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| Funding Request Form |
| Full Review |
| Allocation Period 2023-2025 |
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# **Summary Information**

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| Country(s) | Mozambique |
| Component(s) | Malaria & RSSH |
| Planned grant start date(s) | 01 Jan 2024 |
| Planned grant end date(s) | 31 Dec 2026 |
| Principal Recipient(s) | PR1: Ministry of Health of Mozambique  PR2: World Vision International  Fundação para o Desenvolvimento da Comunidade (FDC)  Centro de Colaboração em Saúde (FDC) |
| Currency | USD |
| Allocation Funding Request Amount | **Malaria: $190,318,587**  *RSSH contribution from allocation***:** *$17,679,869 (8.5%)*  **RSSH: $65,496,112** *(8.5% from all allocations)*  **RSSH including matching: $72,496,112**  ***Total: $255,814,699*** *(+$7M in matching funds in budget)*  ***Total inc. matching: $262,814,699*** |
| Prioritized Above Allocation Request (PAAR) Amount | **Malaria PAAR:** USD 106,567,238  **RSSH PAAR:** USD 55,418,438  ***Total: $161,985,676*** |
| Matching Funds Request Amount  (if applicable) | **RSSH Innovation Fund**: $7.0M |

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# Funding Request and Rationale

## Prioritized Request

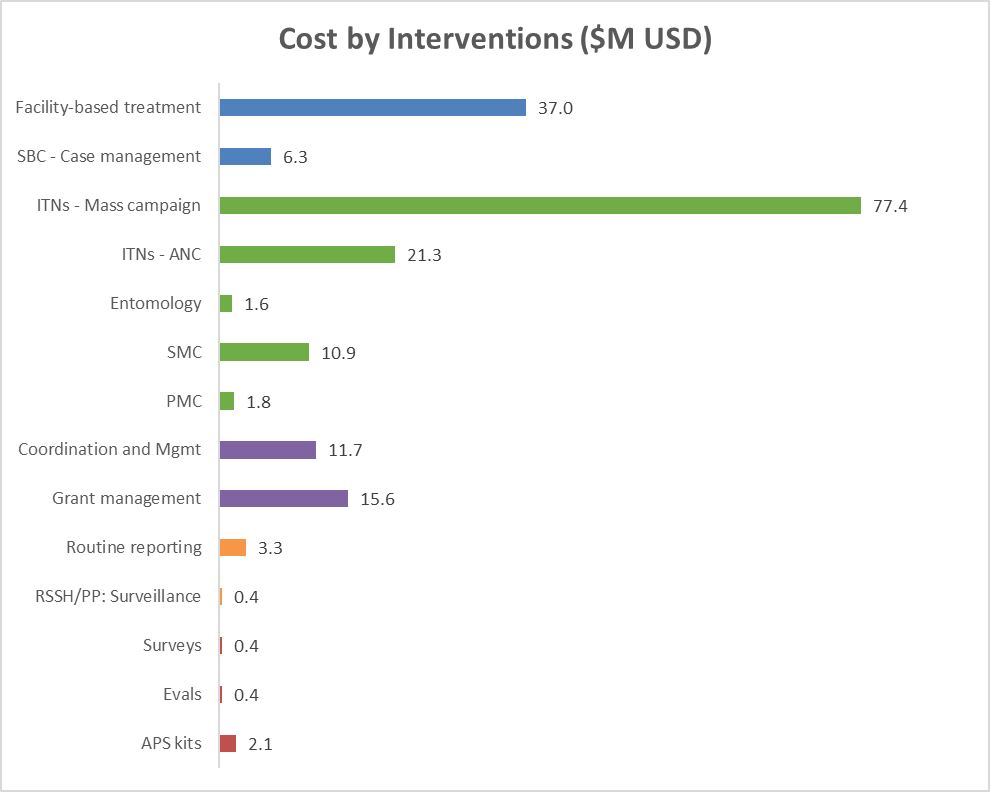
* + 1. For each module, provide information on the funding being requested from the Global Fund, and what is expected to be achieved as a result of the Global Fund’s investment.

The main allocation activities are summarized below be module and interventions.

Table 1: Malaria budget summary by module, main allocation



Figure 1: Malaria budget summary by intervention, main allocation



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| **MODULE** **1** | **CASE MANAGEMENT** |
| **Intervention(s)** | **Intervention:** Facility-based treatment and integrated community case management (iCCM) [planned and quantified together]  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Intervention:** Social and behavior change (SBC)  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | The entire population of Mozambique requires access to quality malaria case management services. Routine supportive supervision and training will be prioritized to the lowest performing areas using data on quality of care. For SBC, women of reproductive age in rural areas constitute a category of interest given the evidence of low complete information concerning malaria prevention, in particular those who speak non-dominant local languages and migrant women coming from other countries.[[1]](#footnote-2)  The primary barriers to access to malaria diagnosis and treatment services relate to the general inequities arising from location (rural/urban) and socioeconomic status. These issues are addressed in this funding request, with particular emphasis on improving care-seeking behavior and quality of care at the community and health facility levels, which has seen substantial improvements over the past decade through improvements in infrastructure and revitalization of the Community health worker (APS) program. In the course of the implementation of this funding request, NMCP will ensure commodities are distributed to all health facilities and to the APSs in order to reach the populations in the rural areas with limited access to health facilities. National Malaria Control Program (NMCP) will also ensure regular supplies of commodities to the health facilities serving IDPs, with particular emphasis on emergency response in Cabo Delgado (as well as other geographies as emergency needs evolve). By doing so, we consider a portion of the provision of investment in commodities to be investment in responding to this emergency.  Reliability and speed of funding flow for supervisions has been a chronic challenge that has affected the implementation of this important activity. Continued action to solve this is critical to achiving the objectives. IEC/BCC messaging will continue to support the importance of addressing gender norms and ensuring that there is equity in the uptake of malaria interventions. SBC will use the existing community structures as a platform for raising awareness on health rights. While this intervention and its activities are included in the Case Management module, it should be noted that this IEC/BCC messaging will include all malaria messages including those seeking to improve uptake of prevention tools. |
| **List of activities** | **Intervention:** Facility-based treatment and integrated community case management (iCCM) [planned and quantified together]    Key activities under this intervention include:   * **Uncomplicated malaria treatment -** In this funding request, a request is made for the procurement and distribution of ACTs, costing **$13,440,566**.   + Contributions by other sources are detailed at the end of the module. This quantity of anti-malaria medicines will ensure that there is no gap of ACTs for treatment of uncomplicated malaria at health facilities or community level. Given the threat of artemisinin and partner drug resistance, Mozambique is developing a plan to introduce multiple first-line ACT treatments (artesunate-pyronaridine or DHA-piperaquine) as the first-line at community level. It will be piloted in 2025 in Manica Province through PMI support. Under the assumption that the price will be reduced, this will be progressively expanded to more provinces using shared funding from GF and PMI.   + **PAAR:** While scaling of this drug is planned within allocation, the current GF reference price for AS-PY and DHAP is 4-5x the price of artemether-lumefantrine, which will be unaffordable unless reaching close to parity with AL. To manage the risk that the price will not be reduced, the difference between the AS-PY reference price and the cost of AL for the desired quantity following pilot is included in PAAR at a total cost of **$6,626,873.** * **Severe malaria treatment** - To support the management of severe malaria cases at the health facility level, a request is made for the procurement and distribution of **injectable Artesunate** doses costing **$2,531,862**, after accounting for the substantial contribution of PMI and the Government of Mozambique. **Rectal artesunate** will also be procured and distributed for use by APSs for the pre-referral treatment of severe malaria, at a cost of **$107,390**, after accounting for for the contribution of PMI. The APS program will continue to improve referral systems to ensure effectiveness of RAS.   + **Mortality audits** will continue to be supported periodically through this grant in 2024 and 2026, following on from the audit conducted in NFM3 – allowing continuous monitoring of progress. It will thoroughly review malaria deaths (and other severe malaria cases) to determine the key causes of malaria mortality, as well as monitor the quality of severe malaria case management, and solve these challenges. Total 3-year cost = **$651,008** * **Rapid diagnostic tests -** We propose the procurement and distribution of **Malaria Rapid Diagnostic Tests (mRDTs)** to cover public health facilities and the APSs across the country, at a cost of **$6,354,543.** Supplementing the substantial support of PMI, this will ensure adequate quantity of mRDTs for the confirmation of malaria diagnosis at health facilities and in the community throughout the grant period. * **Malaria laboratory services -**    + Laboratory equipment and consumables will be procured to ensure the quantified needs are available at all levels, as detailed in the budgeted list. A laboratory needs assessment was conducted prior to the NFM3 grant, and some of these needs procured in 2023, however gaps still remain which are represented by the budgeted equipment list.     - Equipment includes microscopes, balances for weighing chemicals, distillation equipment, heaters for drying slides, PH indicators, and tally counters. 3-year cost = **$745,313**     - 100% of the required laboratory consumables will be procured through this funding request, at a 3-year cost of **$3,823,275**   + Training and QA/QC activities hold a 3-year cost of **$462,667**. These activities will ensure that the procurement of required equipment and consumables is complemented by the availability of trained microscopists with strong EQA. Both of the below QA/QC activities represent an opportunity for a larger integrated approach together with HIV/TB and general clinical laboratory services. While this has yet to be operationally planned, we commit to exploring this possibility in order to unlock operational and budgetary efficiencies. As such the above budgeted amount should be considered conservative, and will likely yield savings in grant making or implementation that can be applied to critical PAAR activities.     - Diagnostic QA/QC (slide EQA, RDT lot testing) will be conducted in collaboration with INS to ensure microscopy quality is routinely assessed, and RDT quality remains high. RDT proficiency testing will be conducted as part of supportive supervision and mentoring mentioned below.     - External Competency Assessment Malaria Microscopy (ECAMM) training of expert microscopists will be increased in order to decentralize training capacity and allow for increased coverage of routine QA/QC. Training of district-level microscopists will be conducted by WHO certified microscopists. * **Innovative approach to digitally-enhanced integrated supportive supervisions**   + Frequent supportive supervision and on-site mentorship at health facilities and community-level APS will be conducted, with the objective improving case management quality, at a total of **$3,592,590**. Supervisions will be done twice per year from the central level to provinces, twice per year from province to district, and three times per year from district to health facility. These supervisions to health facilities integrate case management, stock, data quality, and malaria-in-pregnancy related services; and at district and province level additionally include supervision of prevention activities, SBCC, and data use.   + Procurement of 13 double cab 4x4 vehicles (one for each province and two for central level) are requested to ensure reliable transportation for conducting supervision visits. A comprehensive needs assessment at province level will be conducted prior to procurement, to ensure efficiency across programs at this level. Total 3-year costs = **$680,641**   + This activity will be coordinated through **trimesterly integrated supervision review meetings** in each district to review data and set priorities based on progress toward targets. Intra-office, structured district data review will be conducted more frequently at all levels, however will not incur additional costs to this funding request. Total 3-year costs = **$4,553,084**   + This cross-intervention activity has been placed in this module, rather than other potential ones, to emphasize the impact that strong implementation is expected to have on the quality of case management services. Additionally we felt it preferrable to emphasize the *mentorship/on-site training* actions as the primary purpose of the activity, thus placed in this module, rather than the data systems/use which while important are merely a means to better target these quality of care improvement actions. While opportunities for integration with non-malaria needs will be explored, it will be explored cautiously so as not to dilute the focus on action versus simply completing a checklist, which is a risk as more elements are added.   + This activity will build on the use of the supervision digital tool, built within the iMISS data repository, which collects data using standardized checklists for each service area, generates automated findings, and support development of action plans based on those findings. This allows follow up of the findings to target improvements of specific weak areas, as well as strengthens data-driven planned to target supervision to low-performing facilities for more frequent mentoring to drive improvement. The budget for these integrated services is included in this module, but this investment equally supports those interventions under the *RSSH: Routine reporting* and *Specific Prevention Interventions (SPI)* modules. * **Trainings**   + Continuation of the current mHealth approach to conduct training for health workers on case management (in development with MISAU’s National Department of Training) has at 3-year cost of **$75,000.**   + This cost caters for the development and updating of the curriculum as required.   + All facility-level health workers are targeted for these trainings, but digitized supervision data and user data from the mHealth module will be used to target supervisions and on-site mentorship to facilities with poor performance or without connectivity. Budget to conduct this is integrated within the supervision budget, requiring no additional budget here. |
| **Intervention:** Social and behavior change (SBC)  Key activities under this intervention include:   * **SBCC activities** will be conducted in all high priority districts of the country, with the following package of interventions:   + Training of all existing community health structures (CHS) which are formalized committees made up of community leaders, religious leaders, APS, teachers, and other activists influential in communities   + Training for teachers in all district primary schools   + Community radio programming   Messaging will focus on improving community knowledge of malaria, and demand generation to improve malaria service uptake (for case management as well as the various malaria prevention interventions). Age and sex-disaggregated epidemiological data, which will be improved at no specific cost to this grant, will be used to refine messaging to high risk groups.  Two key lessons have been learned during the current implementation, which will result in a refinement in strategy:   1. The targeting of specific districts for SBCC has led to gaps in activities within non-targeted but important high burden provinces. To maximize value-for-money in SBCC, decisions on prioritization of time will be done by CSO partners during the implementation based on data on burden, intervention uptake, and other data. 2. The operational intensity of ITN campaign activities has often resulted in the lack of SBCC focus after the campaign; to resolve this, implementation arrangements will be explored to ensure focus on both ITN distribution and SBCC is maintained. Collaborative workplanning will be done with each CSO partner –including staffing structure discussions, to ensure that balance in focus can be achieved for these two important activities.   The implementation approach going forward is still being deliberated upon, however looks to account for these lessons, and is committed to be finalized by the SBCC TWG by December 2023. Total 3-year cost will be **$5,093,017**.   * Following experimentation with **cell phone-based SBCC** campaigns during the current grant, we will continue to use a combination of communication methods with cell phone technology, namely:   + Targeted malaria messaging campaign, utilizing Interactive Voice Response and text messaging, given relatively low literacy rates in the country   + Continued use of a 3-2-1 National Information Service for malaria SBCC, including both static messages and gamified content   + Total 3-year cost will be **$1,238,733** |
| **Amount requested** | **Within allocation: $43,349,690**  **PAAR: $6,626,873** |
| **Complementary funding and partner support** | The contributions of PMI and Government to the commodities under this module are summarized in Table 2, noting that these are inclusive of facility and community level needs. Operational costs for APS (e.g. training and supervision) continue to be funded primarily through the World Bank.  Table 2: Case management commodity needs and funding by source[[2]](#footnote-3)    Given the increasing threats posed by artemisinin resistance and Plasmodium falciparum HRP 2/3 gene deletion across Africa, PMI has committed to additional funding for therapeutic efficacy and HRP 2/3 gene deletion surveillance efforts and development of a response plan. These efforts to monitor key biological threats has existing budgetary support from WHO, as well as the GenMoz genetic surveillance efforts being carried by CISM with financial support from the Bill and Melinda Gates Foundation. |
| **Expected outcome** | The timely diagnosis and treatment of cases according to national guidelines, enabled by continuous commodity supply and well-capacitated health workers, will lead to a reduction in severe malaria and deaths, and improve the sensitivity of the routine surveillance system. |

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| **MODULE 2** | **VECTOR CONTROL** |
| **Intervention(s)** | **Intervention:** Insecticide treated nets (ITNs) - mass campaign: universal  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Intervention:** Insecticide treated nets (ITNs) - continuous distribution: ANC  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Intervention:** Indoor residual spraying (IRS)  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☐ Continuation, or ☒ Scale-down |
| **Intervention:** Entomological monitoring  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Intervention:** Other vector control measures  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | Per national policy, LLINs are the primary vector control measure used in Mozambique, which are now recommended to be next-generation LLINs for areas not implementing IRS due to widespread pyrethroid resistance. IRS supplements this coverage (a) for purposes of insecticide resistance management; and (b) in elimination-targeted areas such as southern Mozambique. Globally, limited information is known about the incremental impact of IRS in areas with high coverage and use of dual-AI ITNs – so as mentioned above, this policy may be reviewed based on evidence generated locally or in other countries.  As LLINs are the primary vector control tool used in Mozambique, the vast majority of the population is targeted for coverage. In order to optimize resources for impact, prioritization of prevention tools was done as part of the stratification exercise with those outputs described in section 1.2. As described there, targeted LLINs to provincial capitals were placed as a lower priority than higher risk rural areas and thus due to budget constraints are included in PAAR (except for Pemba, which was given special attention due to the number of informally settled IDPs). Distribution of LLINs through ANC visits to target pregnant women and infants is done in all areas.  For LLINs barriers and inequities have been categorized into 3 categories, with mitigation measures included below for each:   * Geographical barriers: Some people fail to access ITNs because they reside in hard-to-reach areas, and there have been challenges with measurement of coverage in the past. This will be mitigated by:   + Digitization of the ITN campaign, begun in 2022 with support of C19RM funding, to improve the management and measurement of campaign coverage outcomes.   + Validation of coverage measurements, and improved management of population geo-registries from the 2022/23 campaign, to improve coverage accuracy and thus reach in hard-to-reach areas. These geo-registries will be regularly updated as new data is available (e.g. following a campaign), with the aim of providing a “single source of truth” for all health campaigns in the country. Systems and procedures for these routine updates are under development through collaboration of DIS and DNSP at MISAU, and the Spatial Development Agency (ADE) as the manager of common geo-registries across all government agencies.   + More involvement of local leaders in planning and implementation of campaigns. * Cultural practices, social norms, and misconceptions with respect to ownership and utilization of nets that will be addressed by:   + Community leaders’ engagement to address and mitigate these misconceptions.   + Intensified community mobilization before, during and after household registration and distribution.   + Engaging civil society and community partners to address gender and cultural inequities (ensuring implementers are thoroughly capacitated with the tools to address these issues)   + Continuous distribution of ITNs through ANCs targeting the pregnant women throughout the country * Pyrethroid resistance has been documented in the vast majority of the country, and is a major source of ineffectiveness that it limits the community’s protection when using the primary prevention measure deployed in the country. This will be mitigated by:   + Deployment of next-generation ITNs, which are shown to be highly impactful when challenges with durability are overcome   + Targeted usage of IRS to manage insecticide resistance   + Strengthened entomological surveillance to monitor resistance and provide data to drive strategy revision when necessary |
| **List of activities** | **Intervention:** Insecticide treated nets (ITNs) - mass campaign: universal  Key activities under this intervention include:   * A total of **15,018,935** ITNs will be procured, shipped and distributed over the grant period. Total 3-year cost is **$77,372,941**.   + ITN quantification utilized data from the past 3 campaigns to analyze variance from official INE population projections, to ensure challenges with under-quantification were solved. Budget constraints forced this variance amount into PAAR, as detailed in the referenced LLIN quantification worksheet. This variance is essential to be funded prior to 2025/26 distribution – total need in this highest-risk category equals 18,001,829 ITNs at a cost of $92,652,751.   + Key distribution-related activities to be supported by this funding request will include:     - Macro and microplanning, coordination and budgeting at both national and district level; the logistics of ITN distribution including warehousing, transportation to distribution sites and waste management. Training at district and community levels will be conducted for the health workers and communities involved in the distribution. Community sensitization and engagement of the community, including the distribution of communication materials will be prioritized. Finally, the program will seek collaboration with the Ministry of Environment and private plastics companies for opportunities to manage packaging waste at no cost to the program - as has been successfully started with the current IRS program.     - During and following the Covid-19 pandemic, a door-to-door distribution method has been adopted which has been preferred by community members, has not increased budgetary expenditure, and is perceived as achieving superior coverage results (though quantitative attribution is challenging). For these reasons, this door-to-door methodology is planned to continue. During Strategic Planning, alternative distribution methods were considered – including increasing distribution channels e.g. school-based – however cost scenarios adapted using [information from previous pilots](https://pmivectorlink.org/wp-content/uploads/2021/05/PMI-VectorLink-School-Based-ITN-Distribution-Exemplar.pdf) did not yield any scenario where continuous distribution ($1.81 - $3.89/ net distributed operational cost) was more cost-effective than campaign distribution (average of $1.22/net distributed operational cost). Nonetheless, continued piloting and OR on alternative methodologies to provide more sustained, effective coverage – at comparable costs to campaigns – will be explored to find scalable models. In particular innovations around more demand-driven replacement would be welcome in providing more targeted and efficient methods at tackling the ITN durability challenge.   + **ITN type:** Because of widespread pyrethroid resistance, the 2022/23 ITNs distributed were either dual-AI or PBO ITNs. Household prevalence evidence from the New Nets Project (NNP) and analysis of routine HMIS data, which are summarized in the MPR report as well as in section 1.2, show that both dual-AI and PBO-pyrethroid ITNs performed well in year 1 and were responsible for statistically and epidemiologically significant reductions in malaria prevalence and incidence (Royal Guard being somewhat of an exception with disappointing results). In year 2 however, the chlorfenapyr-pyrethroid nets began clearly outperforming PBO-pyrethroid nets - with NNP data showing this was largely due to chemical and physical durability issues. Given the price reductions of dual-AI products, their superior performance in durability, and the [WHO recommendation in March 2023](https://www.who.int/news/item/14-03-2023-who-publishes-recommendations-on-two-new-types-of-insecticide-treated-nets) due to these results, Mozambique will procure aim to procure all dual-AI ITNs. If global supply makes this impossible, PBO-pyrethroid ITNs will be procured under a request to GF to jointly review product durability to maximize cost-effectiveness. These results are summarized in section 1.3.   + **ITN mass distribution frequency:** Evidence from Mozambique, and many countries around the world, clearly shows that ITNs are not lasting 3 years in real-world conditions, leaving coverage gaps prior to the next distribution. Analysis done by NMCP in collaboration with CHAI and STPH indicated that a reduction to 30-month intervals for mass distribution could reduce prevalence by an additional 25% (from the predicted reduction at 3 years). This was discussed and approved by Global Fund in July 2021. Mozambique uses a phased provincial distribution method, rolling from north to south. This has no implications on the planned number of distributions for any province in the 2024-26 period. However, this decision will result in multiple distributions in the 2027-29 and 2030-32 periods for some provinces. Details of projected distribution by province are included in the LLIN quantification worksheet, and were used for projecting costs in the MSP.   + **Consideration of displaced populations:** The vast majority of internally displaced people (IDP) in Mozambique are settled informally in communities, and they along with residents of accommodation camps are covered in all major ITN campaigns - including notably in the successful campaign in Cabo Delgado Province in 2022. Funding was also reprogrammed in March 2023 following Cyclone Freddy to cover affected areas in Quelimane. For the 2025/26 mass distribution, high risk portions of Pemba have been considered in the main allocation quantification due to the high number of IDPs that need to be covered, while higher-risk sections of all other provincial capitals are included in PAAR. Should major displacement events take place in future, including due to natural disasters, it is likely that displaced populations will require ITNs to replace lost nets. While it is challenging to predict future episodes, the country realizes the necessity of creating flexible mechanisms for supplementary campaigns. The NMCP and partners will seek collaboration with humanitarian actors and the GF Emergency Fund to ensure these populations receive urgent and special attention in such crises.   + **Digitization of the campaign:** Budget is included under RSSH per modular framework guidance, with investment in digitalization of the campaign proposed to be cost-shared through other donors (i.e. hardware, trainings, and other core operational costs), with technical support from partners. An integrated approach will be taken to use a common platform to digitize all malaria campaigns, with possible expansion in future to other health campaigns (NTDs, PAV) pending good results.   **PAAR:** Due to budget constraints at the time of funding request submission, two ITN-related items have been included in PAAR – at different levels of priority:   1. “Essential” priority level ITNs – the ITN quantification utilized data from the past 3 campaigns to analyze variance from official INE population projections, to ensure challenges with under-quantification were solved. Unfortunately budget constraints forced this variance amount into PAAR, with quantification based on INE projections in the main allocation. This gap must be filled prior to 2025/26 distribution to ensure high coverage in highest-risk areas, and will be the subject of intense resource mobilization – but if those efforts are unsuccessful will revert to discussion with GF as the highest priority gap. Needs for 2025/26 equal **2,982,894 ITNs** at a cost of **$15,279,810.** 2. Provincial capital ITNs (“Moderate” priority level) - As described later, the intervention stratification identified ITNs for provincial capitals as a relatively lower priority than other preventive measures – except for the city of Pemba given the high quantity of IDPs. Given funding constraints a targeted ITN distribution to certain portions of these capitals has been placed in PAAR. This lower priority is supported by [WHO Global framework for the response to malaria in urban areas](https://www.who.int/publications/i/item/9789240061781), as well as the [WHO Guidance on the prioritization of insecticide-treated nets in situations where resources are limited](https://www.who.int/publications/i/item/9789240069428). Total needs for 2025/26 equal **993,021 ITNs** at a cost of **$5,092,944.** |
|  | **Intervention:** Insecticide treated nets (ITNs) - continuous distribution: ANC  Key activities under this intervention include:   * A total of **5,491,982** ITNs will be procured for ANC distribution across the country over the grant period at a total 3-year cost of **$21,253,970**. * All supply chain-related transportation and distribution costs will be covered by the government through the NMCP’s collaboration with the Maternal and Child Health Department. * **ITN type**: ITNs procured for ANC distribution will match those distributed through mass campaigns in each province, with plans for all nets to be dual-AI ITNs unless global supply constraints dictate the need to procure PBO ITNs. |
| **Intervention:** Indoor residual spraying (IRS)  **PAAR:** Due to budgetary constraints, the full cost of this current activity was deprioritized to PAAR. Key activities under this intervention in PAAR include:   * Within this funding request, the full cost of IRS insecticide for the currently targeted districts in Nampula and Zambezia has been placed in PAAR. Operational costs for IRS in these provinces, including IEC/BCC to drive uptake, have traditionally been covered by PMI and the Government of Mozambique. * The NMCP recognizes the risks of scaling back IRS from districts, such as those experienced in Uganda[[3]](#footnote-4), particularly with the immediate speed indicated here. It hopes that with strong coverage of dual-AI ITNs it will be possible to manage these risks. If this necessity comes to pass, a robust study (perhaps an adaption of the valuable Mopeia IRS incremental effectiveness study[[4]](#footnote-5)) will be designed to closely monitor the results, serving both as vigilance against resurgence as well as providing new evidence of the effects of such withdrawal. * Challenges have been experienced in recent years with securing Government funding for IRS in Nampula Province. While this is hoped to be resolved in future, it is a reality that the NMCP is facing an increasingly constrained fiscal space. As such, if this insecticide gap is unable to be filled and/or there are shortfalls in Government or PMI budgets for operations – IRS will unfortunately be withdrawn from these provinces.   + In addition to reducing the insecticide costs in this funding request, this has the additional effect of freeing up PMI resources previously spent on IRS operations in Zambezia – which will be spent on increasing allocation to case management commodities and the operational research mentioned below on vigilant study of the effects of IRS withdrawal. These assumptions are built into this budget. * Complementing initiatives:   + **MOSASWA:** Complementary IRS activities, including insecticide procurement, for 22 districts in Inhambane, Gaza, and Maputo provinces will continue to be supported by the MOSASWA regional GF grant and the South Africa government, in order to contribute to the regional elimination goals of South Africa, Eswatini, and southern Mozambique.   + **Emergency funding in Cabo Delgado:** Complementary IRS activities in humanitarian emergencies, such as those implemented by the MENTOR Initiative and funded by the USAID Bureau for Humanitarian Assistance in Cabo Delgado, will continue to be explored as required through those humanitarian channels.   + **Digitization of the campaign:** Budget for campaign digitization is included under RSSH per the modular framework guidance, however IRS campaigns will be digitized. An integrated approach will be taken to use a common platform to digitize all malaria campaigns, allowing for resource efficiency (e.g. device re-use) as well as operational improvement through sharing of granular population/household geo-registries. The 2022/23 ITN campaign is the first to be digitized in this way, utilizing C19RM resources, with IRS and SMC to come onboard in the future through this investment and complementary partner support. * **PAAR:** As described in the “prevention prioritization matrix” in Section 1.2, two IRS-related activities are included in PAAR at different priority levels.   + Maintenance of the same scale of IRS in existing 13 high burden districts of Zambezia and Nampula provinces. In particular 2024 is a potentially risky year, considering it will be 2 years post PBO-pyrethroid ITN distribution and prior to the next dual-AI ITN distribution, and as such a slower withdrawal is preferrable if funding allows. As described above, due to budget constraints this full amount has been included in PAAR. The total 3-year cost included in PAAR is $**23,178,673.**   + An expansion of IRS to an additional 20 districts is included in PAAR - 6 districts in Zambezia, 4 in Nampula, 4 in Cabo Delgado, 2 in Niassa, 2 in Manica, and 2 in Sofala. This expansion would only be feasible if funding were dramatically increased, and would begin in 2025 at total cost of **$28,096,444**. |
| **Intervention:** Entomological monitoring  Key activities under this intervention include:   * Monitoring of vector density and resistance is to be done in 44 sentinel sites, with a subset of these sites monitoring vector bionomics, feeding and resting behavior of vector species, and bioassay tests to measure IRS quality. This requires funding for:   + Supply of entomological equipment and consumables to 6 insectaries and 4 entomology laboratories   + Refresher training of entomology technicians   + Increased urban entomological surveillance due to the threat of *A. stephensi.* A large-scale survey to gather a baseline is planned and funded by the E8 Initiative, and this supplement will serve to routinize this surveillance through the grant period in 6 urban sites.   + Entomological surveillance costs are cost-shared between the country Global Fund grant, PMI, and the MOSASWA regional GF grant.   + Total 3-year cost = **$1,596,504** * **PAAR:** Procurement of additional containers to expand provincial insectaries in 9 provinces are included in PAAR, at a total cost of **$659,671.** |
| **Intervention:** Other vector control measures  **PAAR: Larval source management (LSM)** - The allocated budget was inadequate to accommodate this activity, however it is included in PAAR as a moderate priority activity as described in section 1.2, with the priority potentially increasing greatly in response to further surveillance on *A. stephensi.* Key activities under this intervention include:   * LSM (specifically, bio-larvaciding) is currently being trialed in Matola through the support of Goodbye Malaria, and if successful it is a potential addition to the urban malaria control strategy, particularly important should an invasive urban vector species gain a foothold in Mozambique (*A. stephensi)*. * Larviciding in 11 provincial capitals: 3-year PAAR budget = **$6,964,062** |
| **Amount requested** | **Within allocation: $100,223,415**  **PAAR: $79,271,605** |
| **Complementary funding and partner support** | Vector control commodity needs by funding source are summarized in Table 3 below.  Table 3: Vector control needs and funding by source    In addition to the commodity support described above, additional financial support for the operational costs of IRS comes from MOSASWA GF and the South African government in Inhambane, Gaza, and Maputo provinces. Additionally cost-shared support for entomological surveillance comes from PMI and the MOSASWA regional GF grant – with the amount requested in this funding request representing the current gap of the total need. |
| **Expected outcome** | It is expected that improved access to effective ITNs will contribute significantly to high utilization among the population, and when combined with targeted quality coverage of IRS in southern Mozambique to reduce vector density and manage insecticide resistance, will contribute to reduction of malaria cases by at least 45% from a 2022 baseline of 392 per 1000 population to 216 per 1000 population by 2030 (MSP 2023-2030).  The stratified intervention mix presented in this funding request are expected to achieve a significant reduction in burden when strong vector control is combined with other strategies. |

