13,045,847
Public providers	4,368,717	140,942	0	0	0	0	78,462	0	4,588,121
Private non-profit: NGO	7,636,180	0	0	105,520	0	0	2,397	0	7,744,097
Bilaterals and Multilateral providers	701,434	0	0	0	0	0	12,195	0	713,629
Not targeted interventions	40,000	0	0	5,769,878	4,461,730	0	21,127	112,098	10,404,833
Public providers	0	0	0	2,739,096	2,582,407	0	0	65,402	5,386,905
Private non-profit: NGO	40,000	0	0	1,505,880	292,678	0	0	0	1,838,558
Bilaterals and Multilateral providers	0	0	0	1,524,902	1,586,645	0	21,127	46,696	3,179,370
Total	23,365,806	10,336,214	3,633,405	6,413,186	4,461,730	9,841	171,606	112,098	48,503,886

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Appendix 22: Mozambique Beneficiary – Service Provider - Function, 2005

Beneficiary populations and Service providers	Prevention	Care and Treatment	Orphans & Vulnerable Children	Program Management and Adm. Strengthening	Human Resources Recruitment & Retention Incentives	Social Protection & Social Services	Enabling Environment & Community Development	HIV and AIDS related Research	
People living with HIV (regardless of having a diagnosis of AIDS)	50,151	8,468,833	587,140	10,850	0	41,794	0	0	9,158,768
Public providers	0	3,445,105	0	0	0	0	0	0	3,445,105
Private non-profit: NGO	50,151	4,668,540	587,140	0	0	41,794	0	0	5,347,625
Private for-profit	0	81,500	0	0	0	0	0	0	81,500
Bilaterals and Multilateral providers	0	273,688	0	10,850	0	0	0	0	284,538
Most at risk populations and key populations at higher risk	111,422	0	0	0	0	0	0	0	111,422
Private non-profit: NGO	111,422	0	0	0	0	0	0	0	111,422
Other key populations at high risk	4,577,528	0	3,575,553	0	0	0	0	0	8,153,081
Public providers	2,338,442	0	400,465	0	0	0	0	0	2,738,907
Private non-profit: NGO	1,347,608	0	2,846,588	0	0	0	0	0	4,194,196
Bilaterals and Multilateral providers	891,478	0	328,500	0	0	0	0	0	1,219,978
Specific "accessible" populations	6,537,002	0	0	0	155,310	0	313,812	0	7,006,124
Public providers	4,606,577	0	0	0	16,870	0	313,812	0	4,937,259
Private non-profit: NGO	1,556,656	0	0	0	138,440	0	0	0	1,695,096
Private for-profit	104,800	0	0	0	0	0	0	0	104,800
Bilaterals and Multilateral providers	268,969	0	0	0	0	0	0	0	268,969
General population	11,829,564	59,695	0	448,505	0	0	63,837	0	12,401,601
Public providers	2,416,550	8,302	0	138,657	0	0	8,293	0	2,571,802
Private non-profit: NGO	8,734,145	51,393	0	309,848	0	0	47,699	0	9,143,085
Private for-profit	491,029	0	0	0	0	0	0	0	491,029
Bilaterals and Multilateral providers	187,840	0	0	0	0	0	7,845	0	195,685
Not targeted interventions	3,257,062	4,492,211	11,767	9,884,099	3,660,301	0	95,485	505,243	21,906,168
Public providers	724,839	3,772,715	0	4,230,548	1,694,062	0	0	0	10,422,164
Private non-profit: NGO	2,514,823	719,496	4,074	2,761,606	682,175	0	83,456	0	6,765,630
Bilaterals and Multilateral providers	17,400	0	7,693	2,891,945	1,284,064	0	12,029	505,243	4,718,374
Beneficiary populations not elsewhere classified	0	0	0	173,569	82,240	0	0	0	255,809
Private non-profit: NGO	0	0	0	173,569	82,240	0	0	0	255,809
Total	26,362,729	13,020,739	4,174,460	10,517,023	3,897,851	41,794	473,134	505,243	58,992,973

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Appendix 23: Mozambique Beneficiary – Service Provider - Function, 2006

Beneficiary populations and Service providers	Prevention	Care and Treatment	Orphans & Vulnerable Children	Program Management and Adm. Strengthening	Human Resources Recruitment & Retention	Social Protection & Social Services	Enabling Environment & Community Development	HIV & AIDS related Research	Total
People living with HIV	3,171,418	34,682,322	0	0	0	407,322	89,760	0	38,350,822
Public providers	1,241,708	21,626,401	0	0	0	0	89,760	0	22,957,869
Private non-profit: NGO	1,929,178	3,815,476	0	0	0	407,322	0	0	6,151,976
Private for-profit	532	133,213	0	0	0	0	0	0	133,745
Bilaterals and Multilateral providers	0	1,168	0	0	0	0	0	0	1,168
Other Providers	0	9,106,064	0	0	0	0	0	0	9,106,064
Most at risk populations and key populations at higher risk	140,000	0	0	0	0	0	0	0	140,000
Private non-profit: NGO	140,000	0	0	0	0	0	0	0	140,000
Other key populations at high risk	8,048,666	359,732	7,356,543	0	0	0	0	0	15,764,941
Public providers	6,672,062	359,732	1,253,287	0	0	0	0	0	8,285,081
Private non-profit: NGO	1,370,980	0	4,910,557	0	0	0	0	0	6,281,537
Private for-profit	5,624	0	0	0	0	0	0	0	5,624
Other Providers	0	0	1,192,699	0	0	0	0	0	1,192,699
Specific "accessible" populations	7,286,355	0	0	20,246	0	0	0	0	7,306,601
Public providers	3,889,864	0	0	20,246	0	0	0	0	3,910,110
Private non-profit: NGO	2,533,621	0	0	0	0	0	0	0	2,533,621
Private for-profit	819,870	0	0	0	0	0	0	0	819,870
Bilaterals and Multilateral providers	43,000	0	0	0	0	0	0	0	43,000
General population	13,606,135	74,548	0	0	0	0	1,019,486	0	14,700,169
Public providers	2,202,624	74,548	0	0	0	0	440,198	0	2,717,370
Private non-profit: NGO	9,743,530	0	0	0	0	0	576,788	0	10,320,318
Private for-profit	733,784	0	0	0	0	0	0	0	733,784
Bilaterals and Multilateral providers	910,112	0	0	0	0	0	2,500	0	912,612
Other Providers	16,085	0	0	0	0	0	0	0	16,085
Not targeted interventions	118,231	509,398	0	14,633,708	4,827,748	1,607	237,009	33,544	20,361,245
Public providers	0	492,398	0	4,716,461	2,500,059	0	5,042	26,691	7,740,651
Private non-profit: NGO	118,231	0	0	5,949,310	680,552	1,607	158,573	0	6,908,273
Private for-profit	0	17,000	0	7,357	0	0	0	6,853	31,210
Bilaterals and Multilateral providers	0	0	0	3,960,580	1,647,137	0	73,394	0	5,681,111
	32,370,805	35,626,000	7,356,543	14,653,954	4,827,748	408,929	1,346,255	33,544	96,623,778

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