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| **MODULE 3** | **SPECIFIC PREVENTION INTERVENTIONS (SPI)** |
| **Intervention(s)** | **Intervention:** Seasonal malaria chemoprevention (SMC)  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Intervention:** Perennial malaria chemoprevention (PMC)  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | Specific interventions financed in this investment (or in PAAR) will target children under 2 years (PMC) and children between 6 and 59 months (SMC), with districts prioritized based on the stratification exercise described in Section 1.2. IPTp for pregnant women is funded through complementary funding, however targets all pregnant women in the country.  Similar to the barriers described in the vector control module, chemoprevention strategies must overcome challenges with geographic access. SMC campaigns will adopt similar strategies to ITNs by digitizing the campaigns to improve access to coverage data that can trigger response to maximize coverage in hard-to-reach places. PMC will require consistent outreach to mothers to maximize coverage through their attendance for immunization, with hopes to capitalize on the behavior change communication conducted through the immunization program. In addition to this, SMC and PMC are still new interventions in Mozambique – and as they expand to new geographies there will be a need to do strong M&E on the impact as well as the operational hurdles encountered in order to adjust deployment strategies. Some research is already planned, and additional research is budgeted under the RSSH module in this funding request. |
| **List of activities** | **Intervention:** Seasonal malaria chemoprevention (SMC)  Key activities under this intervention include:   * Procurement of sulfadoxine-pyrimethamine + amodiaquine (SPAQ) as well as campaign costs for SMC in Niassa Province. Total 3-year cost = **$10,940,641** * Following its identification as an intervention to explore in Mozambique during the 2020 MTR, SMC was introduced as a pilot in selected districts of Nampula Province. Nampula SMC is financed by Malaria Consortium via Givewell. Following success and apparent impact, it was expanded to all of Nampula Province in 2022/23. Following identification of Niassa as the top expansion priority during the 2022 stratification, it underwent an operational expansion assessment in 2022/23. * **Digitization of the campaign:** Budget for campaign digitization is included under RSSH per the modular framework guidance, however SMC campaigns will be digitized. An integrated approach will be taken to use a common platform to digitize all malaria campaigns, allowing for resource efficiency (e.g. device re-use and shared resources across donors) as well as operational improvement through sharing of granular population/household geo-registries. The 2022/23 ITN campaign is the first to be digitized in this way, utilizing C19RM resources, with IRS and SMC to come onboard in the future through this investment and complementary partner support.   **PAAR:** Expansion of SMC is a priority in the following areas of high burden and high seasonality, as informed by the intervention stratification, and would begin in 2025 if funded as above allocation requests:   * 6 districts of Cabo Delgado * All districts in Manica   Total 3-year PAAR cost = **$11,208,746** |
| **Intervention:** Perennial malaria chemoprevention (PMC)  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down  **Activities:**  Key activities under this intervention include:   * Procurement of sulfadoxine-pyrimethamine (SP) as well as implementation and oversight costs for PMC in Sofala Province, for the years 2025 and 2026. Total cost = **$1,807,205** * Following its identification as an intervention to explore in Mozambique during the 2020 MTR, PMC was planned for introduction as a pilot in selected districts of Sofala Province under the PSI/Unitaid operational research project. While implementation is only now beginning, the successful results of SMC has gained MOH confidence in the use of SP as a chemoprophylactic even in the face of SP resistance in the country. As such, it was identified as a top priority during the 2022 intervention stratification. Implementation in Sofala is funded by PSI via Unitaid through end of 2024 (and proposed here for 2025/26), and Zambezia for all years via PMI.   **PAAR:** Expansion of PMC into the following geographies, prioritized in this order as informed by the intervention stratification, which considered areas of high burden but low-to-moderate seasonality. The following scale up would begin in 2025 if budget is secured:   * 11 districts in Cabo Delgado * All districts in Tete * All districts in Inhambane * All districts in Gaza   Total 3-year PAAR cost = **$4,622,920** |
| **Amount requested** | **Within allocation = $12,747,846**  **PAAR = $15,831,666** |
| **Complementary funding and partner support** | Commodity needs for chemoprevention interventions, by source of funding, are summarized in Table 4 below:  Table 4: Chemoprevention needs and funding by source    IPTp continues to be supported b the Government of Mozambique. To date SMC introduction in Mozambique has been supported by Malaria Consortium via Givewell funding, with PMC being introduced by PSI (via Unitaid funding) and PMI (with committed funding to begin soon), as described above. Additionally Mozambique has recently submitted its application to Gavi for the introduction of the RTS,S malaria vaccine in targeted districts. |
| **Expected outcome** | Reduced mortality in the highest risk groups (children <5 and pregnant women). |

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| **MODULE 4** | **PROGRAM MANAGEMENT (PM)** |
| **Intervention(s)** | **Intervention:** Coordination and management of national disease control programs (MOH)  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Intervention:** Coordination and management of national disease control programs (Civil Society PR)  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Intervention:** Grant management (Civil Society)  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | NMCP staff, provincial, and district health management teams, partners, TWG partner members, other MOH Departments.  Bureaucratic government processes and procedures have contributed to delays in recruitment for some key positions, in turn delaying activity implementation. The human resource challenge is compounded by high attrition and turnover rates at all levels. With respect to concerns over financial accountability and transparent systems, the Ministry of Health is part of a pilot government financial accountability and transparency reform that will streamline financial procedures and instill confidence in the government system. Bureaucratic processes have at times led to low or delayed burn rate of grant resources. Several factors contribute to this situation including the challenges of reporting on spending for lower levels of government. It is expected that the financial reform process will address some of these issues in the long-term, but they are expenditure bottlenecks in the short and medium-term. The CCM, in coordination with both PRs, has reallocated some activities from the MoH to the civil society PR to ensure implementation of some critical activities, helping to improve the overall malaria component burn rate.  In response to complex emergencies, such as the provision of services to displaced populations in Cabo Delgado in the past 3 years, a challenge has continued to be the lack of nimble response capacity within the government. This is partly due to the very lengthy lead times for prevention commodities when purchased in large quantities. ITNs, for example, currently require a one-year lead time, meaning that even if Emergency Funding is made available, it will not reach the crisis areas where they are needed in a rapid manner. Mozambique Ministry of Health and its partners (including humanitarian organizations) will continue to collaborate to improve this situation, but it will also require global donor support for the emergency response to these complex challenges if it is to be successful. |
| **List of activities** | **Intervention:** Coordination and management of national disease control programs (MOH)  Key activities under this intervention include:   * Critical **human resources** at the central and peripheral level:   + 1 provincial M&E focal point (for Manica) to improve data quality and reporting (the other 10 provinces supported in previous rounds have been fully absorbed by the government) - 3-year cost = $16,915   + 11 malaria SBCC focal points at provincial level to better coordinate and measure IEC/BCC activities - 3-year cost = $186,061   + 11 provincial entomology focal points to ensure strong implementation of entomological surveillance to guide vector control implementation – 3-year cost = $186,061   + 1 NMCP focal point for resource mobilization and engagement of private sector resources through the Malaria Fund - 3-year cost = $195,000   + **Total 3-year cost = $584,037** * Annual national malaria review and planning meetings to review progress and plan subsequent years’ implementation with all stakeholders - 3-year cost = **$233,892**   Given Mozambique’s vulnerability to natural disasters and conflict, both of which greatly affect malaria risk and access to key services, the 2023-2030 National Malaria Strategic Plan has included a new objective related to response to these complex situations. This objective is seen as critical to ensure good response if/when these situations present themselves. |
| **Intervention:** Coordination and management of national disease control programs (Civil Society PR)  Key activities under this intervention include:   * Human resources to support IEC/BCC and ITN distribution activities led by the Civil Society PR and SRs * Quarterly national and district coordination meetings with implementation CBOs and community structures, as well as oversight-oriented supervision visits from national to provincial and district level * Annual provincial review meetings with health authorities and partners * Community monitoring of malaria services by CSOs will be conducted as well, by integrating malaria content into the community monitoring work done for HIV/TB services. A plan still must be developed to determine how this will be operationalized, but it is expected to require minimal budget from this investment, and strengthen the integrated approach to community monitoring by civil society. * 3-year cost = **$10,907,483** |
| **Intervention:** Grant management (Civil Society)  Key activities under this intervention include:   * Contribution to the Civil Society PR’s grant management costs, including salaries and civil society grant management, office equipment, periodic planning meetings, and bank charges. * 3-year cost = **$15,611,392** |
| **Amount requested** | **Main allocation: $27,336,804** |
| **Complementary funding and partner support** | Support from partner organizations and donors in this area are substantial, particularly at central and provincial level. Quantifying those management and coordination contributions is challenging. However, through strong coordination via the MOH-led technical working group (TWG) structures the Mozambique malaria community is working to minimize duplication of efforts in our collective aims to achieve the goals of the Malaria Strategic Plan (2023-2030). Mid-term review (MTR) will be carried out during the period, but has support from partners for key meetings as well as data analysis preparation. |
| **Expected outcome** | Effective program management with motivated staff, and complementary systems to ensure high quality implementation of the grant. |

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| **MODULE 5** | **RSSH: Monitoring and Evaluation Systems** |
| **Intervention(s)** | **Intervention:** Routine reporting **(malaria-specific surveillance/data items under RSSH module)**  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Intervention:** RSSH/PP: Surveillance for priority epidemic-prone diseases and events(**malaria-specific under RSSH module)**  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Intervention:** Surveys (**malaria-specific survey under RSSH module**)  Change in Programming from current: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Intervention:** Analyses, evaluations, reviews and data use (**malaria-specific evaluation under RSSH module)**  Change in Programming from current: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | Health workers at all levels of the health system, partners, TWGs   * Lack of register tools for data collection at some HFs, which is in progress for resolution – including improvements in the collection of sex disaggregated data. Procurement of registers has faced major bureaucratic hurdles. * Continuing gaps in data accuracy, which requires further improvement * Late detection of epidemics followed with a late response when they are detected |

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| **List of activities** | **Intervention:** Routine reporting **(malaria-specific surveillance/data items under RSSH module)**  Key malaria-specific activities under this intervention include:   * Strengthened implementation of the **Data Quality Assurance (DQA)** system *(integrated under the supervision activities mentioned in the Case Management module, with no additional cost in this module)* * Strengthened **data use,** via review meeting structures and supervision *(integrated under the supervision activities mentioned in the Case Management module, with no additional cost in this module)* * Maintain and enhance the **integrated malaria information system (iMISS)**, ensuring routine use at all level   + Routine replacement of out-of-service mobile devices, routine DHIS2 upgrades and maintenance, airtime/data packages, and contribution to MOH-wide mobile device management systems for these malaria devices. **Total 3-year cost = $281,558** * **Digitization of all malaria campaigns**   + Digitize campaigns end-to-end, using a common, integrated platform across all malaria campaigns (ITN, IRS, and SMC) that is integrated with iMISS, and with the vision of future integration of other MISAU campaigns (e.g. NTDs, and immunization). The objective of this effort is to improve the coverage, quality, measurement, and overall management of malaria and other campaigns, and to do so in a way that reduces fragmentation and maximizes digitization resource efficiency. **3-year cost = $3,036,945**     - Costs include device procurement and training costs. Devices will be re-used across provincial campaigns, as per the operational model of the 2022/23 ITN campaign. Due to multiple overlapping campaigns during the 2024-26 period, it is necessary to forecast the maximum number of devices needed at any given time to ensure adequate resources to digitize while not affecting the sensitive timing of campaigns to maximize their impact. * **PAAR:** Due to budget constraints to cover the full need in this investment, the NMCP will seek funding support cost-shared between other campaign donors (notably Givewell for SMC and MOSASWA for IRS), to ensure the full need is met. Given this is yet to be confirmed, **$2,672,839** is included in PAAR to ensure this full expression of need is included. |
| **Intervention:** RSSH/PP: Surveillance for priority epidemic-prone diseases and events(**malaria-specific under RSSH module)**  Key malaria-specific activities under this intervention include:   * Support for investigation teams field work will also be provided, specifically to cover the costs of field investigators when upsurges in malaria are observed. iMISS integrated Early Warning System will be used for identification of outbreaks. * Scale up of the response system within the case-based surveillance system for malaria in Maputo City, which is integrated with iMISS * **Total 3-year cost = $387,947** |
| **Intervention:** Surveys (**malaria-specific survey under RSSH module**)  Key malaria-specific activities under this intervention include:   * **Health Facility Survey,** which has been a critical supplement to routine case management data from SIS-MA, LMIS, and supervision data, will continue to be periodically supported to improve identification of challenges in case management service provision and to measure progress in improving quality of care. Total cost of the survey to be conducted in this grant period is **$405,000**.   **PAAR: Malaria Indicator Surveys** are critical in providing unbiased data on community impact. This activity will be conducted through cost-sharing from PMI, but due to funding constraints in the malaria allocation and lack of desire to consider malaria-specific surveys in the cross-cutting RSSH grant, the remaining costs of **$2,164,256** has been placed in PAAR for the 2026 survey. |
| **Intervention:** Analyses, evaluations, reviews and data use (**malaria-specific evaluation under RSSH module)**  Key malaria-specific activities under this intervention include:   * **Chemoprevention (SMC, PMC, MDA) evaluation research**   + Operational research and impact evaluation related to the introduction of SMC in Mozambique.     - Operational research will assess the strength, weaknesses, and challenges of implementation; KAP of populations and health workers; and assessment of SMC coverage     - Impact evaluation will include epidemiological impact and cost of delivery to inform future cost-effectiveness analyses   + **Total 3-year cost = $405,000** |
| **Amount requested** | **Main allocation: $4,516,450**  **PAAR: $4,837,095** |
| **Complementary funding and partner support** | Surveillance assessments were conducted in 2016 and 2018 to inform the current strategy, and have been evaluated regularly as part of MTR/MPR. Such assessments will regularly be conducted in a targeted way, informed and overseen by the SM&E TWG and supported by the many partners in this space, to measure progress and identify areas for strengthening.  The MoH has utilized GF and government resources to ensure the regular supply of register books following partners support. However, major procurement challenges have been experienced due to bureaucratic procedures – leading to over a one year delay in procurement. PMI is providing funding support for technical assistance and some field work expense for the MIS/DHS, with the remaining gap budgeted under the RSSH funding request. Complementary support is received from CHAI and the eGov Foundation (via BMGF) for tool development, testing, and technical support for campaign digitization. With partner support the MOH IT Department (DTIC) is leading efforts at improving their management of the inventory of mobile devices used across the Ministry, spurred by expansion of digitization in malaria – including the use of common mobile device management (MDM) software to centrally manage devices, and establishment of a formal HelpDesk for user support. A digitization taskforce is being established, chaired by DIS with members from DTIC, DNSP, and partners – which will oversee these efforts.  Mozambique has been an early champion of the use of robust data analysis to inform MTR and MPR, and conduct stratification and sub-national tailoring for optimal allocation of resources. This will continue periodically, including continued strengthening of MOH capacity to conduct these analyses to inform programming. It has become quite ingrained in the structure of the partner working groups, and will be conducted through partner support – thus not requiring funding from this GF request. |
| **Expected outcome** | * Data collected at all HFs area standardized, with complete, timely and accurate data submission * Improved data quality for decision-making * Early detection of epidemics and responses |

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| **MODULE 6** | **RSSH: Health products management systems** |
| **Intervention(s)** | **Intervention:** Augmenting national supply chain system with outsourcing (**malaria-specific under RSSH module)**  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | Rural population served by APSs, by ensuring consistent and organized stock. The primary barriers to access to malaria diagnosis and treatment services relate to the general inequities arising from location (rural/urban) and socioeconomic status. The revitalization of the APE program seeks to address these discrepancies through the provision of ICCM and integrated health promotion at the local level. One identified barrier to these integrated services has been the issue of stock availability, including malaria RDTs and ACTs, without which service to rural communities is compromised. |
| **List of activities** | **Intervention:** Augmenting national supply chain system with outsourcing (**malaria-specific under RSSH module)**  Key malaria-specific activities under this intervention include:   * **APS malaria kit assembly and distribution** will be supported to ensure CMAM has adequate capacity for supporting ICCM commodities for the nearly 8,000 active APEs nationwide. Costs include kit materials (boxes/straps/sealing/tape/ pallets), and transport to the district level. * Implementation challenges have been experienced with this activity during NFM3 implementation. The tender was published two times with no success, first due to non-familiarity with the specifications by local providers and then the second time due to challenges with document completeness due to overly complex specifications. As of 2023 the local service providers have been sensitized, and the specifications sufficiently sensitized, that the NMCP and CMAM feel confident in identifying a provider by Q2 2023. This service provider will be contracted through December 2023, and if this request is approved would be envisioned for extension through the GC7 implementation period. * The 3-year cost of this support is **$2,144,381**. |
| **Amount requested** | **Main allocation: $2,144,381** |
| **Complementary funding and partner support** | APS RDTs and ACTs are accounted for under the facility-based treatment intervention, with cost sharing from PMI, and non-malaria ICCM commodities are procured by the Government of Mozambique. PMI will no longer support malaria kit assemblage due to budgetary constraints, however several activities to strengthen overall supply chain capacity are budgeted under the RSSH funding request components. |
| **Expected outcome** | Improved stock availability at community level, leading to increased access to malaria diagnosis and treatment for the most at-risk communities |

**RSSH Funding Request:** The country coordinating mechanism (CCM), together with Global Fund, made the decision to integrate the cross-cutting RSSH requests into the malaria funding request. To prioritize these cross-cutting RSSH requests, a working group was formed which identified the following. The budget for cross-cutting RSSH needs is summarized as follows, including the $7,000,000 in matching funds from the RSSH Innovation Fund:



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| **MODULE 7** | **RSSH: Health Sector Planning and Governance for Integrated People centered Services** | | |
| **Intervention(s)** | **Intervention:** National health sector strategy, policy & regulations  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down | | |
| **Population, geographies and/or barriers addressed** | A recent review of the current health sector planning system recommended the development of a capacity strengthening plan to ensure alignment between different levels and health services that is participatory, inclusive and results-oriented, and in compliance with the principle of a Single Plan, a Single Budget and a Single Monitoring and Evaluation.  Global fund funding rules require VAT exemption on the purchase of goods and services. For this purpose, the Government approved the Fiscal Mechanism for VAT Regularization, which, for its implementation, requires the respective certification. The growing volume of projects, and consequently of requests for VAT certification, requires hiring more staff to speed up this process, as well as reinforcing the supervision and monitoring activities of these projects. In addition, will be acquired an electronic Platform for the registration and management of all ongoing projects in the health sector, which also meets the monitoring needs of the Fiscal Mechanism for VAT Regularization. | | |
|  | The considerable amount of financial resources managed by the sector requires increased attention from execution monitoring bodies. Hence the need to strengthen the oversee capacity of the sector. The involvement of community actors in health promotion actions began in 1978, after the Alma-Ata Declaration on Primary Health Care (PHC), when the country established the category of Agente Polivalente Elemerar (APE). Over the years, the expansion of community services related to maternal and child health, malaria, HIV/AIDS, and tuberculosis, among others, coupled with a shortage of human resources, led to the introduction of various other categories of community actors, both by the Government and Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs), and other cooperating partners. Local community actor’s categories were also institutionalized, such as traditional midwives and traditional medicine practitioners (HTM), to promote and prevent diseases in the communities. The aforementioned efforts resulted in fragmentation of interventions, inadequate community involvement, duplication of efforts, lack of integration and complementarity of actions carried out by different actors, and gaps in the provision of healthcare.  The Community Health Strategy (2021-2025) aims to address these challenges, improve healthcare efficiency and coverage, reduce health inequities, and integrate programs and community actors in order to contribute to the provision of the Essential Community Health Package. This includes intervention on Case Management for HIV, TB and Malaria; interventions on Maternal and Child health and nutrition; intervention for health promotion and early diagnosis. Additionally, the strategy intends to establish a community health surveillance system. All that is expected to contribute to the strengthening of the National Health System, as well as to the achievement of the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC), leaving no one behind. The pilot phase of the community subsystem strategy started in 2022 and has been fully implemented and documented in 22 districts of 9 provinces of Mozambique. Full implementation includes selection, pre-service training, supervision, and technical support to the new cadre of CHWs (Agente Polivalente de Saúde - APS).  The APS will work and integrate into a team of community health workers (CHW) already existing in the communities, as previously described. The MoH has established a ratio of 1 CHW (APS) per 1000 inhabitants. Therefore, due to the lack of existing APS at this stage, whenever possible, teams will consist of at least 1 APS + 2 or 3 CHW from NGOs and/or local CHW, who are specialized in providing interventions outlined in the community PECS. Whenever no APS available, the CHWs will team up with an APE or other CHW to contribute to 1:1000 CHW expected ratio.  The APS, as the lead member of the CHW teams, will make the liaison with the primary healthcare facility of reference, where a specific supervisor will support and mentor the APS/and the team, in all their tasks and performance.  The APS will be trained on competency-based skills, using an updated competency-based curricula integrated in the APS courses conducted by the Provincial Health Institutes (IdF). Currently, the MoH is finalizing the development of the competency-based curricula for specific CHW interventions, clustered in the following areas: Mother and Child Health package, Case Management for HIV, TB, Malaria and NCDs package, and Health Promotion package. Those packages are integrated in the community PECS. The technical working group within the MoH and partners are working to align the training package for all CHW, in order to standardize the approaches for the provision of the health community services. Additionally, in that sense, the Community Health Development Committees (government structure), placed in each community, will serve as a dialogue space for integration and coordination of all actors and local workforce, including traditional medicine practitioners.  For the period 2024-2026, the main milestones are based on the lessons learnt on the first phase of the pilot:   * To train APS with capacity and competencies to offer quality health community services, by improving the quality of the training to be conducted in the Health Training Institutes (IdF) and using an updated curricula based on the required competencies. * To establish community health workers teams, coordination mechanisms and supervision systems to improve the performance of the community health subsystem. * To integrate a community health surveillance into the community health subsystem, liaising with the National Health Service (PHC) * To digitize the registration and monitoring community health tools to improve the community Information health systems to improve data quality and guarantee the interoperability with the SISMA (place at health health facility). * To integrate the provision of community health services, enabling the integration of HIV, TB, NCDs and malaria program interventions. * To establish the structure of the Community Health Structure governance.   Based on lessons learned and operational research anticipated under M&E systems module below, the targets defined in this strategy will be updated to guide activity planning for achieving relevant targets of the community Health Strategy and relevant milestones, including the SDGs by 2030. To ensure stakeholders ownership of the strategy, it will also be disseminated at all levels of the sector through implementation of an advocacy, communication, and social mobilization plan. | | |
| **List of activities** | * Develop a Plan to strengthen the health sector planning system. * Hire staff to speed up the VAT certification process * Disseminate the Community Health Subsystem strategy at the national and subnational level in 2024 * Update the Community Health Subsystem Strategy targets in 2025   **PAAR:**   * Conduct integrated planning meetings with stakeholders of the Community Health Subsystem at the national and subnational levels, including in communities is Prioritized Above Allocation Request (PAAR -$509,300) * Establish an electronic Platform for the registration and management of all ongoing projects (PAAR - $100,000.00) * Increase Health Inspection General capacity to oversee budget holders (PAAR - $200,000.00) | | |
| **Amount requested** | **Within Allocation: $540,000**  **PAAR: 809,300** | | |
| ***MODULE 7 TOTAL*** | *Within allocation: $540,000*  *PAAR: $809,300* | | |
| **MODULE 8** | **RSSH: Community Systems Strengthening** | |
| **Intervention(s)** | **Intervention:** Community-led Monitoring (CLM)  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down | |
| **Population, geographies and/or barriers addressed** | Service providers/decision-makers do not routinely include perspectives and experiences of clients to improve accessibility, acceptability, affordability, and quality (AAAQ) of services. Therefore, an independent, robust, and community-hosted, owned, and led CLM program is essential for providing sufficient, ongoing monitoring with a focus on poorly performing facilities and underserved populations such as KPs. This program must be hosted and coordinated by CSO, PLHIV, and KP communities themselves, with direct funding to them for this work to improve the quality and accessibility of services.  There is low coverage of HIV, TB, malaria, GBV and other gender and human rights related issues that different community actors, particularly traditional medical practitioners are better suited to help address at the community level.  Programming for key, and vulnerable populations is not reaching specific groups, or is under-performing because of persistent structural barriers that undermine their reach and impact. | |
| **List of activities** | * Improve and harmonize the current CLM guide considering the current implementation experience and from other different CLM experiences in the country. The guide will cover CLM activities at the health facilities and community level implementation guide and ensure that all intervenients use the same approach for CLM. * Create tools for monitoring the implementation of CLM at the health facilities and community level * Develop a standard package for the training of CLM trainers to empower CBOs on the implementation of CLM at community level * Train CSOs in CLM * Expand MLC to more primary level health facilities including MLC to the community level activities such as functioning of community health committees and monitoring of HTM. * Monitor the changes agreed between the Government of Mozambique (GM) and CSOs * Hire technical assistance to strengthen PLASOC-M's capacity to perform MLC * Map population groups that are not covered by the CLM program focusing on the introduction of new indicators that will capture populations affected by TB Malaria and AGYW * Monitor the performance and functioning of existing community health committees | |
| **Amount requested** | **Within allocation: $3,157,611**  **PAAR: $235,199** | |
| **Expected outcome** | CLM activities will improve accessibility and quality of health services by generating community evidence in service community-led advocacy efforts to resolve chronic problems uncovered through monitoring. | |
| **Intervention(s)** | **Intervention:** Community-led Research and Advocacy  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down | |
| **Population, geographies and/or barriers addressed** | Programming for key, and vulnerable populations is not reaching specific groups, or is under-performing because of persistent structural barriers that undermine their reach and impact. | |
| **List of activities** | * Conduct MLC operational research while the monitoring is being implemented to learn from the daily implementation. This will be used to inform the harmonization of the MLC guide * Publish MLC research results including feedback to the communities covered by this activity * Identify barriers to evidence generation at the community and health facility levels * Based on the results from the MLC advocacy strategy will be implemented through policy briefs, and other tools to improve the quality of health and social services, especially for people with HIV-TB co-infection, key populations, and vulnerable social groups * Map the needs of CSOs, who are they, where are located, the organizational capacity and assess the need of support for their operations, legalization, and capacity building * Advocacy for the availability of harm reduction inputs (paraphernalia) in places of affluence of people who inject drugs * Advocacy for revision of the national guideline of HIV and AIDS Prevention, Care and Treatment Services to include the specific recommendations for provision of services to Key Population * Advocate with the Government of Mozambique for the availability of supplies for the prevention of HIV, TB and other respiratory infections (condoms, lubricant gel, PrEP, masks, alcohol gel, and others), in prisons * Advocacy for the availability of pain relief supplies in the context of palliative care for patients with advanced disease * Advocate for the creation and expansion of functional units of pain in at least the main hospitals at province level. * Advocate for the expansion of screening and treatment of viral hepatitis and expansion of 3HP and Vitamin B6 services in all health units | |
| **Amount requested** | **Within allocation: $1,958,855**  **PAAR: $48,042** | |
| **Expected outcome** | Communities’ advocacy is evidence-based and effective, and communities define their own research agendas and priorities, and have the capacity and means to carry out operational research, particularly addressing the needs of key/vulnerable populations. | |
| **Intervention(s)** | **Intervention:** Community Engagement, Linkages and Coordination  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down | |
| **Population, geographies and/or barriers addressed** | Community involvement and engagement of local health system users and community members in all aspects of health planning, delivery, and governance is a central component of ensuring that the services provided are linked to the needs, priorities, and values of the population, with particular attention to vulnerable people. This can be achieved through community involvement and engagement in the design, financing, governance, and implementation of health services at community level. The new MOH Community Health Subsystem Strategy (August 2021) articulates that community leadership, engagement, and coordination are key to ensure that the community approach responds holistically to the health needs of people in communities and the strategy should reflect the ideas, needs, perspectives, and purposes of the communities themselves. | |
| **List of activities** | * Mapping of CSO-led and community-based networks and their service packages * Establishment of community committees (traditional and community leaders, local authorities, police, religious institutions) to support CP, populations affected by diseases and vulnerable groups in cases of violation of their rights, stigma and discrimination (example of Lambda) * Establish a coordination and exchange mechanism with community human rights committee * Expand community philanthropy to the search for community solutions regarding access to and use of health services * Expand community dialogues, community engagement, at district level, province and national level to monitor the implementation of National Strategic Plan (NSP V) and the grant implementation. * Meetings between decision-makers and focal points of PLASOC and HIV at the local level, to strengthen community involvement in decision-making on the provision of care for HIV, TB, malaria and other health problems * Community-led production, publication and dissemination of policies briefs on the interventions implementation at community level concerning KP populations * Train the activists, volunteers and peer educators from CBO’s providing home care (palliative care, APSS/PP and HIV and TB care). These CBOs ensure the linkage between the NGOs interventions and the health facility level to address advanced disease at community level (home care) * Continue to support groups for adherence and retention in ART and in the treatment of sensitive and multi-resistant TB. * Provide prevention interventions items, such as male and female condoms (100,000) to traditional medical practitioners to distribute to the communities | |
| **Amount requested** | **Within allocation: $657,804**  **PAAR: 4,888,836** | |
| **Expected outcome** | Community-led and community-based services are known and recognized; and organizations providing these services are engaged in joint planning and implementation, and their role and impact reflected in national planning and resource mobilization. | |
| **Intervention(s)** | **Intervention:** Capacity Development and Institutional Leadership  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down | |
| **Population, geographies and/or barriers addressed** | Community-led and community-based organizations and networks require core funding and differentiated capacity building to participate in the health and social services responses, innovate and address changes and shifts in HIV, TB, and malaria. Organizational leadership requires capacity to hold decision makers accountable, engage duty bearers and lead active and well-functioning civil society. However, organizational capacity and leadership development activities are often ad hoc, sporadic, and not tailored to communities’ contexts. | |
| **List of activities** | * Continue training CSOs and their networks in project monitoring and management and in internal management policies, including the new CSOs to be covered by this grant. * Empower CSOs in governance: organization, functioning and transfer of power, administrative procedures, policies and standards, conflict resolution policies, human rights advocacy, monitoring plans and standard operating procedures related to health * Support integration of human rights and gender concerns into CSOs empowerment * Map and create standardized levels of CBOs, to make them eligible to receive funds from the Global Fund, depending on their structure, capacity, scope and other characteristics * Involve CSOs in the strengthening and coordination of health development committees * Conduct monitoring visits to CSOs and their networks * Map community courts and coordinate with human rights community committee * Train and technically capacity building CSOs and their networks in the implementation and management of activities funded by the Global Fund * Form focal points at provincial and district level in the leadership and creation and management of associations and other CBOs * Develop and print material for institutional visibility * Involve local leadership in the selection of PHC/CHA and members of community health development committees * Hold planning meetings, with the involvement of community health development committees * Conduct institutional capacity assessment visits of CSOs focusing on the new CsOs to be covered. | |
| **Amount requested** | **Within allocation: $225,730** | |
| **Expected outcome** | * Strengthened capacities of community- led and community-based organizations (in governance, financial management, strategic and sustainability planning, leadership development, program management, monitoring, and reporting) necessary for meaningful participation in the national response. * Development of strategy, governance, and policy documents for community-led and community-based organizations, such as human resource policies, resource mobilization and social dialogue strategies for either individual organizations and/or networks of organizations will contribute to their capacity to participate in the disease response. Small and nascent community-led and community-based organizations, which represent under-served populations (and/or in priority geographical areas, or specific operational contexts), will be able to take up a stronger role in the national response to HIV, TB, malaria and other related issues, such as Gender-based Violence (GBV). | |
| ***MODULE 8 TOTAL*** | ***Within Allocation: $6,0000,000***  ***PAAR: $5,172,077*** | |
| **Module 9** | | **RSSH: Health Products Management Systems (cross-cutting Health Products Management)** |
| **Intervention(s)** | | **Intervention:** Policy, strategy, governance  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | The Decree 34/2022 of July 19, which transforms CMAM into a Public Institute, with administrative autonomy and responsibility for delivering health products nationwide under a single command, has contributed to significant improvements of supply chain governance. CMAM’s Organic Statute and its Internal Regulation are currently being developed and expected to be finalized in 2023, which will consolidate CMAMs governance.  The review of the PELF 2014-2023 is scheduled for 2023 and the new strategy will cover the 2024-2033 period (ten years), and reflections on key issues like supply chain sustainability, training needs, CMAM capacity and physical space among other. It will necessarily include a roadmap for its implementation and detailed workplans to ensure consistency, effectiveness, and sustainability. Once approved, it will require wide advocacy and dissemination by the main implementers, and with a focus on the Central and Provincial Government, and sector partners.  The PELF advocates for logistician training and in-service training as critical activities to improve supply chain management. Thus, CMAM will coordinate with MISAU’s training directorate (training regulator) and ESCISA (implementing agency) for the completion of the first higher education course on health logistics, as well as the development of a modular training system in logistics that guarantees training credits for existing professionals. It should be noted that the curriculum for the higher education course was developed in collaboration with Village Reach and ARC – Africa Resource Center and was already approved by the Ministry of Science and Technology. |
|  | | CMAM’s new legal framework, gains from the NFM3 investments in warehousing capacity and waste management, availability of dedicated logisticians, and information systems investments will support PELF implementation. It should also be noted that the fully operational PELF, in conjunction with planned EI systems and resources, will increase the efficiency and security of the supply chain, thereby minimizing stockouts of medicines and other essential health commodities, including for HIV programs /AIDS, tuberculosis and malaria, as well as to respond to the expansion of iCCM activities  In fact, the integrated Logistics Management Information System (LMIS) is designed to report on all products, with a dedicated segments that caters to the main health programs: MMIA for Antiretrovirals (ARVs), MMIT, MMTB, and MMCM. Enhanced Transport Support provides for improved transport services, particularly from the Central to Provincial/Intermediary levels, addressing one of the major inefficiencies in the supply chain, that hinders programs such as Tuberculosis (TB) and Malaria that require more frequent distribution. Additionally, it complements one of the significant achievements of the supply chain, the last mile distribution improvement.  To develop the proposal a program-budget approach was used to identify activities (work plans) and estimate costs for all supply chain, under CMAM responsibility, covering the 3 years (2024-2026). With this approach was possible to identify expected funding from several source including GOM and the priority GAPs were then allocated to this FR, considering the amount available. |
| **List of activities** | | * Disseminate the PELF 2024-2033 * Carry out initial and modular training for supply chain logistics, in collaboration with ISCISA. |
| **Amount requested** | | **Within allocation: $428,132** |
| **Expected outcome** | | * PELF disseminated and staff familiarized at key levels of supply chain management * Ensured initial and modular training for logisticians, on-the-job training for supply chain professionals. |
| **Intervention(s)** | | **Intervention:** Storage and distribution capacity, design & operations  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | To reduce drug stockouts, as well as minimize handling times and maximize efficiency, the PELF under implementation and the results of the 2021 optimization study recommends the installation of 32 intermediate warehouses, including 17 Cross- docks across the country. Under this funding request, and based on the project-type already approved, it is intended to build a new Intermediate Warehouse in Nampula because it serves a large number of beneficiaries and has inadequate facilities that cannot be extended. |
|  | | To improve supply chain performance indicators, including product safety, warehouse workers will be trained in safety and firefighting, and the warehouse equipment operators and users of product management systems will be certified. In addition, performance improvement requires interventions for last mile transportation, the personnel transport chain and processing procedures (fuel, maintenance and vehicles), guarantee security services and cleanliness of the facilities, payment of operating expenses ( energy, water and communications) and insurance for facilities, products and equipment. These changes may require adjusting tools, technologies and human resources to the new operating model. At the same time, to regulate activities, RACIs (Responsible, Accountable, Communicable and Informed) and SLAs (Service Level Agreements) will be developed with the departments, health programs and private supply chain providers with a view to formalizing the necessary interactions with them and outsource services to the last mile, including the development of optimized routes, in line with the evolution of the health and road networks, and improvement of intermediate storage capacity.  The revised / updated PELF will necessarily address last mile operations. Currently, the proposal is based on an overall working plan and cost estimations for the SC covering the 3 years (2024-2026). The funding for transportation, including last mile, is distributed among GOM and PEPFAR, the gap will be covered by this FR. |
| **List of activities** | | * Construction of new intermediate warehouse in Nampula. * Central and last mile transport   **PAAR:** Construction of intermediate warehouses in Tete, Xai-Xai, Quelimane, and Matola (PAAR - $26,469,793) |
| **Amount requested** | | **Within allocation: $10,214,484**  **PAAR - $26,469,793** |
| **Expected outcome** | | Reduced stock-outs and/or accumulation of medicines by improving the storage capacity and supply chain performance |
| **Intervention(s)** | | **Intervention:** Planning and procurement capacity  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | Improved supply chain planning and accountability and procurement practices help reduce stock-outs, reduce waste and ultimately improve the availability of medicines and other health products at the point of care. Thus, CMAM will continue to use the ERP (SAP BAiO) to guarantee good financial management and cost accounting, as well as to develop a purchasing information system, ensuring its expansion to various levels of management (headquarters, central and intermediate warehouses and integration of additional modules such as HR. |
|  | | Through implementing PELF, CMAM will continue to implement the new Supply Chain Operational Model which involves the implementation of facilitation, planning, supply, distribution and return processes (reverse logistics) in the supply chain. This includes regular HR training in a hybrid way (face-to-face and virtual) using training materials developed based on SCOR (Supply Chain Operations Reference Model) results, and application of HR4SC (mandatory HR standard) and ASSESSME (gap assessment of knowledge and ability). This process will facilitate the establishment of a “control tower” at CMAM headquarters to oversee the end-to-end supply chain. |
| **List of activities** | | * Implement ERP (SAP BAiO) and expand to more modules and levels of supply chain management * Develop training materials based on SCOR results and application of HR4SC and ASSESSME * Continuously train the HR in the supply chain based on SCOR results and the application of HR4SC and ASSESSME |
| **Amount requested** | | **Within allocation: $1,084,897** |
| **Expected outcome** | | * Strengthened national supply chain planning and procurement system * Improved SAP (stock according to plan), thus reducing the risk of stock outs and overstocks |
| **Intervention(s)** | | **Intervention:** Regulatory/quality assurance support  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | Based on the main inspections findings, ANARME intends to draw up rules and regulations aimed at improving pharmaceutical activities in the country. This will allow timely detection of medicine quality issues, and take necessary measures to protect public health.In addition, there is a need to draw up a pricing policy that is fair, up-to-date and compatible with the country's socio-economic conditions within the scope of improving access to health products for the Mozambican population.  The National Quality Assurance Laboratory (LNCQ) is an indispensable ANARME’s arm in quality health products control from introduction authorization in the national market, to continuous monitoring of production, commercialization and post-marketing. However, according to the latest WHO assessment based on the Global Benchmarking Tool (WHO-GBT), the LNCQ has limited analytical testing capacity and inadequate infrastructure, where in ANARME, IP got a score of 1.25 out of the required 2.0. The GBT report urged ANARME to expand and equip the LNCQ to increase its analytical testing and samples storage capacity, reduce testing costs currently conducted abroad, and ensure national ownership of the testing process.  According to WHO guidelines, market surveillance is a crucial regulatory function that prevents, detects and responds to any medical products quality issues circulating in the market, after granting Market Introduction Authorization (MIA) that may lead to regulatory sanctions to, and corrective actions from, the manufacturer and Marketing Authorization (MA) holders. Due to limited clinical trials, there is a need to perform drug safety studies for ensuring drug safety and effectiveness to protect public health. In addition, procurement of equipment to combat products counterfeit and conducting inspection activities on public and private entities are essential for intelligence operations and investigation of pharmaceutical crime. |
|  | | ANARME has well defined and mapped processes. Nevertheless, the heavy paper based work, combined with limited physical space and high demand for medicine-related information calls for a robust IT infrastructure, an archive system and the establishment of a Medicines Information Center (CIM) to support systems integration and space, resource and time rationalization. Both CIM and the integrated system of ANARME,IP provides information on the import, quality and safety of pharmaceutical products, in this way it can feed the other systems in order to have exact information about medicines that circulate in the country that are registered and that were imported legally. This will support programs to combat disease exacerbation or therapeutic inefficiency due to the use of poor quality medicine (unregistered or illegally imported). It also supports the rational use of medicines by controlling consumption, prescription and adverse drug reactions in the NHS.  The country will have more information on antimicrobial resistance by measuring its appropriate use and the quality of antimicrobials. In addition, the CIM receives queries related to the therapy and medicines for the country's main diseases, guaranteeing the safe use of medicines and records of any information related to them, thus effectively ensuring the shelf life of medicines. ANARME expects this to inform other health sector information systems by capturing drug-disease related data. |
| **List of activities** | | * Equip and expand the National Laboratory for Quality Control of Medicines * Continue to outsource medicine quality control services to foreign accredited laboratories until national capacity is created * Perform quality monitoring of pharmaceutical and health products to combat counterfeit and circulation of low quality products (including inspection in private and public sectors) * Procure equipment to support the implementation of the program to combat the counterfeit and circulation of low-quality medicines. * Create an Integrated IT System for managing ANARME’s regulatory processes. * Perform regulatory activities, including pharmacy mapping nationwide, drugs pricing policy, archive systems, CIM) * Develop awareness on Antimicrobian Resistance through targeted communications. Carry out specialized training (including postgraduate; short and on-the-job-training) |
| **Amount requested** | | **Within allocation: $10,090,386** |
| **Expected outcome** | | * Improved Pharmaceutical regulatory system * Quality assured medicines circulating in the country * Improved ANARME's institutional capacity to fulfill its mandate |
| **Intervention(s)** | | **Intervention:** Avoidance, reduction and management of health care waste  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | It is globally recognized that, as healthcare systems expand, increasing amounts of waste are generated by these systems. This waste, when improperly treated, causes pollution, unnecessary carbon emissions and waste of resources. Furthermore, antimicrobial residues and resistant pathogens present in this waste can lead to their dissemination in the environment and exacerbate antimicrobial resistance. In Mozambique, several public and private institutions produce considerable amounts of health waste, mainly resulting from expired medicines and the ever-increasing volume of care and treatment of communicable diseases and beyond. However, its treatment and potential risk to human health is not well known. Therefore, the sector intends to conduct a national and comprehensive assessment of waste management systems to inform the development of a plan to strengthen health waste management systems.  Pending the availability of this plan, the sector will seek to reduce potential risks of health waste by raising consumer awareness on the importance of proper disposal of anti-infective or antimicrobial waste, creating and disseminating a collection mechanism and return of this waste to supplying units, with a focus on antimicrobials, as well as designing and implementing collection systems, transportation and incineration of unused and/or damaged health products especially resulting from HIV/TB/Malaria therapeutic changes, and also PPE, from health Facilities to incineration points. It will also be important to ensure the maintenance and operation of the incineration and product disposal equipment purchased under the current Global Fund grant. In addition, ANARME will continue to contract services for the disposal of waste resulting from samples taken for quality analysis purposes. Last, but not least, and as a preventive measure, the sector will implement the ISO 14001 Standard for the regulation of environmental management systems concerning medicines through the establishment of correct waste management procedures. |
| **List of activities** | | * Conduct a national and comprehensive assessment of waste management systems (ANARME) * Develop a health waste management systems strengthening plan * Raise consumer awareness on the importance of proper anti-infective or antimicrobial waste management * Create and disseminate a collection and return mechanism for health waste to supply units with a focus on antimicrobials * Implement the ISO 14001 Standard to ensure proper healthcare waste management * Design and implement systems for collecting, transporting and incinerating unused and/or damaged health products * Ensure maintenance and operation of product incineration/disposal equipment * Continue to contract ANARME’s waste disposal services. |
| **Amount requested** | | **Within allocation: $460,773** |
| **Expected outcome** | | * Improved governance of the Health Waste Management System * Reduced potential public health risks resulting from healthcare waste |
| **Intervention(s)** | | **Intervention:** Supply chain information systems  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | The PELF and OIG report emphasize the need for substantial investments in logistic management information systems, including their integration, hardware, end-to-end visibility and traceability. Thus, programming consultancy services will be contracted to ensure the continuous improvement of the central Warehouse Management Systems (WMS), nSIMAM/SIGLUS, the Central Tool (FC), and the establishment of a Data Management Unit (Control Tower) to enable data integration and supply chain end-to-end visibility. These activities will be complemented by the procurement and maintenance of IT equipment necessary for information systems, software licenses (operating systems, specific applications and security) and payment of communication and internet services for all levels of the supply chain. SIGLUS (new code) will also be adapted for use by APEs/APSs and inclusion of new products. In addition, data triangulation will be carried out between health product management systems and programs to improve drug availability and avoid overstocking. It should be noted that CMAM's M&A plan will be adjusted to meet the tracking needs of the new model.  In support of the transition of alternative first line ACT at community level, procedures for managing and recording ACTs (Artimisin-Based Combination Therapy) at this level will be reviewed, as well as registration/reporting models and integration into electronic systems. There will also be a need to print and distribute the chosen ACT’s management manuals (consumption registration/justification map). Once instrument review is complete, APEs/APSs and supervisors will be trained in drugs management, including ACTs, ARVs, tests and other products |
| **List of activities** | | * Adapt SIGLUS (new code) for APEs/APSs use and include new products; * Create a Data Management Unit (Control Tower) for the supply chain * Procure and maintain computer equipment. * Procure and renew software licenses, including payment for internet services for all levels of the supply chain * Adapt CMAM's M&A plan to the new operating model. * Review procedures for managing and recording ACTs at community level * Train APEs/APSs and supervisors in the medication management component, including multiple first line ACTs * Train health professionals who supervise the APE/APS * Print and distribute multiple first line ACT management forms (consumption registration/justification map) |
| **Amount requested** | | **Within allocation: $1,064,420** |
| **Expected outcome** | | * Continuous improvement of supply chain management IT systems, including their extension to the community. * Improved data-driven decision-making process and early warning systems to reduce risk of stockouts/overstocks * Developed and integrated the community drugs management module in nSIMAM/SIGLUS |
| ***MODULE 9 TOTAL*** | | *Within allocation: $23,343,092*  *PAAR: $26,469,793* |
| **MODULE 10** | | **RSSH: Human Resources for Health (HRH) and Quality of Care** |
| **Intervention(s)** | | **Intervention**: HRH planning, management and governance including for community health workers (CHWs)  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | The HRH strategic plan (PNDRHS) under implementation ends in 2025, so there is a need to prepare a new guidance document for HRH development. This plan will be preceded by an evaluation exercise of the current PNDRHS to assess its degree of implementation, and to what extent the objectives have been achieved, and lessons learned throughout its implementation to recommend key issues in the new plan, especially in recruitment, equitable distribution and retention of personnel, professional development and motivation. On the other hand, the new PNDRHS must be aligned with the strategies for pre- and in service training of personnel, as well as policies related to the provision of health services, with a focus on Primary Health Care (CSP).  The community health strategy reinforces the crucial role of APEs/APS in improving access to PHC, especially for the most undeserved. To overcome the challenges of its legal framework and lack of motivation resulting from various factors, the sector intends to prepare and approve its legal status.  The central government has introduced a new HRH management information system for civil servants the eSNGRHE. This, unlike the previous system (eCAF) does not yet collect all the information nor automatically generate all the data required to project, manage and plan HRH needs, nor measure key indicators of the National HRH Development Plan. Because of this, it is essential to develop these functionalities as soon as possible. Technical discussions with CEDSIF (Responsible for managing the SNGRHE) have already been held and the viability has already been confirmed. Additionally, a part of the process (query formulation and development) has already been initiated with Jhpiego technical support. However, the more complex components are still unsupported. Once this HR information system has been adjusted to health sector needs, HRH managers will be trained.  To ensure the production of HRH information that allows formulation of adequate policies and evidence based decision-making, the sector established the HRH Observatory (HRHO) whose operationalization has been deficient due to the weak capacity of data analysis and production of relevant information and limited dissemination of scarce information. Hence, the sector proposes to train technicians assigned to the ORHS, regularly hold ORHS conferences and use digital platforms to disseminate information. |
| **List of activities** | | * Evaluate the National Plan for HRH Development (NPHRHD) 2016-2025 * Develop the NPHRHD 2026-2035 * Develop the Statute of the CHW * Support the CEDSIF in developing the SNGRHE-Health Extension |
| **Amount requested** | | **Within allocation: $1,719,529** |
| **Expected outcome** | | * Improved CHW motivation and performance * Improved HRH management at all levels of the sector, including at community level * Ensured the effective dissemination of quality information generated by the HRHO |
| **Intervention(s)** | | **Intervention:** Education and production of new health workers (excluding community health workers)  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | MISAU approved the 2022-2025 Accelerated Plan for Training Specialized Personnel to respond to the growing needs imposed by the increasing demand for Human Resources for Health (HRH) in the provision of Primary Health Care (CSP), in particular the ambitious goals of HIV, TB and Malaria (HTM) programs. In addition, the National Directorate for the Training of Health Professionals Strategic Plan 2022-2026 prioritizes the training of competent Medium Health Technicians. These plans impose additional budgetary challenges on Training Institutions (IdFs) to respond effectively to the growing demand of health professionals at the primary level, including the first referral level. Hence, it is intended to continue to allocate financial resources from the Global Fund (GF) to the IdFs to increase their training capacity of PHC level HRH.  For an efficient and equitable allocation of scarce financial resources to the IdFs in the country, the sector intends to update the training costs dated 2012, disaggregated by geographic area and type of courses, etc., and institutionalize this process in order to keep this information updated and adjusted to the specific context of the country.  The increasing volume of training courses to respond to the plans described above requires the existence of a mechanism that ensures the training of competent health professionals, so the sector will develop and implement a quality assurance program for training health professionals that is more comprehensive, strategic and long-term. While this quality improvement program is being developed, the sector intends to minimize the quality deficits already identified in pre-service training, namely in the technical and pedagogical skills of trainers, trainees' professional practice and internships, management of IdFs, among others. Thus, the training sector intends to update training curricula and teaching manuals to turn them into competence-based model and respond to the country's epidemiological profile, as well as proposing a revision of the authorization flowchart for updating clinical protocols with the involvement of all stakeholders (programs, training, CMAM, etc) to ensure timely integration of new or updated clinical protocols into training curricula. Trainers will also be trained in pedagogical issues and updated techniques on PHC package for their competences-based A and B Certification, with focus on the contents of the HTM programs. |
|  | | Finally, in order to improve quality standards of both pre-service and in-service courses, an authorization mechanism will be established in consultation with the operational directorates, department and programs of the MoH. This will include a decision-making structure, submission process, as well as formats, templates and standards.  Currently public training institutions of mid-level health professionals rely on extremely limited and often out of date bibliography. This leads not only to problems of training quality, but also prevents the habit of lifelong learning among health workers. To address this issue the sector intends to introduce access to online bibliography, via terminals and subscriptions to online libraries and academic databases. Additionally, library staff will receive training and support to help students access online material.  Skills labs and biochemistry labs are essential for students to acquire the psychomotor skills required to carry out effective physical exams, take and process samples, and administer many common procedures even at the primary level. Because of this, it is essential that labs have sufficient equipment and materials for students to observe, practice and consolidate these skills.  The sector thus intends to re-equip IdFs laboratories not only to replace damaged and out-of-date equipment (last done in 2012) but also to expand the quantities to ensure sufficient access. This is part of a broader plan to increase and improve the use of labs.  Improvement in the quality of teaching has often been compromised by the poor quality of practice. This is related to, among other things, the overloading of practicum sites near training facilities as well as inadequate supervision. To address this issue, the sector intends to both improve the distribution of students to include more distant practicum sites and to increase the intensity of practicum oversite by IdF faculty. As part of this process, the sector intends to obtain vehicles for 12 IdF.  The IT information systems for health training (SIFIn and SIFo) are outdated, making it necessary to revitalize them in order to improve the monitoring and management of training activities, and ensure their interoperability and integration with other Government information systems (SISMA, SNGRHE, ANEP, etc). |
| **List of activities** | | * Allocate additional financial resources to IdFs as to increase their training capacity HRHs focusing on both CHW (APS) and PHC level * Update pre-service training costs to improve allocation of funds to IdF * Develop the training quality assurance program for health professionals * Reinforce the libraries and labs (both skills labs and biochemistry labs) material and equipment * Update training curricula and teaching manuals to fulfill competency-based standards * Train trainers and IdF managers in pedagogical matters to meet competency-based standards to ensure their certification (A and B) * Revitalize health training information systems (SIFIn and SIFo) * Establish standards and mechanism for approval of training programs of the NHS * Develop a centralized online database (or adapt the virtual library of the telehealth platform) for all approved training materials (curricula, manuals, teaching aids etc) |
| **Amount requested** | | **Within allocation: $6,428,537** |
| **Expected outcome** | | * Increased availability of quality human resources for CSP delivery, including CHWs * Improved IdFs management and funding |
| **Intervention(s)** | | **Intervention:** Remuneration and deployment of existing/new staff (excluding community health workers)  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | To accurately project the staff requirements for achievement of universal health care as outlined in SDG3, the NHS needs to take into account both the diversity of services to be provided at different levels of care and the workload of different health facilities at the same level of care. To achieve this, the sector intends to both revise facility-based staffing standards and develop a WISN tool to adjust these standards workloads  Facility-based staffing standards for all levels of health facility, outlined in the July 31 Ministerial Diploma No. 127/2002, are out of date, as they don’t take into account epidemiologic (increase in chronic diseases) and demographic changes (urbanization) in the population as well as changes in health service delivery (for example the expansion of HIV and TB care provision at the decentralized level). Furthermore, they don’t take into account HRH requirements for the recently developed essential service package for Universal Health Care, prepared by the MISAU with WHO support.  To this end the sector intends to revise facility-based staffing standards (Quadro Tipo) based on the Essential Service Package for health facilities at all levels of primary care (including the first level of referral). Additionally, a WISN study will be carried out and the respective staff allocation tool developed. |
| **List of activities** | | * Alignment Facility-based staffing standards (core teams) to the Essential Health Services Package for Rural Health Centers Type 1 and 2, Urban Health Centers Type A,B,C and District Hospitals * Conduct a WISN study and develop the respective tool to project staffing needs based on workload and * Develop SOP for projecting HRH needs using core health team and WISN tools |
| **Amount requested** | | **Within allocation: $2,950,283** |
| **Expected outcome** | | * Improved planning of HRH resource needs * Reduced inequities in the distribution/allocation of HRH at all levels, including the community |
| **Intervention(s)** | | **Intervention:** In-service training (excluding community health workers)  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | The traditional way of face-to-face in-service training to improve staff performance implies frequent absences from their workplace and consequent negative impact on the provision of health services. Also, this approach entails high logistical costs to gather professionals and keep them continuously updated in a context of rapid evolution of knowledge, especially in HIV, Tuberculosis and Malaria programmes. For this reason, the sector has invested in innovative HR approaches to in-service training such as the use of a Telehealth platform that allows distance learning and real-time refreshment of health professionals’ skills. These interventions are not supported by a clear strategic vision and legislation to guide their effective development. Thus, with technical support from Jhpiego and the CDC the training sector intends to develop a Telehealth strategy. To this end, a working group has been established and is currently developing the TOR for developing the strategy. This strategy will focus on teleconsultation (between professionals) and telementoring to improve the quality of care, telediagnostics to improve access to diagnostic support for populations living in periphery areas, and tele-education to improve access to in-service training (as well as to reduce staff absence from the workplace and reduce costs). In parallel with the development of the strategy and associated policies, the sector intends to expand the availability of in-service training packages via tele-education. This includes both primarily the transformation of presential training courses to virtual courses and the development of new courses such as those focused on building the capacity of CHW. Content is transformed to online interactive self-learning packages, which include instructional videos, animations, narrative text, automatic testing and correction. This is done in collaboration with the relevant programs.  To reinforce and institutionalize the teleconsultation service, the department intends to transfer responsibility from the partners (I-TECH) physicians to physicians in the NHS. This will include virtual monitoring and management functions, which will allow providers to provide services from their workplaces.  Finally the sector will develop a telementoring plan appropriate for facility based health workers and CHW. It is expected that this will serve not only to improve quality in itself but also to stimulate demand for health consultation service |
|  | | Given the limited availability of administrative staff, the management bodies of the National Health Service (SNS) are, to a large extent, composed of health professionals who are not familiar with the principles of management and administration of health services. Thus, to remedy this situation, the training sector will design and implement a management and leadership training package for NHS managers at various levels to improve the management of the available scarce resources to the health sector. |
| **List of activities** | | * Transformation of 18 existing courses to the tele-education format. This includes technical updating of content (includes courses in Malaria, TB, and HIV as well as diverse courses related to HSS) * Development of an online telehealth, including teleconsultation monitoring and management system * Development of a promotion strategy focussing on health workers, social networks, training institutions etc - includes virtual and manual posters and videoclips as well as inclusion in existing fora * Landscape analysis to inform the development of a telehealth, including telementoring strategy and plan for primary care health workers and community and community health workers, including regulamentation * Development of an appropriate detailed telementoring plan * Design and implement a management and leadership training package for NHS managers at various levels |
| **Amount requested** | | **Within allocation: $507,579** |
| **Expected outcome** | | * Improved the quality delivery of in-service training activities * Improved efficiency in the management of health sector resources at all levels |
| **Intervention(s)** | | **Intervention:** Integrated supportive supervision for health workers (excluding CHWs)  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | The vertical approach to supervision of health service providers is a programmatic challenge that directly affects health service performance, as it entails high costs, reduces the availability of health professionals in the HFs, among other challenges. Thus, the sector intends to reorganize this activity through the elaboration of a supervision guide to be implemented at the various levels of health care provision by purposely-trained supervisors. The objective of integrated supervision is to guarantee the monitoring of the execution of the activities of the health programs in general according to the plan and to detect practical difficulties and guide in-service training, for the improvement of the quality in the provision of health services in all areas and with special attention to the primary network. The intention is to form a team at the central and local levels to ensure supervision of the health units of the National Health Service, with a focus on the primary network and to avoid the fragmentation of supervision.  For the elaboration of the Integrated Supervision Guide, a technical Assistance service will be contracted and will have the support of the WHO to guarantee the inclusion of good regional/international practices and all programs will be involved. |
| **List of activities** | | * Develop the Integrated Supervision Guide and its implementation rules * Print and disseminate the Integrated Supervision Guide; * Train central and provincial level supervisors to perform integrated supervision. |
| **Amount requested** | | **Within allocation: $350,952** |
| **Expected outcome** | | Improved health works performance through integrated supportive supervision |
| **Intervention(s)** | | **Intervention:** Quality improvement and capacity building for quality of care  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | The current performance assessment tool for civil servants (SIGEDAP) is not suitable for health sector personnel, in particular for health care providers. Hence, the health sector intends to design an adequate tool for assessing the performance of health professionals, especially for health care providers. This tool will allow the evaluation of the specific responsibilities of health workers, will include their work plan, and individual definition and evaluation goals. It is hoped that this approach will serve as a basis for more efficient and effective supervision. Once approved, the performance assessment tool will be reproduced and disseminated to ensure its effective implementation. During the implementation phase of the new tool, special attention will be given to its combination with other key interventions that equally contribute to improving the performance of health professionals, namely continuous training, integrated supportive supervision and innovative quality improvement mechanisms.  The low quality of health services in general has been a recurrent challenge in the health sector. In addition, efforts aimed at improving quality have been isolated, verticalized and fragmented, with limited impact. For this reason, in 2017 the health sector established a central regulatory body for quality management and assurance, whose institutional capacity is still at an incipient stage, even lacking quality improvement guidelines. Hence, the aim is to draw up a holistic and integrated policy and strategy for system quality management and assurance across the health sector, as well as to provide a user manual for the various stakeholders at all levels of the health system. |
| **List of activities** | | * Disseminate and implement the new performance assessment tool (SIGEDAP) Print and disseminate the health care providers performance assessment tool * Develop the Quality Management and Assurance Policy * Develop the Quality Management and Assurance Strategy * Develop the Quality Management and Assurance Manual |
| **Amount requested** | | **Within allocation: $611,133** |
| **Expected outcome** | | * Improved health professional performance, in particular health care providers * Improved quality management and assurance in the health sector |
| **Intervention(s)** | | **Intervention:** Community Health Workers: Selection, pre-service training, and certification  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | This intervention aims to equip the future cohorts of CHWs who will undergo training from 2024 to 2026 with the necessary skills and knowledge to serve effectively their communities with the Essential Health Care Package (PECS), promoting holistic and patient-centered care while embracing advancements in healthcare practices and technology.  CHWs cover APS and ACS, including those responding to TB and HIV, Red Cross volunteers, “lay” counselors, and mentor mothers, integrated nutrition package activists, adolescent and youth program activists, traditional medicine practitioners, traditional midwives, peer educators.  The newly developed competency-based curriculum under the Community Health Subsystem ensures comprehensive and up-to-date materials for effective learning. This new curriculum builds upon the lessons learnt from the recent pilot training package along with the multi-year experience of the PNAPESs while incorporating essential updates. It shifts from a content-based to a competency-based approach, focusing on the Essential Care Package (PECS) for the Community and addressing the complete lifecycle. It also encompasses an updated approach to interventions such as first aid, nutrition, HIV, NCDs and medicines management, while being more dedicated to health promotion and more sensitive to gender and human rights considerations. Additionally, the curriculum embraces the digital transformation of data collection through the utilization of UPSCALE.  This training program, based on the new competency-based curriculum, has a duration of six months. It will include a three-month theoretical and practical competencies training in a classroom setting, followed by an additional three-month internship at a health facility and within the targeted communities. In distinction to the previous PNAPEs curriculum, this curriculum is designed to be implemented and taught at the Professional Institutes of Health Training (IdF in portuguese) and is currently undergoing certification by the National Authority for Professional Education (ANEP in portuguese). This certification process ensures that the curriculum meets the required standards and guidelines, ensuring its quality of learning, scale and subsequent quality of service delivery by CHWs.  Competency-based training of CHWs in the new curriculum will also include CHWs receiving training and technical support for management and dispensation of medicines and equipment kits within a rational and quality of care perspective as part of their pre-service training of 3 months in the classroom and 3 months of practicum at a health facility and community. This will be enhanced by on-the-job training, supervision and technical support, and by using UpSCALE with user-friendly features will help CHWs keep within the required standards; this will also leverage the telehealth platform in use by the Ministry of Health. APS will receive the full training package, which makes them polyvalent; ACS will receive a training package focusing on specific interventions, within the perspective of the essential community health package.  The selection of CHW candidates will be based on the Terms of Reference (TOR) outlined in the CHSS Strategy. Once trained, CHWs will be provided with a medicine and work/equipment kit that will support their work.  The coordination of the network of CHWs, including TB and HIV ACSs, Red Cross volunteers, “lay” counselors, mentor mothers, integrated nutrition package activists, adolescent and youth program activists, traditional medicine practitioners, traditional midwives, peer educators, among others, is done by the Community Health Development Committee. This Committee, as defined in the Strategy, serves as the primary platform for coordinating, managing, and integrating programmatic and strategic actions of the Community Health Subsystem. In terms of complementarity of actions, training, and coordination among APS and above mentioned health actors, ACSs with specific profiles and experience in specific thematic areas of the new curriculum are eligible to undergo training in that specific thematic area to enhance coordination with the APS. The ACSs statutory role should be clearly defined in the updated Strategy (also an activity included in this proposal).  This local coordination will further enhance the promotion of community participation and involvement of local leaders in identifying and addressing health issues, mobilizing local partnerships, as well as reducing the fragmentation of ongoing interventions in communities and maximizing the utilization of available resources.  So far, the APE scope of work is predominantly oriented towards actions to combat malaria, diarrhea and acute respiratory infections. To integrate HIV/TB programmatic activities, the community subsystem strategy plans to expand their scope of work by putting in place a number of actions: updating medicines list based on disease incidence, target group, estimated community cases to be treated, and including first aid, HIV testing, and treatment of uncomplicated acute malnutrition; assigning each APS to a catchment area of 1,000 inhabitants in rural areas, thus approaching the WHO recommended ratio; adjusting procurement process and distribution channels with UNICEF technical support, including establishing efficient reporting mechanisms and Expanding the UPSCALE digital system to provide timely data on stock levels, utilization rates, and expiration dates; predicting future needs through data analytics; implementing quality control measures to ensure adherence to standards; and strengthening end-user monitoring. The corresponding content and cost of APS’ medicine, equipment and work starter kits are described in Annex XX.  To ensure adequate working conditions for APSs and community pandemic preparedness and response to public health emergencies, 490 basic community health posts will be built in 49 districts, of which in 12 districts from the pilot phase of the community health subsystem strategy, and in 37 prioritized districts due to extremely high health vulnerability. Based on lessons learned from Inhambane Province in building community posts with contribution from local community and government to ensure ownership, the total investment cost was brought down to $20,000 each. |
| **List of activities** | | * Pre-service training of 660 CHW in 11 IdF over a three-year period. This involves conducting one course per year in each IdF, with 20 students/CHWs per course. * Procure and distribute non-malaria medicine and equipment kits for each CHW * Provide each CHW with a work starter kit * Procurement and distribution of the kits will be ensured by CMAM, through government channels, with technical assistance from UNICEF * Provide training and technical support to CHWs on management and dispensation of medicines and equipment kits   **PAAR:**   * Training Package: This activity encompasses the finalization, design, and printing of the curriculum and training manuals specifically tailored to the competency-based pre-service training for the CHWs. * Building 490 basic community health posts in 49 districts, including the 37 districts prioritized due to extremely high health vulnerability and the 12 districts included in the pilot phase of the community health subsystem strategy. |
| **Amount requested** | | **Within allocation: $3,679,893**  **PAAR: $9,855,182** |
| **Expected outcome** | | * Completed the development and certification of an enhanced competency-based pre-service training curriculum and training manuals tailored to CHWs, providing comprehensive and up-to-date materials for effective learning. * Enhanced capacity of 660 CHWs with competency-based completed training at IdFs who are attested for and with the necessary skills, knowledge, and resources to effectively serve their communities and deliver essential healthcare services. * Improved CHW working conditions and community preparedness and response to public health threats |
| **Intervention(s)** | | **Intervention:** Community Health Workers: Hiring, Compensation and Retention  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | A report published by UNAIDS in 2017 stated that Mozambique had a community health worker ratio of less than 0.5 per 1,000 population, one of the lowest in the African continent.  By December 2022, the country had x Community Health Workers (CHWs) deployed across x provinces and x districts. In this process of transitioning and expanding community health services, a prioritization exercise was conducted for selecting the most vulnerable districts...  The prioritization exercise was based on Mozambique's health vulnerability index, further described in the rationale section.  Once the CHWs are graduated, the competent authorities of the District or Municipal Decentralized Governance bodies prepare the contract and the respective registration in the e-SIP (Personnel Information System). They are then eligible for a monthly salary (estimated in 8,758 meticais). |
| **List of activities** | | * Phased hiring of 963 CHWs trained in the new competency-based curriculum is proposed, with 303 already trained in 2023 and an additional 660 to be trained during the current funding implementation period (2024-2026). These CHWs will be selected from and assigned to 37 prioritized districts, along with the 12 pilot districts. * Implementation of mechanisms to ensure timely and full payment of monthly remuneration for the graduated CHWs, as well as monitoring of this process. The subsystem needs $3,157,869 to cover the salaries of 963 graduated CHWs in a phased manner until 2026. |
| **Amount requested** | | **Within allocation: $3,125,721** |
| **Expected outcome** | | * Pre-service training and assignment of 963 CHW to high vulnerable districts * Harmonized CHW hiring and remuneration policy approved by the MOH with a monitoring process established to ensure the proper execution of the payment system |
| **Intervention(s)** | | **Intervention:** Community Health Workers: Integrated Technical Supportive Supervision  Change in Programming from current grant: X New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | | Supervision and technical support to CHWs will follow a bottom-up approach, and be completed by a top-down approach. The bottom-up approach consists in the health facility conducting monthly supervisions and technical support to CHWs. Integrated district and provincial level teams conduct quarterly supervisions and the integrated national level supervision teams conduct bi-annual supervision visits (every 6 months). Supervision guides and pocket sized books will be used during supervision, supplemented by the supervision module within UpSCALE.  Supportive supervision and technical support of the new cadres of CHWs (APS and ACS) trained in the new competency-based curriculum, will follow the format of the supervision within the APE CHWs Community Health Program activities is carried out by healthcare professionals from the health units in the area, based on a supervision guide.  The supervision team consists of a clinical supervisor (CS) and a supervisor for Maternal and Child Health (MCH). These health technicians will dedicate 20 percent of their workload to supervision tasks. Each supervisor will be responsible for covering 12 CHWs.  A supervision allowance will be provided, which must comply with the compensation rates defined by the competent authorities. |
| **List of activities** | | * Mapping and training of CHW supervisors. By investing in the development of supervisors, we aim to enhance the overall supervision process and bridge any gaps caused by staff turnover. * Conducting supportive supervision to CHWs, as part of the continuous training, which includes on-the-job training, and cover related costs such as per diem and travel expenses for supervisors at the national, provincial, and district levels. The estimated cost for this activity is $664,335. * Use telementoring of CHWs as part of on-the-job- training to complement face-to-face supervision and technical support interactions between national and provincial level supervisors and CHWs and to reduce travel and other costs related to face-to-face interactions. * Telementoring tools will be developed and adapted as needed, by the the Ministry of Health Training Departments, with validation of contents involving disease programs (HIV, TB, malaria) and the community health program of the Ministry of Health * TA to support the coordination to implement the community health system at national, provincial and district level. * TA to support the coordination and development of tools for operationalization and monitoring, with a focus on continuous improvement. This includes areas such as the training package, supply system, and information system tools.   **PAAR:** (Under PAAR) Procuring 11 vehicles, including one for the central level in Maputo City and one for each of the 10 additional provinces in Mozambique, to facilitate supervision and provide technical support to CHWs. The estimated cost for this is $330,000. These vehicles will contribute to regular supervision from the national and the provincial level to the sub-national level to ensure quality of implementation of the newly created community health subsystem, with urgent a. |
| **Amount requested** | | **Within allocation: $952,335**  **PAAR: $330,000** |
| **Expected outcome** | | * Improved Supervision and Technical Support: Procuring vehicles for CHW supervision in Mozambique facilitates better supervision and technical support. * Strengthened CHW Supervision System: Mapping and training CHW supervisors bridges gaps caused by staff turnover, creating a more robust and sustainable supervision system that ensures consistent support, guidance, and performance monitoring of CHWs. * Enhanced Continuous Training and Support: Conducting supportive supervision with on-the-job training and covering related costs demonstrates a commitment to continuous professional development for CHWs, equipping them with skills and knowledge to deliver quality healthcare services and improve health outcomes. * Improved Operationalization tools and mechanisms for monitoring with a specific focus on on-time updates, ultimately leading to more efficient and effective implementation, monitoring, and overall performance in the relevant areas * Improved and established coordination mechanisms at national, provincial and district level. |
| ***MODULE 10 TOTAL*** | | *Within allocation: $13,325,962 | Matching Funds: $7,000,000 (Total = $20,325,962)*  *PAAR: $10,185,182* |

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| **MODULE 11** | **RSSH/PP: Laboratory Systems (including national and peripheral)** |
| **Intervention(s)** | **Intervention:** RSSH/PP: National laboratory governance and management structures  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | The main guiding tool for laboratory activities expires in 2024, so there is a need to update it to ensure the harmonious and continuous development of the laboratory network. This update will be preceded by an assessment of the current Strategic Plan in order to recommend the key issues to be considered in the new National Strategic Plan for Clinical Laboratories 2025-2030.  At the same time, the sector intends to continue to improve laboratory network governance at all levels of management through the implementation of global laboratory management and leadership program (GLLP) for leadership training of laboratory network managers at its various levels. It is also intended to hire Technical Assistance to support the Institutional development of the Central Division of Laboratories, as well as to continue to hold biannual meetings of the Clinical Laboratories network aimed at assessing the performance of the network, developing guidelines, disseminate new working methods, among others. |
| **List of activities** | * Conduct an evaluation of the implementation of the National Strategy for Clinical Laboratories 2020-2024; * Develop the next National Strategy for Clinical Laboratories - 2025-2035 * Expand the Global Laboratory Management and Leadership (GLLP) training program using the One Health approach to train heads of central, provincial and district laboratories |
| **Amount requested** | **Within allocation: $1,545,040** |
| **Expected outcome** | Improved laboratory network governance at all management levels |
| **Intervention(s)** | **Intervention:** Quality management systems and accreditation  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | The clinical laboratories network is currently in the process of accreditation of 6 laboratories (HC Maputo and Nampula, HP Tete and Chimoio and HG Mavalane and Machava) and to support the maintenance of the level of quality of the laboratories of these laboratories and including the remaining clinical laboratories of HC Quelimane and Beira, HP Matola, Inhambane, Xai xai, Pemba, Lichinga and HG Quelimane there is a need to expand the implementation of AEQ of Hematology, Biochemistry and microbiology with the final aim of ensuring the reliability of the results as well as the clinicians and patients. |
| **List of activities** | * Expand the Quality Improvement program to integrate other areas/exams of the clinical laboratory, namely Hematology, Biochemistry and Microbiology * Train quality managers in quality assurance * Quality Management and Accreditation Systems (INS) |
| **Amount requested** | **Within allocation: $1,510,410** |
| **Expected outcome** | Improved the quality of laboratory services provided at all levels |
| **Intervention(s)** | **Intervention:** RSSH/PP: Laboratory Information Systems  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | To ensure the availability of quality data and consequent effective decision-making, it is necessary to continuously adjust the Laboratory Information System (LIS) data collection tools. Therefore, the sector will hold a workshop to map and update the relevant documentation and subsequently guarantee its layout and printing. To increase the availability of quality data, the Lab sector will continue to automate the SIL, as well as standardize and gradually expand the electronic LIS to approximately 70% of the tier 2 clinical laboratories on the basis of local infrastructure conditions, resources availability, and backed by site level plan. This activity will also be informed by the planned evaluation in 2023 under NFM3/GC6 and complements CDC support to the Labs with Viral load. In addition, an electronic web-based platform and dashboard will be developed that allows the aggregated/integrated management of laboratory data from different systems/databases. This implies equipping targeted laboratories with computer equipment, installing an internet network, training users, and establishing a Helpdesk Center with Information Technologies (IT) personnel for users real time support. These digital connectivity solutions are expected to effectively manage laboratory reagents and consumables, make timely decisions based on external quality assessment (EQA) results and test statistics generated by the system, and timely respond to any equipment breakdowns and maintenance needs. These interventions will support the Lab strategic goal for strengthening the LIS and promote its accessibility to all levels. |
| **List of activities** | * Update LIS guidelines, records and reporting model * Carry out a collegiate activity to validate the proposed updates in the SIL guidelines, logbooks and reporting models * Reproduce and distribute updated and modeled SIL instruments * Expand electronic LIS in clinical laboratories, with greater focus on District Hospitals * Continue to develop and implement an integrated electronic platform (web-based) and dashboard for managing aggregated laboratory data from different systems/databases |
| **Amount requested** | **Within allocation: $680,300** |
| **Expected outcome** | Ensured accessibility to quality laboratory data for effective decision-making at all levels |
| **Intervention(s)** | **Intervention:** Laboratory based surveillance  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | The HIV, COVID-19 and other pandemics have demonstrated the relevance and strategic importance of genomic surveillance for identifying public health threats associated with infectious agents, especially those that cause zoonotic diseases. Therefore, the establishment of an integrated network of genomic laboratories based on One Health approach (human and animal) is of paramount importance for the detection of pathogens genetic variants at animal and human health reference laboratories, identification of the circulation of antimicrobial resistant strains, determination of outbreaks geographic spread pattern and their determinants in the animal and human population, and identification of emerging pathogens associated with possible outbreaks or pandemics at the animal-human interface.  Although the country has invested in genetic sequencing platforms in recent years, there are still challenges in the bioinformatics component to perform genetic sequence analysis, which is why it is urgent to establish a genomics center in Mozambique. This Center will serve both Human and Animal Health, and endowed with specialized personnel from both sectors. |
| **List of activities** | * Build clinical laboratories capacity to identify and report pathogens and the Antimicrobial Resistance (ADR) profile * Acquire production units of culture means * Hire services to supply inputs for the production of culture means and diffusion disks/tape and test, as well as reference and quality control materials * Train and implement key techniques for identifying microbial agents and resistance profiles * Install infection prevention and control equipment in the laboratories, such as biological biosafety booths, eyewash showers, and other collective and area protection tools * Establish an integrated network of genomics laboratories in the context of One Health (human and animal) to respond to outbreaks and emergencies * Create a Bioinformatics Center in the context of One Health in Mozambique |
| **Amount requested** | **Within allocation: $1,200,000** |
| **Expected outcome** | Improved integrated genomic surveillance capability for identifying public health threats associated with infectious agents |
| **Intervention(s)** | **Intervention:** RSSH/PP: Laboratory supply chain systems  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | The Laboratory supply Chain System is fundamentally characterized by stockouts of laboratory reagents and consumables at all levels of care and poor quality data justifying consumption, delays in performing testing activities and consequent delay in providing feedback to HFs and patients. To remedy this situation, and in addition to the improvements envisaged in the LIS, the sector will adapt the training package on Logistical Management of reagents and consumables for e-learning, and conduct training of logistics managers on using a hybrid modality (face-to-face and virtual) to increase accessibility to this package. It is also intended to create an electronic platform to capture deliveries from suppliers in each laboratory to monitor the consumption and service volume of the US. |
| **List of activities** | * Update and convert the training package on Logistic Management of reagents and consumables into a e-learning model through the Telehealth platform * Induce technicians in the new approach of logistic management of reagents (strategy to introduce virtual platforms) * Conduct virtual training for logistics management * Perform quarterly remote follow-up |
| **Amount requested** | **Within allocation: $170,258** |
| **Expected outcome** | * Improved management of the logistical process * Have an indicator of availability of exams/equipment * Logistical information for the process of quantification of reagents for decision making * Ensured the uninterrupted supply of laboratory reagents and consumables to all levels of care |
| **Intervention(s)** | **Intervention:** RSSH/PP: Specimen referral and transport system  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | As the current Specimen referral and transport system (SRS) is predominantly managed by a sector Implementing Partner, it is intended to initiate the transition of SRS management to MISAU. To that end, a transition roadmap will be designed and piloted in two provinces, including stakeholders training from targeted DPS/SPS on SRS management. It should be noted that the SRS monitoring methodology will be updated and standardized within the scope of foreseen SIL investments, including a Dashboard connected to the Link system. |
| **List of activities** | * Design the roadmap for transitioning the SRS management to the MISAU * Pilot SRS management transition to MISAU in two provinces in 2026 * Establish and train the Central Level team (MISAU) in contract management, logistics and SRS operations * Develop the terms of reference procedures in contract management, logistics and operational management of the SRS * Train laboratory supervisors from targeted DPS/SPS on SRS logistical and financial management |
| **Amount requested** | **Within allocation: $680,300** |
| **Expected outcome** | Ensured gradual transition of SRS to MISAU’s |
| **Intervention(s)** | **Intervention:** Biosafety and biosecurity, infrastructure and equipment  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | To reduce the risk of biological exposure within the clinical laboratories, the sector will acquire and supply biosafety equipment such as biosafety signs and booths, protective and emergency equipment, maintenance equipment, etc., and train health professionals in its use and to deal with any cases of accident.  Due to the poor quality of services for checking and maintaining laboratory equipment and instruments and the high costs of contracting services to guarantee the full functioning of these instruments and equipment, the sector intends to create capacity for professionalized assistance within MISAU. For this purpose, regional reference centers will be established in the south (MISAU), center (Sofala) and north (Nampula) of the country by providing trained personnel and equipping the maintenance sectors. |
| **List of activities** | * Make biosafety, bioprotection and emergency equipment available to clinical laboratories * Acquire laboratory equipment and respective accessories and spare parts   **PAAR:** Revitalize the equipment maintenance sector in the National Health Service |
| **Amount requested** | **Within allocation: $550,750**  **PAAR: $3,973,500** |
| **Expected outcome** | * Reduced risk of exposure to hazardous agents in clinical laboratories, including availability of protective equipment for accident cases * Ensured the continuous functionality of laboratory equipment |
| ***MODULE 11 TOTAL*** | *Within allocation: $6,337,058*  *PAAR: $3,973,500* |
| **MODULE 12** | **Monitoring and Evaluation Systems (cross-cutting M&E)** |
| **Intervention(s)** | **Intervention:** Routine reporting  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | The lack of clear guidelines to guide the development of M&E and health information systems of the National Health Sector, combined with the vertical nature of both health service management and health system supporting areas, contributes to the proliferation of M&E and HIS mechanisms and processes. This burdens frontline service providers with data collection and reporting at the expense of data quality and service delivery. For example, a 2018 time and motion study of frontline health workers found that HCW nurses and MCH nurses spent more than 14.6 and 15.4 hours per month on data collection. This also contributes to interoperability issues between the HIS and subsystems, which hinder essential data analyzes and use. The fragmented nature of electronic health information systems mainly managed by implementing partners aggravates HTM programmatic challenges and undermines MISAU’s ability to use data for strategic decision-making. This is also hampered by the limited ability to analyze and interpret data for decision-making at all levels of the NHS.  Despite the country having made headway in the expansion and scale-up of SISMA as the preferred main system for aggregated data reporting, this has not resolved the continued challenge of multiple verticalized and not integrated systems on the ground with most of them still manual and paper-based which has had a significant impact on data quality. To tackle these challenges, the Ministry of Health intends to gradually digitalize the health services (integrated rather than parallel) at PHC facility level and ensure the interoperability of SISMA (DHIS2) with other existing data systems.  To achieve the digitalization, it is important to have an Information and Communication Technology infrastructure for the SNS data network, including internet connectivity, and computer equipment is essential to facilitate access and transmission of data/information. The availability of computational resources, with facilities and simplicity for installation; has contributed to transforming the information generation process, reducing costs, making processes flexible and improving management processes.  To ensure ITC system functionality, the sector will expand data network and servers in locations not covered in LAN I and II, allocatie IT devices and equipment for SIS, SIS-H installation, build IT capacity trough hiring dedicated internet services to improve data transmission and online meetings, and expand shared internet and 4G or more in remote HFs. In addition, supportive supervision and training of IT personnel will be conducted to improve productivity and quality IT service, and develop skills for technical assistance in OpenMRS systems and integrated systems for patient tracking and management.. |
|  | The Community Health Information System is also a priority. The MOH has started the development and harmonization of a routine based community information systems (CHMIS). The main remaining challenge is implementing a standard database for management of community data to avoid duplications (SIS-C, upSCALE formerly known as APE Commcare).  To ensure the use of health data and the governance of HIS, the MoH has developed and approved the Health Information Policy and Health Information System Policy. These Policies will help to guide the Sector and all stakeholders in the use of data, system mechanisms and processes related to health information. |
| **List of activities** | Policy and Documents   * Develop the Health Sector M&E Strategic and implementation plan * Develop policies and guidelines to address the present, and prevent future proliferation and fragmentation of M&A and HIS * Hold biennial national M&E meetings * Disseminate and implement the Health Information Policy and Health Information System Policy   Information Technology and Communication   * Expand data network for all Country’s Health Facilities, including MoH data center infrastructure and equipment; * Improve the interoperability of existing health information systems and subsystems to facilitate comparative analysis between different health information systems and subsystems   Supportive supervision and training at national and district level   * Develop and automate the production of important analyses, graphs and dashboards for managers at all levels of the SNS in order to improve the presentation and dissemination of M&E data for decision making; * Improve the data analysis capacity of the M&E teams at all levels of the SNS * Capacity building to ICT personnel through training and supervision   **PAAR:**   * Establish new Data Network points (LAN and Server) to expand Clinical Laboratories in Hospitals, and LAN Network in Hospitals in the Central Region ($900,000) * License acquisition and implementation of servers for visualization of radiological exams, with web access ($350,000) * Printing of APS log books for registration ($80,000) |
| **Amount requested** | **Within allocation: $4,650,000**  **PAAR: $1,330,000** |
| **Expected outcome** | * Ensured provision of essential data for health system decision-making * Improved data network and communication * Ensure interoperability and functionality of Health Information Systems and subsystems |
| **Intervention(s)** | **Intervention:** Surveillance for priority epidemic-prone diseases and events  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | District surveillance systems for preventing and responding to external shocks will be strengthened through training and renewal of district surveillance teams, including performance of emergency drills at district level. In addition, district emergency preparedness plans will be presented and at least 50 motorcycles will be purchased for the most vulnerable areas. These activities will be seconded by the creation of an Emergency Operations Center in Maputo. Likewise, community-based surveillance systems for the suspicion and early detection of diseases with epidemic or pandemic potential will be strengthened through the training of CHW/APSs in all districts of the most vulnerable provinces (Gaza, Inhambane, Sofala, Zambézia , Cabo Delgado and Nampula) and equipment acquisition (including internet vouchers) for them in order to allow real time data sharing (p.e, mobile phones to scale the upscale platform)  It is intended to improve access to information and the provision of health services at the community level subsystem, through the training of more multipurpose Community health workers, provision of resources of transport to reach more areas and provision of devices for reporting information in real time. Part of these activities are included in the other proposal (C19RM) given the scarcity of resources and the need to complement the acquisition of the necessary quantities, which includes motorbikes, vouchers, electronic devices and a training package. |
| **List of activities** | * Strengthen district surveillance systems to prevent and quickly and effectively respond to external shocks and outbreaks * Strengthen community-based surveillance systems for early suspicion and detection of epidemic-prone diseases |
| **Amount requested** | **Within allocation: $1,000,000** |
| **Expected outcome** | Strengthened Real-Time Surveillance at the district level |
| **Intervention(s)** | **Intervention:** Surveys  Change in Programming from current grant: ☐ New, ☐ Scale-up, X☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | The implementation of health surveys aims to complement the effort to monitor Population based health indicators and support more robust evidence based planning and decision-making. So, the Malaria program intends to complete the study already started on Malaria indicators. |
|  | As Mozambique becomes closer to reaching epidemic control and the 95-95-95 HIV strategic targets, understanding the characteristics and needs of key and priority populations, including their knowledge of HIV status, ARV treatment status, and viral load suppression, becomes more and more critical to achieving epidemic control. Therefore, INS, DNSP and partners are developing the National Strategic Plan for HIV Surveillance population groups for describing priority research activities and routine through a Bio-Behavioral Survey (BBS) during the next 10 years in order to generate the data needed to inform program planning and service delivery to key and priority populations to achieve and maintain HIV epidemic control Mozambique. |
| **List of activities** | * Complete the survey of malaria indicators in the southern region (IIMRS 2024 PHASE II)   **PAAR:** Implement BBS among specific groups in 7-9 provinces by 2024: Sex Workers (FSW and MSW) and their clients, non-paying sexual partners of FSW, and men who have sex with men (MSM) and transgender populations |
| **Amount requested** | **Within allocation: $395,900**  **PAAR: $5,108,586** |
| **Expected outcome** | Ensured availability of population-based data and information for programmatic decision-making |
| **Intervention(s)** | **Intervention:** Data quality  Change in Programming from current grant: ☐ New, ☐ Scale-up, ☒ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | Although there has not been a recent rigorous and nationally representative assessment of data quality (The 2023 National Data Quality Review - DQR is currently ongoing), most users of the Health Information System (SIS), including Malaria, HIV and TB programs highlighted poor data quality as a major challenge for effective evidence-based decision-making. Data quality issues identified include incomplete data (e.g., the private sector does not routinely provide data), inaccurate or highly inconsistent data (e.g., coverage vaccination rates greater than 100%), misalignment between the data necessary for decision-making (e.g., the registration of clinical data), as well as data reporting delays. Quality challenges are also due to the huge amount of data collected, duplication of data collection and entry, parallel manual and electronic data systems, inconsistent verification, issues with records and data collection instructions, underutilization of DHS2 validation, analysis, and quality functions. These systemic data quality issues pose a major challenge to inform policy making, strategic planning, monitor health service delivery performance, accurately estimate resource needs, and identify emerging health and service delivery issues.  Several isolated and largely vertical initiatives aimed at improving data quality have been implemented in the various health information subsystems, but a comprehensive and systemic approach to the root causes of poor data quality is needed, which will be based on various studies and data quality assessments that have been conducted and results from the ongoing National Data Quality Review (DQR). |
|  | MoH has held longstanding technical collaboration (under memoranda of understanding) with the Faculty of Medicine and the Faculty of Sciences at Eduardo Mondlane University (UEM), University of Oslo, National Agency for Geospatial Development (ADE), and Zenysis; under that collaboration, three areas have been covered: i) technical capacity building, both formal (through training of MOH staff in Masters degree courses in M&E, health information management and leadership; ii) informal professional development (through short-term trainings on professional topics such as data analytics - via PERSUADE, program evaluation and statistics; iii) technical consultancy mostly focused on guidelines, policy and strategy development and maintenance of SISMA (DHIS2) |
| **List of activities** | * Develop and implement a National Strategy to Improve Data Quality at all levels of the SNS * Review and reduce the amount of routine data collected to essentials M&E and strategic decision making needs * Review registration forms, reports and other data collection tools and leverage the existing case-based surveillance and case management platform to further strengthen the current SISMA. * Develop Standard Operating Procedures (SOPs) for collecting, compiling, verifying and digitizing data * Update provincial and district HIS managers on the use of the SISMA data quality tool (App Data Quality tool) * Develop an interoperability architecture and ICT framework leveraging the FHIR standard based on WHO SMART guidelines to bring in data from multiple sources and programs such as Surveillance Systems (HIV, TB, Malaria), LIS (including GeneXpert) , CLM data, etc., under an integrated and centralized data storage system, including the internet network. * Develop a comprehensive data analysis and use strategy for national, subnational and US levels, including dashboards, visualizations and reports, designing and building queries, and creating algorithms and models to reveal the resulting information from collected data . * Carry out the National Data Quality Assessment in 2026 * Regulate all HIS revisions, including the introduction of new tools, data elements or additional systems. * Expand the implementation of the TR-BED PLUS module (Real Time - Daily Epidemiological Bulletin) to all HFs * Expand gradually the computerization of HIS from hospitals and high-volume primary HFs, as part of a structured project to integrate the Hospital Management System and Monitoring of Chronic Patients * Expand gradually the computerization of the Laboratory and Pharmacy information systems * Introduce routine Community Health Information Subsystem (SIS-C) in all provinces. |
| **Amount requested** | **Within allocation: $5,500,000** |
| **Expected outcome** | Improved access to, and use of accurate, complete, relevant, contemporary data NHS managers for evidence-based planning and decision-making |
| **Intervention(s)** | **Intervention:** Civil registration and vital statistics  Change in Programming from current grant: ☐ New, ☒ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | Maintaining accurate and up-to-date civil records of vital events remains a huge challenge in Mozambique due to limited infrastructure, a highly dispersed rural population, frequent national disasters and an ongoing conflict in the north of the country. According to the 2017 national census, only about 32% of births and 15.1% of deaths were registered in the civil registry system, which data was substantiated COMSA 2019 Survey results.  Given the importance of vital statistics in obtaining essential demographic and epidemiological data needed in national health and other sector planning, as well as in measuring the demographic impact of health interventions, it is essential that the National Health System contributes for increasing the reporting of vital events across the public, private and community health subsystems, support data quality monitoring and improvements, and use vital statistics in planning and monitoring of health services performance.  SIS-COVE (previously COMSA) is a community-based platform that allows annual estimates on mortality and causes of death at a national and provincial level and also estimates other vital statistics and health indicators. SIS-COVE clusters are randomly distributed in 700 areas in all 11 provinces of the country where around 800,000 inhabitants have been enrolled since 2018.  The transition process from COMSA to SIS-COVE brought administrative challenges that delayed field work activities and consequently availability of data.  Transitioning of SIS-COVE community workers (CSAs) to APEs was also a challenge given the innovative approach of MoH to establish the community sub-system. Ensuring that SIS-COVE is also part of the community sub-system might guarantee the inclusion of CSAs as part of the community sub-system workforce and interaction between CSAs and other community workers for better coordination of community surveillance activities.  Interoperability between SIS-COVE and e-SIRCEV has been successfully piloted in Inhambane province and expansion to other provinces is expected for the improvement of CRVS coverage for births and deaths. Meanwhile, although a SIS-COVE module within the DHIS-2 has been developed, its deployment into SIS-MA has been delayed. |
| **List of activities** | * Expand HF-based civil registration (in e-SIRCEV) of vital events within HF with in-patient services (hospitals and large primary health care HFs) * Maximize interoperability between SISMA and e-SIRCEV * Expand community-based civil registration through the community health subsystem and the SIS-COVE to improve M&E, quality and coverage of civil registration * Improve in-country dissemination of Vital Statistics through national and international platforms * Train HIS personnel on data management, strategic information, and vital statistics * Train clinicians from HF with in-patient services and/or trainers of trainers on Death Certification based on ICD-10 or ICD-11 once adopted by the country; * Hold coordination meetings with the Inter-ministerial Working Group on Vital Statistics and Causes of Death. * Expand the surveillance system of the Community Health Observation System and Vital Events (SIS-COVE) to monitor health, mortality and causes of death (DIS) indicators. * Leveraging SIS-COVE mortality surveillance platform to strengthen the community early warning system for health events at the community sub-system |
| **Amount requested** | **Within allocation: $2,954,100**  **PAAR: $1,840,000** |
| **Expected outcome** | * Improved quality (completeness, accuracy, timeliness, and reliability/consistency) of vital event registration and reporting * Improved monitoring of population health impacts of health service provision * Improved and more granular monitoring of health, mortality and cause of death indicators a basis for early warning of health events, outbreak investigation and emergency response preparedness |
| **Intervention(s)** | **Intervention:** Analysis, Evaluations, Reviews, and Data Use  Change in Programming from current grant: ☒ New, ☐ Scale-up, ☐ Continuation, or ☐ Scale-down |
| **Population, geographies and/or barriers addressed** | * Lack of a functioning community surveillance system * Weak expansion and consolidation of the community health information system (UPSCALE or others) * Low data quality related to lack of interoperability among community health information systems. |
| **List of activities** | * To conduct operational research, analysis and evaluation of the implementation of the community health system in order to inform the expansion process and the revision of the Community Health Subsystem strategy in 2025 * The operational research will include an evaluation of CHW sensitivity to PLHIV, key and vulnerable populations to HIV, TB, malaria, NCDs, mental health, GBV, and to other human rights gender issues * This operational research will also include evaluations of supervision and technical support practices, to inform its improvements and ensure quality of the services provided by CHWs. * This operational research will also include an evaluation of the contribution of traditional medical practitioners in achieving UHC targets. |
| **Amount requested** | **Within allocation: $1,450,000**  **PAAR: $530,000** |
| **Expected outcome** | * A functional community health information system for surveillance and Monitoring & Evaluation (UpSCALE) interoperable with the routine health information system for Monitoring & Evaluation (SIS-MA) * Implementation of the community subsystem informed by evidence (lessons learned, challenges and facilitators) documented through operational research. |
| ***MODULE 12 TOTAL*** | *Within allocation: $15,950,000*  *PAAR: $8,808,586* |

* + 1. If you are using a Payment for Results modality, provide information on the performance indicators / milestones, targets and amounts that are proposed.

*N/a*

## Rationale

* + 1. Describe the overall approach to how you selected and prioritized the requested interventions (or indicator/milestone if using a Payments for Results modality).

The selection and prioritization of modules and interventions for this funding request were done through a combination of several malaria dialogue convened at provincial and central levels, as well as an inclusive but data-driven Malaria Programme Review (MPR) in 2022. Following this, a new national malaria strategic plan for the period 2023-2030 was drafted. This inclusive but highly data-driven approach utilized the concepts described by WHO in their guidance on stratification and sub-national tailoring to prioritize the modules and interventions[[5]](#footnote-6). Several complementary analytical methods were utilized to prepare and conduct the MPR, and to inform future strategy. This process built on lessons learned from the same process during the 2020 MTR, which included:

1. The NMCP and its partners conducted analyses at a subnational level on all routine data to evaluate impact and intervention coverage and quality
2. The NMCP and its partners collated all available research and evaluation data on intervention impact and other strategy-relevant findings
3. Deliberations on the above data were held by thematic Technical Working Groups, inclusive of partners, as well as structured reviews were conducted on implementation progress and challenges
4. Building on a positive experience during the 2020 MTR, a modeling exercise was undertaken in collaboration with the Swiss Tropical and Public Health Institute (STPH) and CHAI, to simulate intervention mix scenarios to serve as an input to the stratification prioritization decisions.

For the modeling work conducted in 2022, a cost-effectiveness optimization model was also added to the methodology to help inform the optimal ranking of interventions based on value-for-money - thus allowing for a within allocation funding request that maximizes cost effectiveness as well as a robust ranking of PAAR interventions which if funded would result in maximum additional impact.

Figure 2: Process and methods of stratification and sub-national tailoring

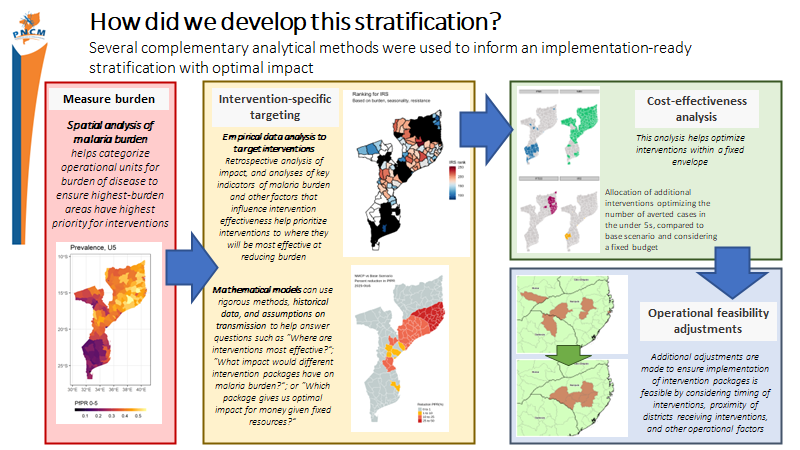
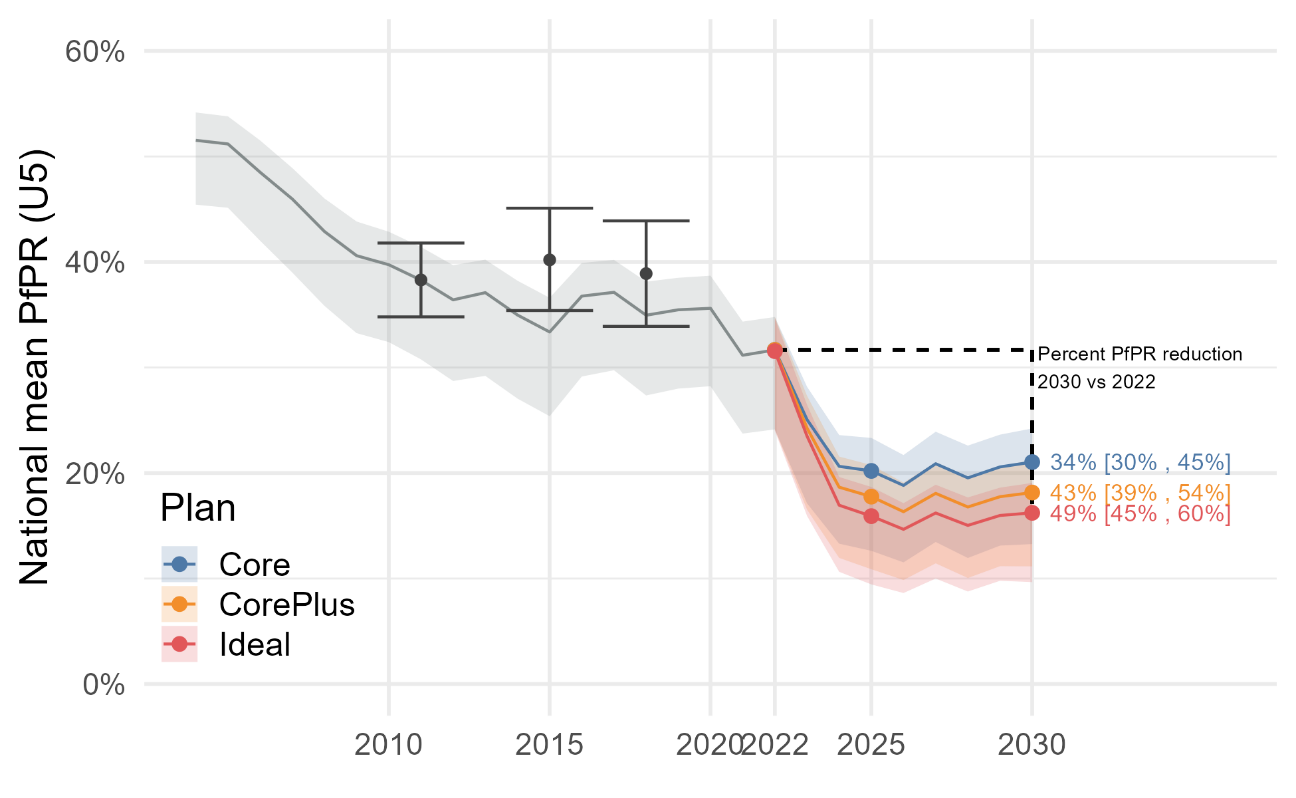


Figure 3: Modeled impact of different intervention packages

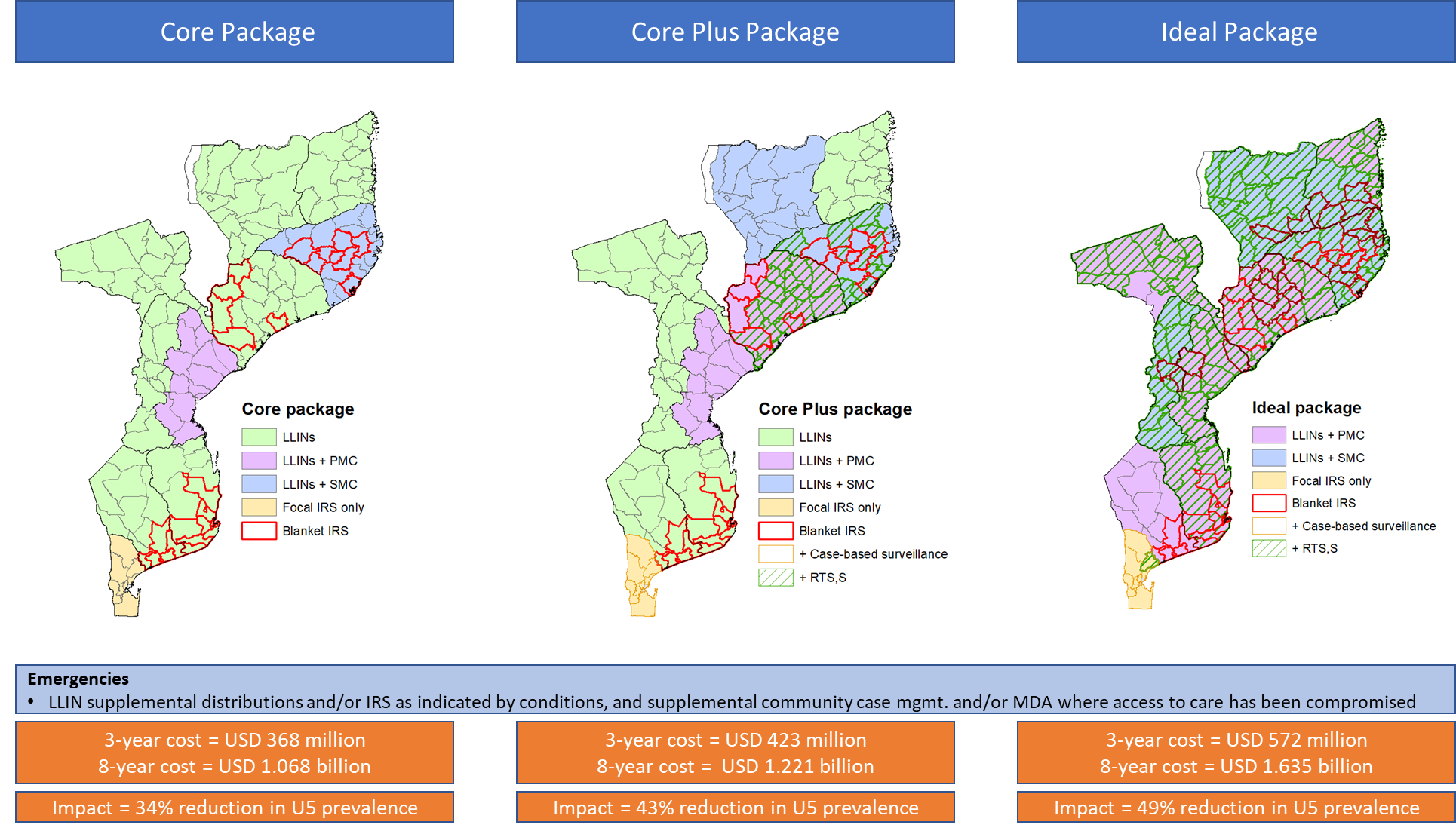


The results of these data were further deliberated by the stakeholders, with successes and challenges discussed in NMCP-led TWGs at a strategic retreat in October 2022. This retreat constituted a broad range of stakeholders including technical and implementation partners, provincial representatives, WHO, women and youth representatives, civil society, and academia, who together made strategic recommendations which were then encoded into the a strategic framework and stratification for the years 2023-2030.

The “ideal stratification” (shown below) was broken down into levels of prioritization based on the cost-effectiveness results, resulting in the following:

* **Core package:** These activities are critical to the building of a sustainable programme for malaria control and eventual elimination, and a lack of funding for which would cause major setbacks to programme progress. These include items such as program and grant management, strong systems for case management, vector control that manages the widespread insecticide resistance, SMC and PMC in pilot provinces, and strengthening of surveillance and M&E systems.
  + *These items all fit into existing resource envelopes from the country’s existing donors - if implemented STPH modeling projects these interventions are estimated to cost a total of USD 368M for the 2024-26 period and result in a* ***34% reduction in prevalence*** *for the period of the strategic plan.*
* **Core plus package:** This package includes the core package but with additional activities that were chosen as the highest priority targets for additional resources, some of which have been confirmed and others are being sought. If implemented as targeted in the stratification, the core plus package would result in a major additional impact. The package includes the expansion of SMC and PMC, which was shown clearly in the cost-effectiveness modeling to be the best use of additional resources. The package also includes the implementation of the malaria vaccine in the areas targeted under proposal already submitted to Gavi.
  + *These items do not fully fit into existing resource envelopes from the country’s existing donors, as highlighted with the need to include parts of the existing IRS in PAAR. However, if implemented modeling projects these interventions are estimated to cost a total of USD 4233M and result in a* ***43% reduction in prevalence*** *for the period of the strategic plan. . Incrementally, core plus is $65M more than the core package, and adds 9% points more reduction in prevalence.*
* **Ideal package:** This package incorporates all aspirations of the full national strategic plan. This includes a further expansion of SMC and PMC, shown clearly in cost-effectiveness modeling to be the best use of additional resources. Once SMC/PMC are expanded to all target areas, it would additionally expand IRS implementation, which is shown to be highly effective but expensive, as well as expand malaria vaccine implementation.
  + *If the total package is implemented, these interventions are estimated to cost a total of USD 572M and result in a* ***49% reduction in prevalence*** *for the period of the strategic plan.*

Figure 4: Final intervention stratification packages, by prioritized cost and impact tier



Based on this national plan, the following modules/interventions were selected in this funding request to align with the Global Fund Modular Framework, namely (1) Case Management; (2) Vector Control; (3) Specific prevention interventions (SPI); (4) Program management; and (5) RSSH priorities relating to surveillance/digital health. Other malaria RSSH priorities are to be deliberated on and prioritized through a separate RSSH coordinating group. Throughout each of these interventions, special attention is also prioritized toward Human Rights and malaria service provision in humanitarian emergencies, which has been created as a special objective in the 2023-2030 Malaria Strategic Plan given the increased challenges faced in certain areas of the country.

1. **Case management (health facility and community)**

This module will contribute to the national goal of reducing malaria morbidity and mortality through effective case management practices by focusing on the early detection, diagnosis and treatment of cases. These areas have seen improvement but continue to face significant gaps (see Health Facility Survey results summarized in section 1.3).

It is imperative that commodity security is guaranteed and health workers are well-supported via supervision and mentorship. The placement of these commodities within the allocation will enable Mozambique to achieve full coverage of RDTs and ACTs for diagnosis of malaria and treatment of confirmed cases. Strengthened supervision will be critical to improve their proper use by health workers. A consistent supply of these commodities, combined with data-driven targeting of supervision resources to drive quality improvements, will contribute to the desired reduction in morbidity and mortality trends as envisaged in the MSP. Digitizing supervision will allow for improved prioritization of targets, and focusing on mentorship during supervision visits will be key to better service delivery. Follow up based on findings from previous visits will cost-efficiently build the capacity of low performing health workers. Implementation of supervision has been hampered by challenges with expenditure and funding flow within government. This has been overcome at district level through funding flowing via civil society, and central level through direct follow up, but must be strengthened at provincial level in the GC7 period to realize the full potential of this intervention. Additionally, this funding request will support mortality and case management audits to continue the progress made in preventing malaria inpatient mortality. In order to continually monitor antimalarial and diagnostic efficacy, Therapeutic Efficacy Surveillance and HRP 2/3 gene deletion surveillance will be conducted routinely in Mozambique but will be supported by PMI as well as supported through genetic surveillance by CISM’s GenMoz project.

Laboratory service improvement is required to ensure that tertiary facilitates are able to provide consistently high-quality diagnostic services, particularly for severe malaria patient monitoring. Done well, this will allow for the continuation of the stark reductions in malaria mortality over the past 6 years. The requests for malaria microscopy equipment and consumables are informed by an updated assessment of lab services. A key area of focus is providing the training required to ensure technician capacity is strong across the country.

Social and behavior change communication has been crucial in mobilizing communities to adopt and change their behavior by influencing their knowledge and attitudes. Mobilization of communities through SBCC activities in malaria prevention before and during campaigns (ITNs and IRS) as well as influencing their health seeking behavior will contribute to malaria morbidity and mortality reduction. Unfortunately, delays in the MIS/DHS surveys mean updated data on care seeking is unavailable. That said, aside from a brief 4-month period at the outset of the COVID-19 pandemic, total OPD attendance has continued to rise and indicates continuing improvements in access to care and care seeking behavior.

1. **Vector control**

Even as prevention tools have expanded, vector control remains the foundation of Mozambique’s malaria prevention strategies. For, it is the only prevention tools that target transmission reduction in the full population. ITNs, delivered through continuous and campaign channels, continue to be the primary tool given their cost-effectiveness. This is in line with the [WHO Global Technical Strategy for Malaria (2016-2030),](https://apps.who.int/iris/bitstream/handle/10665/176712/9789241564991_eng.pdf?sequence=1) as the mass campaign distribution of LLINs is a recommended high impact intervention in high burden areas ([WHO-CDS-GMP-2018](https://apps.who.int/iris/bitstream/handle/10665/275868/WHO-CDS-GMP-2018.25-eng.pdf)). The decision to deploy dual-AI ITNs across the targeted areas is driven by data on: pyrethroid resistance, their effectiveness in the New Nets demonstration provinces, and the superior durability of dual-AI ITNs in comparison with PBO-pyrethroid ITNs in the same studies. Campaign digitization, funded currently through C19RM mechanism, is proposed outside this module per the GF modular framework. But, it will be a priority tactic that ensures nets arrive to the right people, in the right places, and at the right time.

IRS is one of the strategic vector control interventions in the MSP, and it is also recommended in the [WHO Global Technical Strategy for Malaria (2016-2030)](https://apps.who.int/iris/bitstream/handle/10665/176712/9789241564991_eng.pdf?sequence=1) for reducing and interrupting malaria transmission. It has been prioritized for support in this funding request because it is a high impact vector control intervention that also serves as an important insecticide resistance management strategy. The targeted districts are high burden districts in the central and northern provinces of the country. In line with the National IVM strategy, the country plans a rotation of the insecticides used every 2 years (always with non-pyrethroid insecticides) for the purpose of preventing the emergence of further insecticide resistance.

As explained in Section 1.3, local studies from Southern Mozambique (STPH, 2021) and from Zambezia Province showed significant declines in malaria incidence when IRS was deployed in areas on top of high coverage ITNs (though of course ITNs at that time continued to be pyrethroid-only). Based on this evidence, and the reported risks of resurgence upon removal of IRS in high burden areas, Mozambique therefore intends in this grant to maintain IRS in targeted areas of Zambezia and Nampula as far as budget allows. If budget shortfalls do not permit maintenance, careful analysis will be conducted to withdraw in the least risky areas – and epidemiological data will be closely monitored to avoid negative repercussions.

Entomological monitoring will continue to remain a priority for the country, particularly as a key data source to make decisions about the vector control strategy in the country. Efforts have been made during the current period to improve the integration of entomological data with other sources. This process was facilitated by the rollout of the iMISS. So far, the efforts have been successful but will now focus on improving capacity for data analysis and use of data for decision-making. Additional efforts will also be made toward increase surveillance for *A. stephensi* in urban areas, in line with [WHO recommendation](https://www.who.int/publications-detail-redirect/WHO-UCN-GMP-2022.06) for this potentially invasive vector.

1. **Special prevention interventions (SPI)**

The government of Mozambique, in conjunction with other partners, will take the lead in ensuring the provision of IPTp, with a focus on improving ANC coverage in collaboration with the MCH Department. Targeted SBCC messaging to improve ANC attendance and adherence will be integrated with the SBCC package in the Case Management module, and, similarly, integrated malaria supervision visits will help capacitate clinicians. While no budget appears in this module, IPTp remains a key malaria-in-pregnancy (MiP) strategy for the country that is funded through domestic means.

In addition to the need to strengthen the coverage and quality of existing interventions, the 2020 MTR also found that additional interventions needed to be explored if Mozambique was to achieve its burden reduction goals. Specifically, in stratifying interventions, it was found that SMC and PMC should be priorities for expansion. In the intervening years to date, Mozambique has mobilized resources to pilot both interventions. The early results of both pilots show that while SP resistance is high in the country it still seems to be effective for chemoprevention.

An operational model for the scale up of SMC has been established with the support of Malaria Consortium, and the geographic priorities for expansion have been identified through the stratification and modeling analyses conducted in 2022 – with priority areas having been ranked by burden of disease and seasonality. Expansion in Nampula and Niassa provinces was prioritized, and funding for Nampula was confirmed via the same mechanism that funded the pilots. Further expansion is included in this funding request and PAAR.

Because it is delivered through existing EPI platforms, as well as the apparent efficacy of SP for chemoprevention in SMC, PMC is considered a safe, simple, and cost-effective intervention to launch. It has been launched in Sofala Province through the support of PSI and Unitaid, with a strong evaluation component supported by the London School of Hygiene and Tropical Medicine. Additionally, expansion to Zambezia Province is supported by PMI, with further expansion included in PAAR in this funding request.

1. **Program management**

The overall success of Mozambique’s malaria response will hinge on effective, well managed implementation of planned activities, and it will require improved financial absorption by the government. Effective planning, implementation, coordination of partners and stakeholders at all levels, in addition to the effective monitoring of progress against workplans, are essential for the realization of expected results. Thus, program management is a prioritized module in this request. For the malaria program, critical unmet gaps identified include human resources and review/planning meetings; for civil society, key gaps include human resources, supportive management systems, and grant management.

It is critical that the functionality of thematic TWGs are continued during the grant period with the support of partners, particularly given the tightening fiscal landscape of malaria in the country – which requires everyone to do more, in a coordinated manner, with what we have.

1. **Surveillance, Monitoring and Evaluation**

Effective surveillance and M&E are critical to the national malaria response in order to achieve gains in reducing malaria mortality, as both provide the data necessary to improve the effective targeting and tailoring of malaria strategies. Strong surveillance requires inputs from a diverse group of actors, from the health workers at facility and community level, to partners implementing and submitting vector control or chemoprevention reports. Further, it requires the highest level users at NMCP using that data for strategy or policy formulation. To achieve a high-performing surveillance system, coordination of all of these actors is critical. With support from partners, the NMCP has successfully developed and deployed an integrated malaria information storage system (iMISS). This system will continue to need to be actively managed by the NMCP, and provincial and district level users will continue to need to be supported with replacement devices as existing ones reach the limits of useful life. Mobile data is needed to report and use the dashboards for decision making.

The digitization of the 2021 and 2023 MDA campaigns and 2022/23 ITN campaign has transformed the way the NMCP and its partners are conducting and monitoring the implementation of campaigns. Efforts are underway to build technology that will permit the cost-efficient digitization of all malaria campaigns, serving as a key tactic to improve the effectiveness of these campaign in achieving desired coverage levels, and in building population and household georegistries that allow for more accurate measurement of that coverage.

The planned surveys and evaluations will provide critical data to inform future strategy, as well as measure progress against the MSP goals and objectives. Epidemic preparedness and response is a critical core capacity for the country’s peripheral health services, and capacitation of key staff will allow prompt detection and response to outbreaks that can ultimately save lives when outbreaks occur.

**Cross-cutting RSSH planning and prioritization**

Individual and joint discussions with the 3 diseases programs staff to identify common system bottlenecks resulted in the prioritization of 5 key RSSH modules, namely (1) Health Products/Logistics to address medicines stockouts at facility level and supply of drugs with short expiration date, (2) Laboratory Systems to improve testing capacity, sample referral systems, laboratory equipment functionality, and ensure timely retro-information to health facilities and patients, (3) M&E systems to improve data quality and use, reduce paper-based information systems, integrate electronic health information systems, and increase availability of population-based data for strategic decision making; (4) Human Resources and quality of care to address quality issues in pre-service training, staff turnover, and vertical approach to training and supervision, and (5) Community Systems strengthening to improve management of community actors, increase quality and quantity of CHW/APS services. Critical and cost-effective interventions and activities to address programmatic gaps were selected for funding within the 8.5% (~$65.5 million) funding allocation to RSSH. This RSSH funding were distributed across the 5 priority modules through an inclusive and participatory decision-making process that took into account synergies across modules and/or interventions. E.g., interoperability of information systems and integrated supervision will provide efficiency gains.

* + 1. Describe the decision process for interventions selected for allocation funding versus those included in the unfunded Prioritized Above Allocation Request.

***Top priorities are securing strong case management, cost-effectiveness optimized prevention, and strong surveillance and M&E systems***

The first priority considered in this funding request was ensuring adequate supply of diagnostic and treatment commodities, with cost-optimized supportive interventions to ensure the consistent availability where these commodities are needed and to ensure their rational use by health workers at all levels. These commodities are lifesaving, and their procurement is considered non-negotiable in prioritizing across available resources.

Following the top priority of an uninterrupted supply of live-saving case management commodities, the prioritization turned to prevention measures that maximize value-for-money. These were prioritized by intervention and geography during the stratification exercise, with a cost-effectiveness optimization analysis conducted in collaboration with STPH to prioritize for optimal value-for-money. The outcomes of this prioritization are summarized in Table 5.

Per national policy, LLINs are the primary vector control measure used in Mozambique, which are now recommended to be dual-AI ITNs due to widespread pyrethroid resistance and longer-lasting impact, as found during the New Nets Project study. IRS supplements ITNs (a) for purposes of insecticide resistance management; and (b) in elimination-targeted areas (such as southern Mozambique).

Further to this, SMC and PMC have been added as new interventions in the country per the recent [WHO recommendation](https://app.magicapp.org/#/guideline/7087) (WHO/UCN/GMP/2022.01 Rev.1), with SMC prioritized first to areas of high burden and high seasonality and PMC prioritized first to areas of high burden but moderate-to-low seasonality.

The malaria vaccine was targeted according to WHO methodology through a collaborative analysis conducted at WHO’s targeting workshop in Accra in 2022. Overall, the vaccine falls somewhat low in terms of cost-effectiveness priorities relative to other interventions. However, given the segregation of funding from Gavi that is not fungible, there are currently no cost trade-offs for the country; and the country hopes that in future other vaccines will be more effective and available at a more affordable price to improve their cost-effectiveness in comparison with other malaria interventions.

Table 5: Prevention prioritization matrix

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Priority level** | | **Intervention** | **Geography** | **Funding (2024-26)** |
| Essential | 1a | Dual-AI ITNs  (via ANC channel) | Full country | GFATM = **$21,253,970** |
| 1b | Dual-AI ITNs  (mass distribution) | Cabo Delgado, Niaassa, Zambezia, Nampula, Manica, Tete, Sofala, Inhambane, Gaza  *Pemba included, other provincial capitals lower priority* | GFATM = **$92,652,751**  *Note: ITN quantification utilized data from the past 3 campaigns to analyze variance from official INE population projections, to solve challenges with under-quantification. Budget constraints forced this variance amount into PAAR – but it must be filled prior to 2025/26 distribution to ensure high coverage in highest-risk areas.* |
| 1c | IRS (regional elimination targets) | High priority regional targets: high burden districts of Inhambane, Gaza, and Maputo Province | Insecticide and operations: MOSASWA GFATM, SA government = **Full cost** (est. $28.3) |
| High | 2a | SMC | Nampula  Niassa | MC/Givewell = **Full cost** (est. $33.9M)  GFATM = **$10,940,641** |
| 2b | PMC | Sofala  Zambezia | PSI/Unitaid = **Full cost** 2024(est. $0.9M)  GFATM (2025/26) = **$1,807,205**  PMI = **Full cost** (est. $6.6M) |
| 2c | Malaria vaccine (RTS,S) | 18 districts of Zambezia, 11 districts of Nampula | Gavi = **Full cost** (est. $42.2M) |
| 2d | SMC | 6 districts of Cabo Delgado (*beginning 2025*) | PAAR = **$4,279,298** |
| 2e | PMC | 11 districts of Cabo Delgado (*beginning 2025*) | PAAR = **$897,280** |
| Moderate | 3a | SMC | Manica Province (*beginning 2025*) | PAAR = **$6,929,448** |
| 3b | PMC | Tete, Inhambane, Gaza (*beginning 2025*) | PAAR = **$3,725,640** |
| 3c | IRS (core targets in Zambezia/Nampula) | Maintenance of high-priority targeted districts in Zambezia, Nampula | Insecticide: PAAR = **$23,178,673**  Operations: PMI, MOH = **Full cost** |
| 3d | Larval source management | Provincial capitals  *Priority level dependent on A. stephensi surveillance* | PAAR = **$6,964,062** |
| 3e | Dual-AI ITNs  (mass distribution) | Targeted distribution in provincial capitals  *Except Maputo City and Matola* | PAAR = **$5,092,944** |
| Moderate-low | 4a | IRS expansion | 4 additional districts in Nampula, 6 additional districts in Zambezia, 4 districts in Cabo Delgado, 2 districts in Niassa, 2 districts in Manica, 2 districts in Sofala (*beginning 2025*) | PAAR = **$28,096,444** |
| 4b | Malaria vaccine (RTS,S) | Expansion to rest of targeted areas | Would await future Gavi funding –  Need = $81,694,944 |
| Low | 5a | Dual-AI ITNs | Untargeted portions of provincial capitals  Maputo Province  Maputo City | No funding sought, exclusion savings:  $8,210,735  $3,675,100  $2,803,309 |

Additional to this, the country considers investment in surveillance and M&E data systems as a high priority, in order to improve programmatic decision-making and measure progress. In the past these systems were under-invested in relative to commodities and this resulted in these systems not improving as hoped. Significant investment has occurred in recent years through other partners (e.g. BMGF in surveillance, and GF C19RM for campaign digitization), and the country has reaped the benefits with better intervention targeting and quality as a result. The country will work its campaign donors share costs for these activities, but investment in them through GF is considered a high priority.

**Cross-cutting RSSH prioritization**

The 8.5% funding allocation to RSSH proved to be insufficient to achieve intended results and effectively tackle programmatic gaps. Therefore, some relevant interventions and activities to increase RSSH impact on diseases performance are proposed to be funded under PAAR. E.g. one intermediate warehouse to meet storage capacity needs and upgrades of four provincial warehouses are anticipated in the PAAR. Consideration of other donors’ contributions were taken into account during this process to prevent duplications and ensure complementarity.

## Context

Describe the main changes to the country context since the previous funding request submission to the Global Fund.

The public health system in Mozambique is largely unchanged since the previous funding request, though it has certainly been stretched to its limits with the Covid-19 pandemic, multiple natural disasters, and a conflict-related displacement in Cabo Delgado. Due to these issues, Government budgets, staff morale, and partner support systems have been deeply affected. Covid-19 required some adaptations in the health system to mitigate the spread of Covid. For example, malaria services during the pandemic were encouraged to be taken at the community level through SBCC messaging, which resulted in an increase to over 12% of all cases being detected at that level in 2020 and 2021, compared to 8% in 2019 (MPR Report, p. 22).

**Epidemiological and entomological context**

Malaria remains a top public health issue in Mozambique, with the entire population of 32.4 million inhabitants at risk of infection. However, as described in the stratification description in Section 1.2, that risk falls on a continuum that is largely driven by the environmental and social conditions of a geographic area. The consistently high burden of malaria in Mozambique places it amongst the highest endemic countries in the world (World Malaria Report, 2022). Although the disease is endemic throughout the country, its transmission is, in general, higher in northern and coastal areas of the country (MPR Report, p. 18).

The malaria burden in Mozambique accounted for 23% of outpatient consultations in 2021 (compared with 24% in 2017), 10% of inpatient admissions in 2021 (24% in 2017), and 1.2% of inpatient deaths in 2021 (5.6% in 2017), which is illustrative of malaria’s declining but still significant contribution to morbidity and mortality in the country (MPR Report, p.16). Data from the national health information system (SIS-MA) show that malaria incidence declined by 12.5% from 2020 to 2021. As is described later, this is at least partially explained by the targeted introduction of next-generation ITNs. However, the malaria incidence increased by 19.5% from 2021 to 2022 to return to the upward incidence trend observed from 2016 to 2019. An analysis was done during the 2020 MTR to understand this trend, and it was subsequently followed-up with an analysis at the subnational level in 2021. The two analyses showed several factors likely have contributed to the incidence growth, including:

1. The reporting bias created by the successful scale up of confirmatory diagnosis using RDTs (MTR Report, Section 1.1.1, p. 10)
2. Increases in health facility reporting completeness, which followed investments to improve the health information system
3. The inclusion of previously unaccounted cases treated at the community level and now reported by the increasing number of APS
4. Resistance of the vectors to pyrethroids, which has been partially addressed through IRS and next-generation but which will only reach full scale in 2023
5. Year-on-year climatic fluctuations.

Annual Blood Examination Rate has risen from 58% in 2016 to 73% in 2022, while test positivity rate (TPR) has remained quite stable since 2016, moving from 55% in that year to 54% in 2022, lending support to the conclusion that after controlling for increased testing and surveillance the true incidence of malaria has remained somewhat flat. As described with robust data from the New Nets Project evaluation, it is possible that the 2022 rebound in incidence in Cabo Delgado, Tete, Niassa, and Manica stems from durability challenges with distributed ITNs. Details on this data, as well as response to the challenge of durability, is described in the vector control portions of sections 1.2 and 1.3.

Unfortunately, under 5 prevalence data still has not been updated since the 2018 Malaria Indicator Survey (MIS). However, a survey has just been completed with preliminary results promised to the NMCP by end of May 2023.

In response to comments from the Global Fund Technical Review Panel in 2020, the NMCP and its partners conducted a “Sub-national Analysis of Malaria Situation in Mozambique”, first in the north and central provinces and expanded to all provinces for use in the 2022 MPR (see reference “Subnational Analysis”). The objective of this analysis was to understand trends and driver of malaria burden in each province, and thus provide specific recommendations for each to drive improvement. At an aggregate level the findings were quite similar to the five factors referenced above, with nuance in each province providing valuable insights to drive implementation improvements.[[6]](#footnote-7)

Figure 5: Trends in incidence (SIS-MA), prevalence (MIS/IMASIDA/DHS), ABER (SIS-MA), and inpatient deaths (SIS-MA)

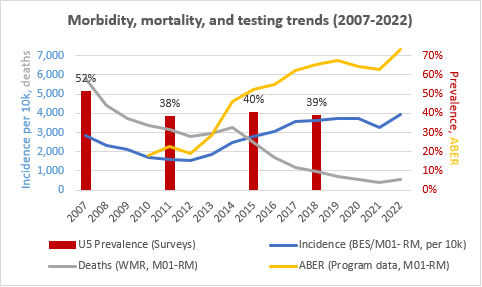
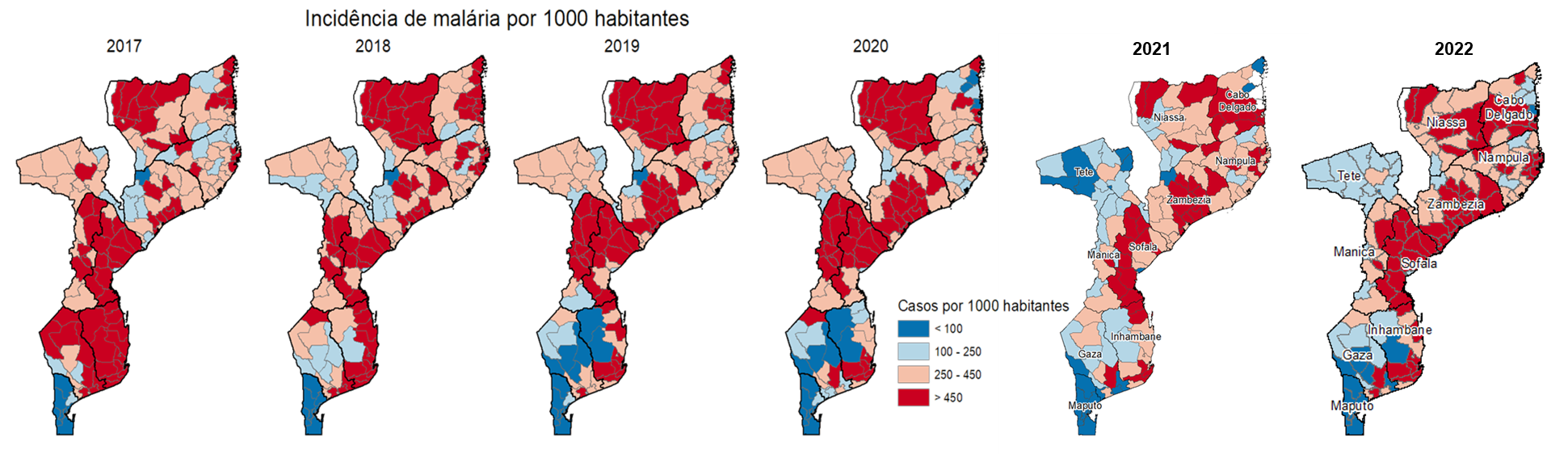


Table 6: Malaria cases per 1000 population in Mozambique (2017-2022). (Source, SIS-MA, 2023)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Province** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **Major intervention changes during period** |
| Niassa | 408 | 425 | 434 | 449 | 252 | 342 | Dual-AI LLINs in Oct 2020 |
| Cabo Delgado | 374 | 418 | 386 | 293 | 431 | 484 | PBO LLINs in Jul 2019; displacement surge in 2020/21 |
| Nampula | 328 | 398 | 378 | 379 | 412 | 468 | Pyr. LLIN + targeted non-pyrethroid IRS through full period; SMC pilot 2020-22 |
| Zambezia | 318 | 362 | 436 | 489 | 463 | 553 | Pyr. LLIN + targeted non-pyrethroid IRS through full period |
| Sofala | 465 | 439 | 468 | 464 | 425 | 556 | Pyr. LLIN throughout; Cyclone IDAI related displacement in 2019 |
| Tete | 289 | 217 | 258 | 279 | 133 | 184 | PBO LLINs in Jun 2020 |
| Manica | 530 | 470 | 617 | 755 | 310 | 311 | Dual-AI LLINs in Nov 2020 |
| Inhambane | 667 | 683 | 561 | 378 | 444 | 595 | Pyr. LLIN; targeted IRS begun in 2019 |
| Gaza | 599 | 423 | 312 | 260 | 216 | 273 | Pyr. LLIN; targeted IRS begun in 2019 |
| Maputo Prov. | 51 | 35 | 33 | 25 | 24 | 19 | Targeted IRS throughout; bairro-level targeting beginning in 2020 |
| Maputo City | 46 | 31 | 19 | 11 | 11 | 13 |  |
| **Mozambique** | **358** | **362** | **372** | **375** | **328** | **392** |  |

Figure 6: Malaria incidence 2017-2021. SIS-MA



While the country did not reach its morbidity reduction goals in the last MSP, it did achieve the mortality reduction goals by reducing the inpatient mortality rate by 41%. While this success is celebrated, malaria remains an important cause of child mortality in Mozambique. In 2017, 1,114 in-patient malaria deaths were reported, 970 in 2018, 734 in 2019, 563 in 2020 and 406 in 2021 (MPR Report, p. 11).

Table 7: Malaria mortality per 100,000 population in Mozambique between 2015 – 2022 (Source, NMCP Database, 2023)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Malaria Deaths per 100 000 Population** | | | | | | | |
| **Province** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** |
| Cabo Delg | 8,0 | 9,6 | 5,6 | 5,0 | 5,0 | 3,3 | 4,0 | 2,3 |
| Gaza | 6,3 | 2,1 | 1,6 | 1,5 | 0,8 | 0,7 | 0,8 | 0,5 |
| Inhambane | 5,1 | 1,6 | 3,2 | 3,1 | 1,7 | 1,1 | 0,8 | 1,1 |
| Manica | 6,0 | 5,6 | 6,4 | 4,6 | 1,5 | 0,1 | 0,2 | 0,4 |
| Maputo Cit | 3,1 | 2,1 | 2,0 | 0,8 | 1,8 | 1,4 | 0,2 | 0,7 |
| Maputo Pr | 1,7 | 1,2 | 1,0 | 0,8 | 0,5 | 0,3 | 0,3 | 0,3 |
| Nampula | 18,5 | 12,5 | 3,3 | 3,3 | 1,8 | 1,1 | 1,1 | 0,9 |
| Niassa | 11,3 | 10,5 | 9,5 | 8,3 | 8,1 | 9,6 | 5,0 | 7,5 |
| Sofala | 9,1 | 5,3 | 5,2 | 4,8 | 4,1 | 2,2 | 1,5 | 1,5 |
| Tete | 10,4 | 2,5 | 3,3 | 2,3 | 1,4 | 1,0 | 0,2 | 0,7 |
| Zambezia | 8,4 | 5,8 | 3,5 | 2,6 | 2,0 | 1,5 | 0,9 | 0,7 |
| **TOTAL** | **9,6** | **6,4** | **4,0** | **3,4** | **2,5** | **1,9** | **1,3** | **1,4** |

The major malaria vectors in the country are *An. Gambiae s.s*. (more prevalent in the centre and north), *An. Arabiensis* (more prevalent in the south and central areas), and *An. Funestus s.s* (widely distributed along the coast; it is the member of *funestus* group found almost exclusively inside human dwellings[[7]](#footnote-8)).

In 2021, the NMCP performed insecticide resistance monitoring in 44 sentinel sites, vector density in 32, and WHO bioassays for residual efficacy in nine sites. Insecticides tested were: Alphacypermethrin (0.05%), dichloro-diphenyl- trichloroethane (DDT – 4%), bendiocarb (0.1%), lambdacyhalothrin (0.05%), deltamethrin (0.05%), fenitrothion (1%), Permethrin (0.75%) and pirimiphos-methyl (0.25%).

Generally, the country has recorded an increase in the geographical spread of insecticide resistance to pyrethroids (deltamethrin and lambdacyhalothrin), with every province in the country observing pyrethroid resistance in at least one species in 2021. The country has recorded more limited distribution of resistance to carbamates (bendiocarb) and organochlorines (DDT), and all vectors remain susceptible to organophosphates (pirimiphos methyl and fenitrothion). The maps below show that *An. gambiae s.l.* and *An. funestus s.l.* have a confirmed resistance based on data from 2012 through 2020[[8]](#footnote-9). The 2021 map shows confirmed resistance for both *An. gambiae s.l.* and *An. funestus s.l*. This data led the NMCP to move away from pyrethroid IRS and introduce the distribution of PBO-pyrethroid and dual-AI ITNs in order to fight against this resistance. For IRS, the NMCP has also adopted the rotation of insecticide every two years to proactively guard against the emergence of resistance to other insecticide classes (DNSP, p. 31).

Figure 7: Insecticide resistance profile 2012-2021 (MPR Report, p. 39)

Map

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The focus of the Malaria Strategic Plan 2023-2030 is on reducing morbidity and mortality from malaria in high transmission areas, and on eliminating malaria from low burden areas of the country. In line with globally recommended best practices, the country and its partners have undergone significant collective efforts to stratify and target interventions in the country to maximize impact.

***Vulnerability to climatic and conflict-related emergencies, and the need for agile response***

Mozambique has undergone a peaceful transition from a war context to a multiparty political democracy. However, since 2019, it has experienced a period of intensified conflict in Cabo Delgado Province that has displaced nearly a million people in recent years. The challenges have severely disrupted health services, including primary healthcare services in nearly half of health facilities. Cabo Delgao is also the highest malaria prevalence province in the country. Government and humanitarian have responded to these challenges with attempts to ensure services are as reinforced as possible, including through the GF Emergency Fund with MDA in high burden, high disruption districts.

In addition to these conflict-related vulnerabilities, Mozambique has widespread vulnerability to natural disasters. Malaria services are frequently threatened by tropical cyclones, including major storms Idai, Kenneth, and Freddy in the past 4 years. These threats require health and government systems with agile response capacity, and in coming years these agile systems must be reinforced if Mozambique hopes to be as responsive as possible to these emergency situations.

**Case management**

***Strong case management remains the foundation of Mozambique’s efforts, with improved quality of care but several remaining gaps***

The 2018 Health Facility Survey found that testing of suspected cases at the primary care level remained low, with only 33% of suspected cases in Maputo Province being tested and 62% and 69% respectively in Zambézia and Cabo Delgado[[9]](#footnote-10).

This survey was repeated in 2021, and it showed some improvements but still many gaps. The 2021 Health Facility Survey[[10]](#footnote-11) found that the percentage of suspected cases that were managed correctly ranged from 61% in Manica to 85% in Inhambane, while the percentage of true cases that were treated appropriately ranged from 32% (Maputo) to 86% (Inhambane). Some improvements were seen since the 2018 HF survey: the percentage of true cases that were managed correctly grew from 14% to 32% in Maputo and from 52% to 61% in Zambezia.

Similar to the results of the 2018 Health Facility Survey, the 2021 survey showed that the treatment of negative or non-tested patients remained very low, and the availability of RDTs and ACTs was very high. This indicates that any challenges with stock are at community level, and that the primary challenges at health facilities continue to be ensuring fevers are consistently tested for malaria, especially in lower burden areas.

The 2018 Health Facility Survey found very low levels of stock out throughout the 3 provinces surveyed, with 92.3% of facilities with no stock outs of RDTs for more than 3 days in the 3 months prior to the survey and 94.7% of facilities with no stock outs of ACTs for more than 3 days in the 3 months prior to the survey.

The proportion of facilities without RDT stock outs improved slightly to 97% in 2021, while the proportion of facilities without ACT stock outs remained stable at 93%. However, at community level, stock outs remain a large challenge with important programmatic implications: in four of six provinces, over 50% of APEs reported stockouts of AL. (MPR Report, p. 106)

Table 8: Quality of case management in provinces surveyed in the 2021 HF survey

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Maputo | | Inhambane | | Manica | | Zambezia | | Nampula | | Niassa | |
|  | % | 95%CI | % | 95%CI | % | 95%CI | % | 95%CI | % | 95%CI | % | 95%CI |
| Suspect malaria cases receiving malaria test | 67 | 50-80 | 85 | 77-90 | 64 | 54-73 | 79 | 69-86 | 80 | 72-85 | 75 | 63-83 |
| Confirmed malaria cases treated with appropriate antimalarial1 | 50 | 4-96 | 91 | 78-97 | 74 | 56-87 | 78 | 66-86 | 82 | 73-88 | 82 | 70-90 |
| Suspect malaria cases negative for malaria but treated with antimalarial2 | 1 | 0.1-9.5 | <0.1 |  | <0.1 |  | 4 | 1-14 | 3 | 0.5-15.3 | 2 | 0.5-5.6 |
| Suspect malaria cases not tested and treated with antimalarial | <0.1 |  | 3 | 0.6-14.4 | <0.1 |  | 5 | 0.6-26.4 | 2 | 0.7-5.1 | <0.1 |  |
| Suspect malaria cases managed correctly3 | 62 | 44-77 | 81 | 72-87 | 61 | 52-70 | 65 | 55-74 | 70 | 62-77 | 70 | 58-79 |
| True malaria cases appropriately treated4 | 32 | 3-88 | 86 | 74-93 | 60 | 45-73 | 61 | 50-72 | 68 | 59-76 | 62 | 47-76 |

*1: Tested during routine health visit and confirmed positive during re-examination*

*2: Tested during routine health visit and testing negative during re-examination*

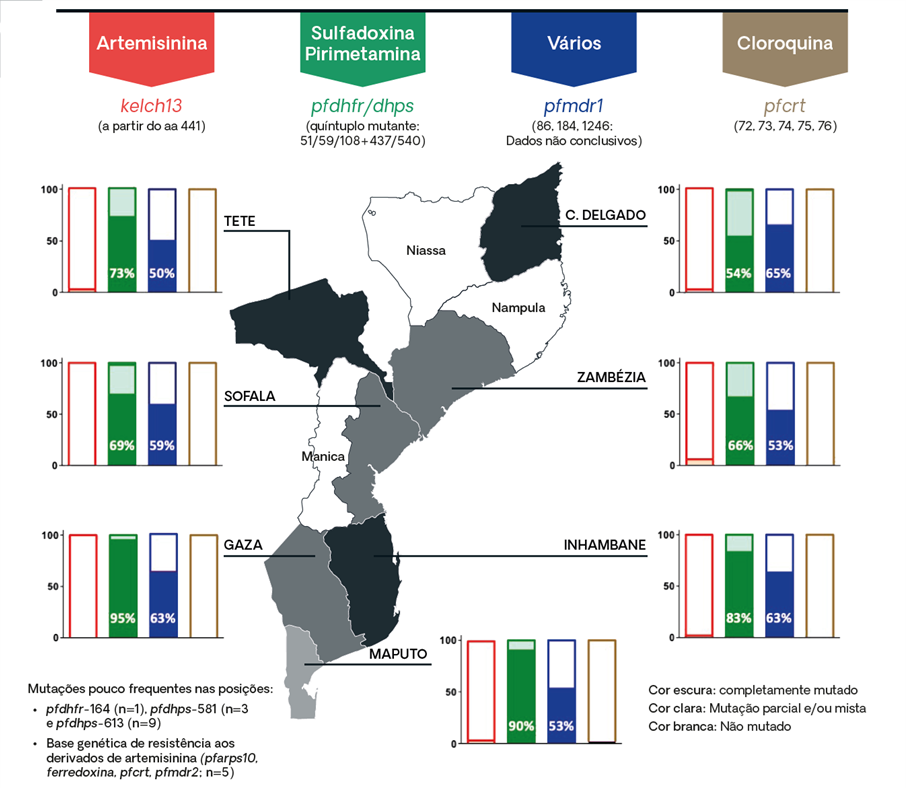
*3: Tested and treated with antimalarial only if positive*

*4: True malaria case confirmed during re-exam*

Health worker training was found to be low in the provinces surveyed in 2021, with the percentage of HWs receiving formal training in malaria case management ranging from 33% in Inhambane to 61% in Manica. Interestingly this is inversely correlated with health worker performance, validating the NMCP’s decision to de-prioritize large institutional trainings in favor of more interactive e-training (the development of which is nearly complete) and on-site mentorship via more frequent supervision.

***Increasing markers of artemisinin resistance and HRP2/3 gene deletion in Africa call for increased vigilance in Mozambique***

Important genetic mutations have been detected across Africa that reduce the effectiveness of important diagnostic and treatment tools.[[11]](#footnote-12) Genomic surveillance from GenMoz analysis and an analysis of samples from the 2018 health facility survey showed that there was no evidence of P*fhrp2-* and *Pfhrp3*-deleted parasites, showing the continued effectiveness of RDTs for malaria diagnosis in Mozambique. The analyses also concluded that the sensitivity and specificity of RDTs were acceptable.[[12]](#footnote-13) Furthermore, the GenMoz analysis showed that parasites continue to be susceptible to ACTs, and a return of susceptibility to chloroquine. Sulfadoxine-pyrimethamine (SP) on the other hand showed high levels of resistance.

Figure 8: Genomic surveillance results from the GenMoz project (IMISS)

Preliminary results from the 2022 Therapeutic Efficacy Study (TES) showed an alarmingly low efficacy of artemether-lumefantrine (AL) at 28 days post-treatment (86.3%). Caution is being taken in interpretation, as the 2018 version showed a similar result before the final PCR-corrected results indicated a 97.9% efficacy. Given genetic surveillance has shown few genetic markers of resistance to artemisinin, the expectation is that a similar result may appear when the final results are available. Nonetheless, given the identification of resistance elsewhere on the continent, it is critical for Mozambique to conduct robust surveillance and develop clear plans for treatment variation according to the guidance from the recently released WHO guidance.

**Vector control**

***Introduction of dual-AI and PBO-pyrethroid ITNs can be remarkably impactful, but action is needed to retain high coverage and usage***

Unfortunately, due to delays with survey completion, updated nationally representative data on ITN ownership and usage do not exist. However, in the years prior, all survey indicators have shown a substantial upward trajectory. Households with at least 1 net per 2 people increased from 39% in 2015 to 57% in 2018. Usage of LLINs among children in households owning at least 1 LLIN increased to 73% in 2018, up from 48% in 2015. Similarly, usage amongst pregnant women in households owning at least 1 LLIN was 76% in 2018, up from 52% in 2015 (IIM 2018, p. 42-5). This indicates a clear increasing trend in access and the normalization of LLIN usage.

In order to fight resistance and leverage on the increasing community usage to drive impact, the country has proactively sought the widespread introduction of new next-generation LLINs to manage resistance, and by the end of 2023, Mozambique will have covered all of the highest risk populations with a non-pyrethroid-only vector control intervention.

The introduction of next-generation LLINs demonstrated an impact on malaria trends. Notably, following the 2019/20 LLIN distribution, the provinces receiving PBO-pyrethroid or dual-AI LLINs recorded marked decreases in reported incidence when compared to provinces who received standard pyrethroid LLINs (see Figures 9 & 10 below). Household survey data from the New Nets Project evaluation study aligns closely to data from routine HMIS data, indicating a strong likelihood that this effect is real. With these LLINs being deployed at national scale in 2022/23, it is believed that the resulting impact will be high.

Figure 9: Prevalence at baseline and midline, by district and LLIN type – New Nets Project evaluation

Chart, bar chart

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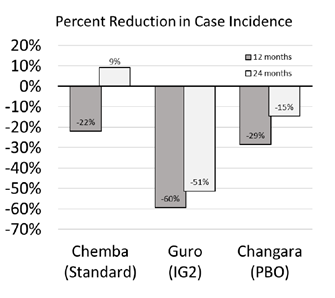
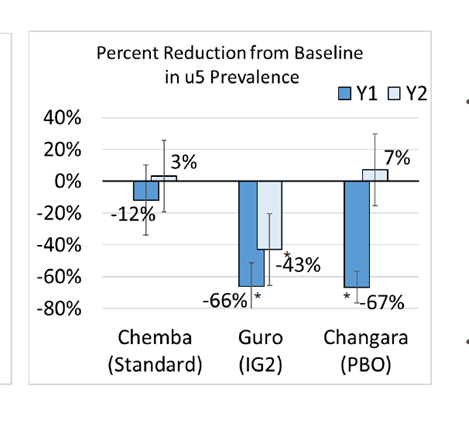
Figure 10: Incidence trends following next-gen and standard net distributions, by province

Chart, line chart, histogram

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Unfortunately, however, by the end of Year 2, the New Net Project data showed that the initial impact of the PBO-pyrethroid ITNs had reversed, largely due to suboptimal chemical and physical durability. This has been seen across countries in the New Nets Project data, with dual-AI nets consistently outperforming other ITNs due to this durability in field conditions. For this reason, given that the costs of dual-AI nets have reduced dramatically to be on par with GF reference prices for PBO-pyrethroid ITNs, a decision has been made in Mozambique to deploy dual-AI ITNs in the coming grant period.

Figure 11: Changes in U5 prevalence and incidence across different arms of the NNP West Study Zone (NNP Endline Results Summary)



While the IG2 dual-AI ITNs appeared to outperformed Royal Guard and PBO-pyrethroid nets in terms of durability, they still were failing to last the 3 years between cycles of mass distribution. Only 71.1% survived by the end of the 2nd year, resulting in reduced ownership (NNP Endline Results). Prior studies in three provinces showed that a large proportion of LLINs were unusable due to physical wear and tear after 36 months - 41% in Tete, 33% in Nampula, and 28% in Inhambane. Insecticidal effectiveness was optimal for all sampled nets (100%) in all three sites up to the 24 months follow-up but declined by 36 months. IN Inhambane, only 3% of samples showed optimal effectiveness at 36 months, with only 11% in Tete and 29% in Nampula at 36 months.[[13]](#footnote-14)

Based on this evidence and the modeled predicted impact of different net distribution intervals on malaria morbidity and mortality, the malaria program decided to decrease the interval between distribution from 3 years to 2.5 years for the 2022/23 campaign. This decision was approved by the Global Fund in July 2021 based on this evidence and is in the process of being implemented.

***Indoor Residual Spraying***

Over 90% of households targeted for IRS have reported to have been sprayed over the implementation period (MPR Report, p. 97), although there have been challenges with accurate IRS coverage denominators, as in many other countries. The districts targeted with IRS grew from 2020-2022 due to investments in regional elimination initiatives. Only focal IRS was conducted in Maputo Province, which allowed for budget savings to expand IRS to higher burden districts of the southern region. This more limited but targeted sprays still led reductions in incidence in Maputo province (e.g., incidence in the province reducing by 62.7% between 2017 and 2022). IRS has been shown to be impactful, notably through two robust local studies conducted in Mozambique. An evaluation of the MOSASWA IRS in southern Mozambique (commissioned by the Global Fund) was conducted in collaboration with the Swiss Tropical and Public Health Institute (STPH), and it showed evidence of substantial impact, particularly in Inhambane and Gaza provinces. The below is an excerpt from the evaluation, alongside a chart displaying the impact following IRS introduction (Figure 12).

Figure 12: Relative changes in incidence pre and post IRS in 2019 (STPH evaluation, 2021)

Text, chat or text message

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Similarly, an evaluation of IRS in Zambezia Province published in 2021 showed the significant impact of IRS in a high endemic area with high iTN access and pyrethroid resistance – with an 18% reduction in incidence in the actively followed cohort, a 35% reduction in incidence via passive surveillance, and a 46% reduction in household prevalence[[14]](#footnote-15). However, as in all settings, IRS remains more expensive than nets and more labour-intensive to implement, leading to challenges in sustaining coverage of targeted areas in northern provinces when competing for limited resources.

**Specific Prevention Interventions (SPI)**

***Introduction of new chemoprevention strategies, their success and future as a highly cost-effective strategy***

The 2020 MTR found that additional interventions needed to be explored if Mozambique was to achieve its burden reduction goals. The stratification process identified SMC and PMC as priorities for this expansion. In the intervening years to date, Mozambique has mobilized resources to pilot both interventions. The early results of both show that while SP resistance is high in the country it still seems to be effective for chemoprevention.

SMC was successfully introduced in Mecuburi and Malema Districts of Nampula province. About 81,000 children aged 3-59 months benefited, with >100% coverage and 99% adherence on day 2 and 3. In 2021 SMC was expanded to two additional districts of Nampula (Lalaua and Muecate) reaching around 115,000 children from the same target group. Both implementation pilots showed that SMC with SPAQ is safe, feasible and well accepted in the local context, which supported increasing the scale of the intervention beginning in 2022/23.

Importantly, given the initial uncertainty of its effectiveness given documented SP resistance, SMC also appears to be highly effective. In a non-randomised controlled trial, children who lived in a district where SMC had been implemented (Muecate) had 86 percent lower odds of developing clinical malaria during the peak transmission season compared with children who lived in the control district without SMC implementation (Lalaua). During phase 1, trends of SP and AQ resistance were monitored in the two intervention districts receiving SMC, and in a neighbouring district with similar epidemiologic characteristics but with no SMC coverage (Lalaua). Preliminary results found high rates of SP resistance but low AQ-associated resistance markers. One annual round of SMC did not appear to have had a negative impact on the SP resistance profile. However, continued research is needed to determine any resistance and efficacy implications from repeated implementation.

**Surveillance, M&E**

***Improved data can improve programming***

The completeness of surveillance reporting has progressed since 2017, increasing from 90.1% in 2017 to 97.7% in 2021. This has ensured better representativeness of the routinely collected data. Timeliness targets fell slightly short of MSP targets, but still saw significant improvements—moving from 73% timeliness in 2017 to 90.1% in 2019 (MPR Report, p. 115).

Data quality and accuracy has been a challenge for the country. The Health Facility Survey conducted in 2018 showed that facilities in three provinces were over-reporting cases into SISMA by 52-178%. While a follow up survey in 6 provinces showed an overall lower degree of error, it still showed an overall trend of over-reporting, with five of six provinces over-reporting by 8-67% (see Figure 13 below).

Figure 13: Percent differences in total confirmed cases, SIS-MA vs facility registers

Chart, bar chart

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Beginning in 2019, the NMCP, with the support of partners, began implementing surveillance strengthening activities with an emphasis on Data Quality Audits (DQA) integrated with supervision visits. At baseline, only 51% of health facilities had good data accuracy, and by the end of 2 years of implementation this figure had risen to 80% of facilities (MPR Report, p. 117).

Additionally, during that implementation period, the NMCP and partners designed the integrated malaria information storage system (iMISS) as a malaria data repository that houses and visualizes malaria data from all sources in the country, with the aim of improving data access and use.

Beginning with the 2021 MDA campaign, and continuing for the 2022/23 ITN and 2023 MDA campaigns, the NMCP began to implement a vision of digitizing campaigns to improve the visibility of data in real time and use that data to improve the coverage and quality of campaigns. While many challenges existed in implementation, this effort was considered a resounding success and re-doubled the NMCP’s enthusiasm to envision a future that includes an integrated campaign management platform which can be used for all malaria campaigns (and further can be extended to non-malaria campaigns such as those conducted by the NTD program and immunization program). While far from a panacea for these challenges, **digital health technology can play a catalyzing role** in improving local ownership and oversight of well-planned and efficiently executed campaigns. Digital health tools and innovations can enable public health campaigns to achieve higher coverage – and measure it more accurately – by better managing logistics and improving visibility into where interventions have been delivered and what remains to be achieved.

**Program Management**

The primary donors supporting malaria commodities and activities in Mozambique continue to be the Global Fund and the United States President’s Malaria Initiative (PMI) (currently approximately $66.7M and $29M per annum, respectively). Of late, Givewell has also supported SMC activities through Malaria Consortium, and has been expanding their investment. There are complementary surveillance strengthening investments by the Gates Foundation. Additionally, there are vector control investments by the MOSASWA regional Global Fund grant and South African government (at an average of $8M and $2.2M per annum, respectively). The World Bank is an important cross-cutting funding source relevant for malaria, as it is responsible for funding the operational costs of the APE program, which is a key platform for delivering care at the community level.

The Mozambique NMCP collaborates extensively as a member of two regional malaria multi-lateral initiatives, the Elimination 8 and MOSASWA, as well as the health initiatives of the Southern Africa Development Community. The country firmly supports the concept of a regional approach to burden reduction and elimination, and actively collaborates with its neighbors to ensure the needs of an interconnected epidemiological block are jointly considered. This includes active participation in the E8’s Technical Committee, TWGs, and Situation Room calls, as well as co-chairing of the Regional Coordinating Mechanism (RCM) of the MOSASWA Initiative.

The second and third rounds of MOSASWA grant development were particularly encouraging in their ability to align regional and country priorities, and in ensuring that the country and regional grants were complementary. A particular lesson learned by the NMCP was the value of developing comprehensive, thoughtfully-deliberated subnational operational plans to help clearly articulate needs before grant development.

The program was able to organize training for health professionals at all levels. At central level, NMCP staff and health care providers (doctors and nurses) were trained. At provincial and district levels, malaria focal persons, M&E staff and SBCC personnel received training in their respective areas. APSs at community level were trained in malaria diagnosis and treatment. The following training activities were organized in the country during the GF funding period (Table 9):

Table 9: Training of health workers and community members (2019-2023) (Source: SM&E /NMCP database, 2023)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Item | Number trained | Year of training |
| 1 | Training in case management of health care practitioners (doctors and nurses) an on-job training | 10607 | 2019 -2023 |
| 2 | Training APSs in malaria diagnosis and treatment | 7329 | 2020, 2022 |
| 3 | Training in laboratory techniques: exploration data analysis (EDA), training of trainers on WHO External Competency Assessment for Malaria Microscopy (ECAMM) | 312 | 2019 - 2023 |
| 4 | Training in SBCC (teachers and volunteers including Civil society) countrywide | 116,121 | 2019-2023 |
| 5 | Training in M&E, Data QA and Data audit, Epidemic preparedness, and response | 815 | 2021-2023 |
| 6 | Training on IRS for spray operators, supervisors, and SBC teams for the 6 provinces | 8630 | 2022 |
| 7 | Training in Mass Drug administration (MDA): | 1257 | 2022 – 2023 |
| 8 | Training in ITNs | 75253 | 2020-2022 |
| 9 | Training in SMC | 1200 | 2020-2021 |
| 10 | Training in IPTi/PMC | 330 | 2022/2023 |
| 11 | Training in Programme management at central, provincial and district levels | 6786 | 2019 - 2021 |
| 12 | Training in genomic surveillance (or genomic sequencing) | 54 | 2022 |

**Cross-cutting RSSH Context**

Like in many other countries, the COVID 19 pandemic had a considerable impact on the Mozambican health systems by diverting human and financial resources to tackle this public health emergency, and slowing down implementation of planned RSSH investments. In addition, natural disasters that have cyclically affected the country and resulting in destructions of key infra-structures like health facilities and medicines warehouses further stress the health systems. Lastly, but not least, the armed conflict in the northern provinces has demanded new service delivery models for displaced people and reconstruction of destroyed infrastructures. As part of the response, some interventions to increase system capacity to prepare and respond to these shocks are anticipated in this funding request. Investments in laboratory and community systems surveillance, and last mile supply chain are just few examples.

## Lessons Learned

Describe the main lessons learned from current programs.

***Case management strengthening***

* **Supply chain management remains moderately strong at the facility level, but it continues to be challenging at community level –** Malaria commodities were found to continue to be widely available at health facilities, with the proportion of facilities without RDT stock outs at 97% in 2021 while the proportion of facilities without ACT stock outs remained stable at 93%. However, at community level, stock outs remain a large challenge with important programmatic implications: in four of six provinces, over 50% of APSs reported stockouts of AL (MPR Report, p. 106.). Changes to APS supply chain and stocking practices are under discussion with the Central Medical Store (PSM) and the National APS Program in the RSSH funding request, as fixing this problem is critical to the functioning of the community cadre.
* **Quality testing of suspected cases has improved, but it remains to be the biggest gap in the cascade of correct fever management -** as described under section 1.3, there is still under-testing in health facilities, though with some noted improvement. During the current grant, the NMCP began to implement the integrated malaria supervision tool, which is now a mobile-based checklist that includes case management, malaria in pregnancy, DQA, pharmacy, and SBCC activities with associated visualizations. In this proposed grant, the NMCP will continue to strengthen implementation of the integrated supervision visits, using this tool to inform data-driven targeting of supervision to improve quality in the lowest performing facilities and therefore improve value-for-money. Implementation of supervision has been hampered by challenges with expenditure and funding flow within government, which must be improved. Understanding of the supervision objectives and methodology have been improved, and NMCP is working closely with civil society and MOH/MEF to overcome the challenges with funding flow.

***SBCC to improve intervention uptake***

* **Without survey data, updates on SBCC outcomes is lacking; however, the MPR noted key lessons for improving SBCC implementation**
  + The targeting of specific districts for SBCC has led to gaps in activities within important high burden provinces, and thus all districts will be included in SBCC activities in this request.
  + The operational intensity of ITN campaign activities has often resulted in a lack of SBCC focus after the campaign; to resolve this, Mozambique will explore changing implementation arrangements to ensure focus on both important activities is maintained.
  + The implementation approach going forward is still being deliberated upon, however looks to account for these lessons, and is committed to be finalized by the SBCC TWG by December 2023.

***Vector Control***

* **The vector control intervention mix has improved and been impactful, but it must continue to address key challenges (e.g., resistance, durability) to sustain impact:**
  + **Continued management of insecticide resistance –** the previous funding request highlighted the urgency of managing insecticide resistance, and the New Nets Project (NNP) results summarized in Section 1.3 showed the substantial impact of new tools designed to do just that. Mozambique has continued to respond to robust local data in choosing dual-AI ITNs as the likely future preference, given their superior performance. Though, of course, it will also be open to updated data prior to procurement for the 2025/26 distribution which is budgeted in this funding request.
  + **ITN quantification –** in every campaign, household data from the distribution has shown far larger population figures than the census projections, particularly in the north/central provinces, resulting in LLIN shortages and thus suboptimal ownership. In the last funding request which planned for the current 2022/23 distribution, the percent variance from the 2017 distribution was used to quantify upward from the census projections. The result was substantial improvements in the supply challenge. In planning for the 2025/26 distribution, the program has therefore analyzed the variance across the last 3 campaigns and chosen a reasonable figure for adjustment based on those to sustain this improvement in quantification. During microplanning of the 2025/26 campaign, it is anticipated that the geolocated data from a digitized 2022/23 campaign will serve as an improved foundation for village-level population estimates.
  + **ITN durability –** as described in Section 1.3, 2018 studies showed that ITN durability is a challenge in Mozambique. In the three provinces studied, a large proportion of LLINs were unusable after 36 months due to physical wear and tear - 41% in Tete, 33% in Nampula, and 28% in Inhambane. Based on this evidence and the modeled predicted impact on malaria of different distribution intervals, the program made a policy decision to decrease the interval between distribution from 3 years to 2.5 years for the 2022/23 campaign. This decision was approved by the Global Fund in July 2021 based on this evidence, and this shortened interval is in the process of being implemented. NNP data showed that this durability challenge still exists for new types of ITNs, though with an advantage shown for dual-AI nets thus far which makes them a superior choice.
  + **Potential impact of digitization –** during the 2022/23 ITN mass campaign, the NMCP began to implement a vision of digitizing campaigns to improve the visibility of data in real time and use that data to improve the coverage and quality of campaigns. While many challenges existed in implementation and many lessons were learned, this effort was considered a resounding success and re-doubled the NMCP’s enthusiasm to envision a future that includes an integrated campaign management platform which can be used for all malaria campaigns.
  + **Continued reinforcement of usage –** Usage amongst those with access to nets had improved substantially to 82% in 2018 (IIM 2018, p. 42.51). However, delays in surveys make updating this data challenging. Nonetheless, it remains critical to maintain strong messaging to reinforce consistent usage.
  + **IRS has been impactful, but given funding constraints and the rollout of next-generation ITNs, the country must think deeply about the future of IRS** 
    - Several analyses and studies in Mozambique, including those highlighted in Section 1.3, have shown the impact of IRS in the country. It is hypothesized that this was particularly true in an era of limited options to manage pyrethroid resistance. However, it is likely that its impact is also due to its non-dependence on daily human behavior as well as its timed annual application.
    - For these reasons, the NMCP seeks to continue IRS, both in areas of priority for regional and sub-national elimination targets as well as selected high burden areas (see the inclusion in stratification under Core and Core Plus packages). However, IRS is somewhat expensive and unlikely to be as cost-effective as next-generation ITNs, SMC, or PMC. As such, in the constrained fiscal environment the NMCP will begin to reduce the scale of IRS in high-burden areas – monitoring closely the effects of withdrawal to avoid resurgence.

All of these challenges must continue to be managed in the context of an increasing population, which creates budgetary challenges that must be managed to achieve the projected impact.

***SPI – Chemoprevention***

* **Chemoprevention interventions look to be a highly cost-effective addition to the country’s intervention mix, if able to be scaled up** - as described in the MPR Report, Section 1.3 of this application, as well as the stratification of the MSP 2023-2030, given their effectiveness and low cost, SMC and PMC are high priorities for expansion in the country. Resources from a variety of donors have been critical to launching the intervention in high priority geographies, with thanks to those partners for adhering to priorities from the national stratification. To bring these to their full ideal scale per that stratification, however, additional resources are required.

***Program management***

* **Bureaucratic processes can hinder implementation –** challenges have continued with timely disbursement of funds by the Ministry of Health and Ministry of Finance, with additional challenges noted from the transition of the LFA. Activities are often implemented with a delay of 2 months or more, leading to serious programmatic challenges. This includes foundational delays like the procurement of adequate health facility registers, which has been a root cause in challenges with data accuracy in SM&E.

***Surveillance, M&E***

* **Improved data quality** – data completeness and timeliness, already moderately strong, have continued to improve. Completeness increased from 90.1% in 2017 to 97.7% in 2021, and timeliness increased from 73% in 2017 to 90.1% in 2019 (MPR Report, p. 115). As described in section 1.3, data accuracy, which had been a weakness, has improved greatly through intervention. Beginning in 2019, the NMCP, with the support of partners, began implementing surveillance strengthening activities with an emphasis on Data Quality Audits (DQA) integrated with supervision visits. At baseline, only 51% of health facilities had good data accuracy, and, by the end of 2 years of implementation, this figure rose to 80% of facilities (MPR Report, p. 117).
* **Better data can lead to better decisions and improved programming, but this requires further investment in building staff capacity -** during the implementation period, the NMCP and partners designed the integrated malaria information storage system (iMISS) as a malaria data repository that houses and visualizes malaria data from all sources in the country, with the aim of improving data access and use.This has been successful overall, but at lower levels of the health system, there remains a need for capacity building and fostering a data use culture. Continued supervision and support to these levels from NMCP and partners will help achieve this.

***Cross-cutting RSSH Lessons Learned***

As stated in the previous section, the COVID 19 pandemic, the cyclical occurrence of natural disasters and the armed conflict in the north of the country had, and continues to have, a negative impact on efforts to build a resilient and sustainable health system. These events have implied adaptations to implementation mechanisms, application of mitigation measures, including new approaches to implementing RSSH activities. Some relevant lessons learned and resulting changes are described below.

Mozambique’s vulnerability to natural disasters and health emergencies resulted in the creation of coordination structure and responses at central and decentralized level, including communities. These contributed to the definition and recognition of the role and responsibilities of communities’ health and primary health care in pandemic response and continuity of health delivery services. These led to the approval, in June 2020, of the first community response strategy to COVID-19, which specifies the role of the community health workers. This and the previous experience in responding to health emergencies to address health-related challenges effectively at community level. Key lessons include the importance of health system strengthening, community engagement, and the use of digital health solutions, integrated approaches, inclusive and participatory methods, and strengthened coordination mechanisms in the context of protracted crises or emergencies. Additionally, the context-specific research, improved data collection and management systems, and a focus on innovation and adaptation are also emphasized. By operationalizing these lessons, programs in Mozambique strive to enhance resilience, response capabilities, and overall health outcomes.

The preliminary findings of a study commissioned to Eduardo Mondlane University and disseminated in early 2023, within the scope of implementing a pilot of the subsystem in six provinces, have revealed the need for training program enhancements. These improvements primarily pertain to competencies related to governance, emergency response, and road safety, among others. Consequently, the new competency-based curriculum has been modified to accommodate these recommendations. It is worth noting that the forthcoming cohorts undergoing training will adopt the revised curriculum to ensure alignment with the updated standards.

On the supply chain, distribution routes were updated on both permanent and routine basis, including alternative ones to address disruptions resulting from extreme climate events with the aim to gain efficiencies in the supply chain operations. A Medicines and Health Products Emergency Supply Chain Unit was also developed and installed in CMAM as part of SC response within MoH and the "national emergency entity" with support from USAID and GOM.

To avoid recurrent contact between users and Health Facilities, especially during the COVID 19 pandemic, the lab system took advantage of existing TB testing platforms for COVID 19. This is how Genexpert was used for testing COVID 19 samples that increased COVID 19 screening rate and reduced the spread of the disease in HFs. Likewise, the use of Disalink for referencing COVID 19 samples facilitated the return of COVID results and precipitated the expansion of the LIS electronic system in GC7.

In the area of ICT, some geographic areas were left without communication due to natural disasters that damaged IT infrastructure in the center of the country. Likewise, many Health Facilities were destroyed in the North, but this time as a result of the armed conflict. Thus, the increasing use of ICTs in HFs has been favored, including the use of virtual platforms and new internet technologies, combined with local data network modem and centralization of servers, resulting in better data protection. Reinforcing HR and training in ICTs has also been a key element in improving the quality of services in this area.

## Focus of Application Requirements

Describe how the funding request complies with the focus of application requirements specified in the Allocation Letter.

As Mozambique is classified as a low-income country, there are no restrictions on the programmatic scope of malaria requests, but it is strongly encouraged to include RSSH interventions. This has been done for malaria specifically in this request through the separate RSSH request. The application includes interventions that respond to key and vulnerable populations, human rights and gender-related barriers, inequities and vulnerabilities in access to services. This is done through special attention paid to and the provision of services to these populations throughout the interventions described.

## Matching Funds (if applicable)

If Matching Funds were designated for the 2023-2025 allocation period:

* + 1. Describe how integrating the Matching Funds will increase the impact and improve the outcome of the allocation for the Matching Funds area.

The RSSH component of the funding request is eligible for US$7,000,000 for the RSSH Innovation Fund allocated to HRH. Over USD 10 million within funding allocation were assigned to HRH, including CHW to meet HRH needs and secure these matching funds. The bulk of these additional resources are dedicated to further strengthen the CWH programs and increase production capacity of primary health care workers in line with the community subsystems strategy and the accelerated training plan for health professionals. Through this investment approach, the MoH expects to increase its response capacity to the ever-increasing volume of HIV/TB and Malaria patients and other programmatic gaps highlighted in RSSH annex. The entire amount of FR allocation and Match funding will be programmed in the detailed budget.

* + 1. Describe how programmatic and access conditions have been met.

To access the RSSH Innovation Fund matching funds, several conditions were provided which must be met to be eligible for this $7,000,000. The evidence for meeting these is detailed below:

Table 10: Completion of access conditions for RSSH Innovation Fund

|  |  |  |
| --- | --- | --- |
| **Access Conditions** | **Met?** | **Evidence in FR** |
| Countries must invest a portion of their total country allocation that is greater than or equal to the amount of available Matching Funds, in the focus area that the country is eligible for: •Health workforce / quality of care including CHWs | Met | $13.33M is proposed for investment in the Health workforce/ quality of care module, including an additional $7M proposed for the matching funds, for a total of $20.33M. |
| Inclusion of plans to pilot or scale up evidence-based, high-impact interventions based on country context, epidemiological profile and lessons learned. (relates to CHW) | Met | Module 10 includes strengthening and scaling of community workforce at **total of $9.48M** – including HRH planning, management and governance, pre-service training of 660 CHWs, hiring/renumeration of 963 additional CHW, CHW supervision. |
| Alignment of investments with the RSSH “Critical Approaches” outlined in the Global Fund’s RSSH Information Note. | Met | All 3 critical approaches for investing in HRH have some investment planned:   * **A package of more effective interventions to improve HRH performance** – more and better supervision, including for CHWs; improved training, including through institutionalized pre-service training; and equipment/kits * **Catalytic support for integrated HRH strategic planning** – HRH strategy review and development is planned * **Enhance system readiness to scale CHWs aligned with WHO guidance** – support to the integrated APS cadre, even while primary support remains through World Bank; evaluation of implementation to inform improvements |
| Completion of the funding request’s RSSH Gaps and Priorities Annex and alignment with national strategies/plans | Met | RSSH Annex included |
| Demonstrated meaningful engagement of Ministry of Health (MoH) community health units, CHWs/CHW associations, and community-led organizations (CLO)/ community based organizations (CBO) employing CHW in funding request development and grant making. | Met | RSSH Annex included |
| Inclusion of investments that are aligned with the guidance on CHW and CSS outlined in the Global Fund’s RSSH Information Note, including the eligible interventions outlined in the investment focus (which will be included in the Global Fund’s Matching Funds Guidelines 2023-2025, on the Global Fund’s website in 2023). | Met | All investments are aligned to this guidance. The funding request includes a description of investments in CSS priority areas of community-led monitoring, community-led research and advocacy, social mobilization, building community linkages and coordination, and institutional capacity strengthening and leadership development (pages 18-20 of the RSSH information note), also described in the "[Decision-making Guide for Community Systems Strengthening Interventions in Global Fund Grants](https://linkprotect.cudasvc.com/url?a=https%3a%2f%2fwww.theglobalfund.org%2fmedia%2f12737%2fcore_css-strengthening-grants-decision_guide_en.pdf&c=E,1,u8kmVt_x-_RjaYJLXb8AXIVNg3_Zx8D-2g1G0qOcb9-0ALhaYx5roX60FzaDgqsPuSmUwREqunE9BfQGWxQByyCbXHEjkHKhDsP9nyg38JxjaIA-&typo=1)", following critical questions described in pages 6-21. Civil Society Organizations defined these priority interventions and associated activities, themselves, within their congregating platform (PLASOC-M), costed those activites and interventions and ensured that those were included in the Funding Request as decided in their General Assembly and other internal coordination mechanisms. |
| Submission of a completed CHW Programmatic Gap Table, aligned with national strategies and plans. | Met | CHW Programmatic Gap Table included |
| Inclusion of a Community Health Strategy (or plan to develop one) that integrates CHW, community-led and community-based services, and a costed operational plan. | Met | Community Subsystem Strategy attached as reference, which has been finalized and costed (a summary of the costs is provided in pages 33-34 of the strategy). The detailed, costed operational plan is being finalized this year. |
| Inclusion of an analysis or assessment and plans for strengthening systems components needed for effective CHW and CLO/CBO service delivery, including leadership and governance, workforce (including planning, training, remuneration and supervision), sustainable financing, digital tools and systems, supply chain, referral systems, and community-led monitoring, as well as the capacity of the MoH and of CLO/CBO in service delivery. | Met | Module 12 - $1.45M included for evaluation of implementation of the community health system |

Given these conditions are considered met, an additional $7,000,000 was budgeted in addition to the RSSH priorities. In addition to the $65,496,112 RSSH allocation budget brings the total request to $72,496,112.

The completed CHW Programmatic Gap Table and Community Subsystem Strategy are included as attachments to the FR. Plans to conduct operational research, analysis and evaluation of community health system implementation to inform the expansion process and the revision of the Community Health Subsystem strategy is anticipated in coming years.

# Maximizing Impact

[The 2023-2028 Global Fund Strategy[[15]](#footnote-16)](https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf) describes clear pathways for control and elimination of the three diseases at a global level. The [Review Criteria of the Technical Review Panel](https://www.theglobalfund.org/media/3048/trp_technicalreviewpanel_tor_en.pdf#page=15)1F1F[[16]](#footnote-17) will be used to help evaluate optimal program design.

## Ending AIDS, TB and Malaria

* + 1. Describe how the Global Fund-supported program(s) advance the primary goal of ending AIDS, TB and malaria.

The Global Fund is the largest malaria donor in Mozambique, and as such provides a large amount of the funding required to achieve priority activities of the country’s National Malaria Strategic Plan – a plan which is designed to achieve the goal of reducing morbidity and mortality by 45% by the year 2030.

Specifically, Global Fund-supported programming provides critical funding to:

1. Increase access to quality diagnosis and treatment – through provision of key commodities and supportive interventions to improve the quality of care.
2. Scale up access and usage of effective prevention methods – through the distribution of ITNs, and targeted IRS, which prevent transmission and thus reduce morbidity and mortality
3. Engaging communities – through SBCC activities that improve usage of key interventions and provide communities with the knowledge required to protect themselves
4. Strengthening capacity of the health workforce – through trainings, supervisions, and other activities which provide the right skills to frontline workers
5. Building strong and resilient health systems – including for malaria through investment in support to key surveillance activities which improve epidemiological, entomological, and intervention intelligence that guide programmatic strategy and thus greater impact.

A strong emphasis on value-for-money was taken in the stratification, as described in Section 1.2, with priority given to the most cost-effective interventions when making prioritization decisions.

* + 1. Indicate if any of the Program Essentials are currently not fulfilled, explain why, and describe the proposed pathway to reach them in coming years.

To the extent that budget allows, all program essentials have been fulfilled.

Two areas of incomplete fulfillment are:

* **Ensuring optimal vector control coverage** – through stratification ITNs have been targeted and prioritized according to risk, however due to increasing population and increasing price of effective ITNs, there are budget gaps to cover some high risk populations. These are included as the top PAAR request, and will also be the subject of intensive resource mobilization from other donors. If the gap is unfilled before the 2025/26 mass distribution, the lowest risk populations would be excluded to maximize impact with available resources.
* **Optimize chemoprevention –** Mozambique is working to expand SMC and PMC as highly cost-effective interventions targeted at high risk populations in the country. The highest priority geographies are being funded through other donors (See Section 1.1) however as part of the NMCP’s approach to prioritizing the stratification to maximize value-for-money, with the full expansion of the stratification included in PAAR.

## Resilient and Sustainable Systems for Health

Describe how the Global Fund-supported program will maximize people-centered, integrated, systems for health to deliver impact, resilience and sustainability.

Mozambique’s malaria response, particularly in the areas of case management and surveillance, is built on the foundations of a strengthening primary healthcare system – both at health facility and community level. Through this integrated system access to care, diagnostic uptake, and rational use of treatments have improved greatly – and have improved somewhat through malaria-specific supportive interventions like training and supervision. As described in Sections 1.2 and 1.3, there is still substantial room for improvement in quality, but by targeting these improvements onto the foundation of a strong integrated system we feel they will be built to last on Mozambique’s journey to end malaria.

Prevention methods for malaria, as in most countries, are conducted in a way that is standalone and often through campaigns – given the need to ensure the most equitable, highest possible coverage. When conducting these vertical malaria campaigns, however, efforts are taken to ensure the services are delivered in a people-centered way – including hiring campaign workers from local communities to ensure ownership of these methods of prevention as well as build capacity for future delivery. Additionally the NMCP is taking extra effort in recent years to build data systems that are integrated into the national health information architecture, to improve the way the data is owned and housed at MOH.

The malaria vaccine introduction, financed through Gavi, is additionally being coordinated through the routine EPI program at MOH – to ensure that its introduction is done in an integrated manner, and with modalities that can accommodate future more effective vaccines that may come on the market.

The revision of CHW scope of work and training package to integrate HIV/TB services will maximize people-centered, integrated, systems for health to deliver impact, resilience and sustainability. Competence-based methodologies to pre-service training and new approaches to in-service training and quality improvement initiatives will also contribute to this end. Successful implementation and expansion of NCD related drugs integration in multi-month drug dispensing models to people living with HIV and TB will improve provision of integrated, quality services.

## Engagement and Leadership of Most Affected Communities

Describe how the design for the Global Fund-supported program(s) will maximize the engagement and leadership of most affected communities.

The selection and prioritization of interventions and activities for this funding request commenced with provincial-level and central level dialogues convened by the Country Coordination Mechanism (CCM) – where inputs on HIV, TB, and malaria were gathered to inform decisions for this funding request. Additionally, a thorough review of the 2017-2022 Malaria Strategic Plan was conducted in 2022 to inform the new strategic plan – which provided valuable lessons and recommendations for improving malaria programming.

In line with the national policy toward health program decentralization, the Global Fund-supported malaria programs have devolved decision making and execution to structures that are increasingly at the local levels of the health system. This includes the local government level, but also civil society and community level structures. Over the past years, structures for the inclusion of provincial representation from government and civil society in planning and coordination discussions have been greatly improved – including since 2020, with the wide-scale adoption of remote meeting as an option, through virtual forums that allow for cost-efficient participation from a variety of actors.

The approaches taken toward community case management (via the APS program), as well as SBCC approaches that involve local community leaders together with civil society, are also critical components of ensuring that programming maximizes the engagement and leadership of communities most affected by malaria. While not primarily supported by government, once fully implemented the newly adopted Community Health Sub-system will also serve as a critical mechanism to support malaria programming in the country.

## Health Equity, Gender Equality and Human Rights

Describe how the Global Fund-supported program(s) will maximize:

1. Health Equity.
2. Gender Equality.
3. Human Rights.

Mozambique has a favorable legal framework in place for health and equity. The Constitution of the Republic defines Mozambique as a State of social justice. The protection and promotion of human rights are key fundamental objectives of the State. The National Health Strategic Plan guarantees the protection of special groups such as children, physically disabled people, the elderly; establishes the principle of gender equality, assures all citizens the right to medical and sanitary assistance and promotes equality in their access (PESS, p 11). In 2022, with the support of a partner, a malaria-related Gender and Social Inclusion Analysis was conducted. This analysis highlighted several recommendations to improve malaria programming by including a gender lens in intervention design and implementation. These included recommendations at legislative, health-specific organizational, community, interpersonal, and individual levels. While the analysis was specifically conducted for the purpose of PMC planning, the opportunities identified there are being considered by MOH and its implementing partners in other areas to improve implementation.[[17]](#footnote-18) In addition to this referenced study, the NMCP and partners await the results of the 2022/23 household survey which includes relevant gender, age, and other demographic disaggregation of key impact and outcome indicators. These will be closely analyzed, including at subnational level where powered to do so, to identify risk factors which can be targeted for greater impact.

The 2017-2022 MSP (MSP p. 27), as well as the new 2023-2030 MSP (Objective 6), recognize the potential barriers to accessing health services resulting from cultural practices and social norms such as lack of equal access to resources by women, high female illiteracy and male decision-making households. A review of gender-disaggregated data of key malaria indicators in the last malaria indicator survey (IIM, p. 47, 61) do not show significant difference between male and female children in prevalence of disease, or in care seeking and utilization of LLINs. Evidence however demonstrates significant disparity between rural and urban settings and among different wealth quintiles in the coverage and use of malaria prevention and treatment services. While data shows no significant gender differences in prevalence nor intervention coverage, the NMCP will continue to analyze data for changes in this situation while also zooming that analysis to more granular administrative units to identify any localized disparities, as well as prioritize the delivery of services in the rural areas through the APSs to tackle rural/urban disparities.

In line with the previous funding request, this funding request works to maximize value-for-money by improving the approach to stratification and learning lessons from the current implementation, as well as aligning all donor/partner efforts under the banner of a government-owned National Malaria Strategic Plan. Health equity, gender equality, and human rights all are necessary components to consider in our programming, in that the lack of each is a barrier to achieving maximum impact.

In particular we feel that because our interventions maximize impact for available resources, these objectives are intrinsically targeted; however there are several specific ways in which the programs maximize these objectives:

**Stratification and modeling to optimize prevention (*health equity, gender equality, and human rights):*** the stratification conducted was informed by in-depth retrospective data analysis (including gender-disaggregated data where available) and mathematical modeling, conducted in collaboration with the country’s technical partners, to maximize effectiveness and efficiency of the intervention mix. The NMCP collaborated with the Swiss Tropical and Public Health Institute (STPH) and CHAI to conduct a modeling analysis in support of optimizing the intervention mix to maximize impact as efficiently as possible. Different stratification scenarios were modeled for impact, and then combined with robust costing data and additional local empirical evidence, to choose the prioritized packages of interventions. By prioritizing resource allocation to areas of greatest need, including displaced populations and other vulnerable groups, this maximizes the allocation of resources to advance health equity, gender equality, and human rights.

**Collaboration with humanitarian partners to address malaria needs of IDPs *(health equity, gender equality, and human rights)*:** During current implementation, extra effort has been paid to displaced populations affected by large-scale displacement in the ongoing conflict, including through support from the GF Emergency Fund. In the new Malaria Strategic Plan (2023-2030) a special objective has been created to improve the strategies and responsiveness to such crises when they occur – and for each service planned in this funding request consideration has been given to such emergencies to ensure needs are considered.

**Data-driven integrated supervision *(health equity, gender equality, and human rights):*** Intensified case management and data quality are the foundations on which Mozambique is working to build a sustainable and strong malaria program, in large part because these elements of the program can be built on an existing integrated primary health system – which continues to improve its accessibility for the population. Using a digital tool, which will be strengthened with lessons from the first 2 years of implementation, will allow for a more data-driven and targeted approach to supervision that pinpoints low-performing facilities for improvement. Such use of data provides major improvements in health equity, gender equality, and human rights by targeting improvements to low performers rather than the daunting task of blanket implementation to all of the country’s >1,700 health facilities or nearly 8,000 APSs.

**Digitization of campaigns to maximize coverage in hard-to-reach places *(health equity, human rights)*:** Improved availability of real-time, geolocated data for MDA and ITN campaigns has allowed managers at all levels of campaigns to maximize coverage in every area – with priority given to those most in need. Use of digitized data from the 2021 MDA campaign to refine campaign strategies clearly improved coverage from 51% in round 1 to 79% in round 3, improving coverage in hard-to-reach populations in an equitable way and saving lives.

**Donor and partner alignment to support a common strategic plan *(health equity, gender equality, ad human rights)*:** With the objective of improving allocative efficiency and minimizing duplication of efforts, during the course of the past two grants the program has worked intensively with its donors and partners to ensure that all work in the country is aligned with the national priorities. By generating data-driven plans collaboratively with its partners and creating decision-making structures in the form of inclusive national thematic TWGs who meet regularly, the NMCP has successfully navigated this complex environment and greatly improved alignment. The new Malaria Strategic has prioritized service provision to vulnerable groups (including those affected by human rights barriers and gender vulnerability) in a special objective, and alignment across all partners in this regard will allow us to maximize achievement of these objectives as we work to achieve the goals of malaria morbidity and mortality reduction.

## Sustainability, Domestic Financing and Resource Mobilization

1. Describe the major challenges to the sustainability of the national response and efforts to address these challenges.

Mozambique’s health response is highly dependent on external funding. According to the previous Health Sector Strategic Plan (the next being currently under development), about one third (36% of health resources come from the Government of Mozambique, and two thirds (64%) come from development partners (PESS, p. 118). The Global Fund and PMI are the primary funders of the malaria program, however new donors have increased investment – most notably Givewell (via MC) in Seasonal Malaria Chemoprevention (SMC). Additionally, while Government financing for malaria-specific interventions continues to be challenging, it has begun to increase investment in the integrated primary care system and some malaria-specific areas. For example, Government has successfully absorbed 10 of 11 provincial M&E foca points and funds IRS operations in Nampula (though shortfalls have been experienced in 2 of the last 3 years, which is concerning). In the short-term, sustaining the current interventions and expanding as described in the MSP 2023-2030 is likely to continue to depend on external financing.

Capitalizing on the Government’s prioritization of malaria as a public health priority, and with the support of ALMA and the Roll Back Malaria Partnership, Mozambique has created a malaria investors’ forum under the leadership of the President. Leveraging this high-level advocacy, the country aims to increase investment in malaria from both the public and private sector to fund key strategies.

In addition to these initiatives to grow the funding base, the malaria program and its partners have undertaken painstaking effort to maximize efficiency and eliminate duplicative efforts. Key to these efforts have been the creation of unifying strategic documents, including the National Malaria Strategic Plan (2023-2030). By developing these documents based on evidence, and in a participatory way with all partners, the program has cultivated buy-in for all partners to align under a common strategic vision. This improved efficiency is evident in the increased alignment between the national Global Fund grant and regional MOSASWA grant. In the past, the funding of insecticide for Maputo Province in the national Global Fund de facto removed these resources from higher burden priorities in the north and central regions of the country. By creating aligned strategies that clearly articulated (and differentiated) the objectives of the country, the MOSASWA regional grant’s design was improved to ensure regional priorities were fully financed by regional funding (those regional priorities being districts that have been identified as key sources of importation in neighboring countries, and therefore targeted for regional elimination). This design ensures these regional priorities do not siphon resources away from national priorities.

In terms of governance, the MoH has committed to shifting its mindset from an inputs-driven approach to one that emphasizes results, public accountability, and alignment of all activities under strengthened national malaria strategic plans. This has started centrally, with thematic TWGs co-chaired by NMCP and partners allowing the program and partners to continuously update each other on execution, troubleshoot challenges together, and ensure collaborative efforts are maintained.

1. Describe how co-financing commitments for the 2020-2022 allocation period have been realized.

The Government of Mozambique is very committed to meeting its co-funding commitments for programs on HIV, Tuberculosis, Malaria and on resilient and sustainable health systems, to access the full allocation of the Global Fund and ensure the sustainability of investments in health. During the allocation period (2020-2022), the Government of Mozambique contributed a total amount of USD 1,275.6 million) in domestic resources to the health sector as shown in Table 10 below, which represents an amount above the commitment made to the Global Fund to invest $112.65 million in domestic resources in the health sector.

Table 11. Domestic contribution to health sector budgets – budgeted and executed, 2020-2022



It should be noted that from 2020 to 2022, the Government of Mozambique increased the internal financing of the Health Sector from USD 351.7 million to MT 513.8 million in 2022, an increase above what it committed to make available until 2023. This fact demonstrates the Country's dedication to a sustainable response and an approach to the Government's priorities in the Health Sector.

1. Describe how co-financing will increase over the 2023-2025 allocation period, how these co-financing commitments will be tracked and reported, and planned actions to address remaining funding gaps.

As described in the documentation provided from the Ministry of Economy and Finance, during the allocation period 2023-2025, Mozambique intends to increase the State Budget for Health from USD 567.6 million in 2023 to USD 763.5 million by 2026, corresponding to a rate of increase of 34.5%. We expect health to represent 14.1% of total public expenditure, excluding General State Charges, in 2023 and 16.0% by 2026. With the support of ALMA and the Roll Back Malaria Partnership, and in line with the Zero Malaria Starts with Me campaign, Mozambique has re-doubled its efforts to increase domestic investment in malaria – including engaging the domestic private sector as a key partner in the fight. The Malaria Forum was launched with the support of the President during the current investment, and will be a key resource for addressing remaining funding gaps.

Co-financing commitments are tracked and reported by the public financial system in Mozambique, and commits to providing the Global Fund with verifiable and reliable documentation on expenditures from national funds, or when not yet available, the latest budgeted amounts, from the following:

* For past expenditures: *General State Account, presented annually in June for the previous year*
* For future planned expenses: *(i) Economic and Social Plan Law and State Budget, presented annually in December for the following year; (ii) Medium-Term Fiscal Scenario Projections, generally approved in May of each year*

Each year, by August 15th, we will submit a co-funding report to the Global Fund, which covers the annual period beginning January 1st and ending December 31st of the previous year.

Table 12. Deadlines for co-financing reports

|  |  |
| --- | --- |
| **Date** | **Due information (illustrative)** |
| 15 Augusto 2024 | Conta Geral do Estado 2023 (General State Account) |
| 15 Augusto 2025 | Conta Geral do Estado 2024 (General State Account) |
| 15 Augusto 2026 | Conta Geral do Estado 2025 (General State Account) |
| 15 Augusto 2027 | Conta Geral do Estado 2026 (General State Account) |

1. If applicable, describe specific arrangements and modalities related to innovative financing approaches linked to this funding request and/or the national response.

No innovative financing approaches are currently planned for this funding request.

## Pandemic Preparedness

Describe how the Global Fund-supported program(s) build capacities that are most critical to prevent, detect and respond to infectious disease outbreaks.

The National Malaria Control Program, through GF support as well as the support of other partners, has taken substantial efforts to improve its data systems, including where possible leveraging malaria-specific funding to strengthen integrated epidemiological surveillance systems (e.g. increased febrile illness surveillance via SIS-MA and IDSR). Additionally, malaria-specific data systems have been strengthened to ensure that in the face of pandemics malaria services continue to be ensured. Specific investments in pandemic preparedness (e.g. laboratory systems and cross-cutting surveillance) are expected to be made through RSSH funding request, with due consideration for complementary investments from other sources.

# Implementation

## Implementation Arrangements

1. Describe changes to implementation arrangements which will maximize implementation effectiveness and optimize efficiency.

The proposed Implementation Arrangement Map is attached in the application packet.

The proposed implementation arrangement remains similar to the current grant – MoH and World Vision International serving as joint PRs, are proposed to continue with a focus on improving MoH capacity as a PR to drive the long-term efficiency and effectiveness of the government in managing its malaria control program. Funding flow to the MoH PR will continue to be managed by the Program Management Unit (PMU) that sits within the MoH, PMU will assist with planning, budgeting, prudent controls, cash flow, top down management structures, and reporting. Coordination on these matters at NMCP will be improved by the appointment of a focal point included in this funding request. Commodities will be procured through the Global Fund PPM in order to access the best available prices for critical commodities.

As in the current grant, a number of SRs will be contracted by World Vision, particularly to focus on community level activities such as LLIN distribution and SBCC. Selection of these SRs will be done based on the SR selection process led by the CCM, and will also consider expertise in implementing newly-added interventions like SMC. Partnership between the MoH/NMCP and World Vision is well established and effective, ensuring strong coordination of activities. Routine grant coordination meetings will be held and supervision will be conducted to ensure strong oversight of all parties. Implementers will participate regularly in national and provincial TWGs to conduct participatory planning and coordinate implementation.

The program has a number of technical and operational partners that will continue to support its efforts as well to improve performance.

***RSSH Implementation arrangements***

Even though the RSSH Funding Request is integrated within the malaria request, management and implementation of RSSH activities will be done in a standalone approach. The principal recipient implementing RSSH investments will be the MoH in collaboration with CSOs for strengthening community systems. Strategic focus on some RSSH modules will increase the likelihood of successful implementation.

Despite the fact that RSSH FR integration in the Malaria portfolio, management and implementation of RSSH activities will take a standalone approach. This demands specific implementation arrangements. Overall, based on lessons learned from current grants and GF recommendations a strong management structure to coordinate and oversee implementation will be put in place. This will include clear chain of command and responsibilities, regular meetings with main implementers and stakeholders for coordination, monitoring and accountability, and implementation of corrective measures whenever necessary. Action plans and performance frameworks to track progress will be key to this process.

MISAU intends to use existing SWAP platforms for planning and monitoring RSSH activities in order to avoid overburdening staff and duplication of effort. These SWAP working groups are led by the Planning and Cooperation Departments and comprise all national directorates, relevant departments and health programs such as HTM, as well as other government ministries, health sector partners and representatives from CSO. A detailed and comprehensive RSSH annual work plan with clear timelines, milestones and responsibilities, including other donor’s contributions, will be developed and approved under these forums, and, thereafter, quarterly meetings will be held to track progress. during this process, special attention will paid to the roll out of Community Health Subsistem strategy and coordination of community led interventions.

Delays in procurement processes due to understaffing of the procurement unit and long lead time for process approval has slowed down implementation of RSSH activities. Therefore, a quality and detailed procurement plan will be developed, and held discussions with the Administrative Court and Global Fund for agreements on ways to speed up the approval process, and innovative implementation arrangements like UN platforms.

1. Describe the role that community-based and community-led organizations will have in implementing programs supported by the Global Fund.

Equity in access to services, irrespective of geographic remoteness, ethnicity, nationality or gender, is essential to achieving the desired impact of this funding request. Community-based organizations play a significant role in the implementation of the current grant, and their role in the proposed work will increase as described below.

Priority area 1: Community delivery of malaria prevention (ITNs) via mass campaign

* Strong emphasis will be placed on improving ITN distribution, including the use of technology to facilitate more accurate and granular M&E to measure LLIN coverage
* Promotion of ITN usage at community level, building on the improvements in access and usage demonstrated in the current investment (with increased impact by addressing resistance)

Priority area 2: Community response and SBCC

* Development and delivery of community SBCC materials that target service uptake in the most at-risk communities, to continue the strong upward trend over the last decade in ITN usage, IRS acceptance, and treatment-seeking
* Improved data and reporting of SBCC activities, as part of the program’s overall effort to improve operational efficiency by targeting interventions to the areas in most need

Priority area 3: Addressing the needs of IDPs

* Rapid assessment and response to the needs of populations affected by climatic and conflict-related emergencies, as has been done for IDPs in Cabo Delgado Province. This includes close collaboration of national, provincial, and district health authorities with humanitarian agencies who are active in the response to such disasters.

**RSSH Involvement of CSOs**

Under Community Strengthening interventions, the SCO will continue to refine and implement accountability mechanisms led and implemented by community-led organizations to improve accessibility and quality of health services, in particular for addressing barriers to accessing services by specific and most vulnerable groups, and include perspectives and experiences of clients. Capacity building Community-led and community-based organizations will be trained and empowered to have a meaningful participation in the provision of health services responses, innovate and address changes and shifts in HIV, TB, and malaria. Organizational leadership requires capacity to hold decision makers accountable, engage duty bearers and lead active and well-functioning civil society..

## Key Risks and Mitigation Measures

Describe up to three risks and mitigating measures for each of the following risk areas:

1. Procurement of health products, management of health products and laboratory related activities.

|  |  |  |
| --- | --- | --- |
| **Key Risks** | **Corresponding Mitigation Measures** | **Entity Responsible** |
| Commodity prices are a substantial risk, particularly given the biological threats facing (insecticide resistance, artemisinin resistance, and HRP2/3 gene deletion)  The NMCP has a strong desire to nimbly respond to data on these threats, but the constraint of costs presents a risk to doing so. | Proactive forecasting at the country level, as well as coordinated support from global actors to project commodity needs and negotiate pricing with manufacturers, will be key to ensure the coverage of life-saving interventions are delivered and maintain (or improve) their effectiveness.  Surveillance for these biological threats will also improve decision-making and program effectiveness. | NMCP, CMAM with Chemonics/PSM, and GF |
| Lead times for key commodities disrupting prevention interventions with sensitive timing | Long commodity lead times exist at least partially due to successful efforts to reduce prices globally, constraining manufacturing capacity. To mitigate this risk the NMCP has improved its capacity to place timely orders, as well as communication with the GF Wambo team to predict delivery schedules. These efforts must be maintained, and globally support must be given to reduce lead times as much as possible. | NMCP and CMAM, with support from GF and PMI |
| Loss of commodities due to natural disasters and conflict | Where possible diagnosis and treatment buffer stocks have been incorporated into the commodity quantification, however the increasing frequency and severity of these events puts a strain on the system.  The NMCP and CMAM have strengthened collaboration with disaster management agencies, however will also require support and flexibility from key donors (GF, PMI) in order to quicken response when emergencies occur. | NMCP and CMAM, with support from GF and PMI |

1. Flow of data from service delivery points.

|  |  |  |
| --- | --- | --- |
| **Key Risks** | **Corresponding Mitigation Measures** | **Entity Responsible** |
| Lack of register books continue to plague the program, driven recently by administrative challenges described below in category (C) | Continue to solve for the bureaucratic delays through collaboration with MEF and DPC, with increasing MOH senior leadership support in improving administrative timeliness. | NMCP and DPC, with procurement dept. |
| Data completeness and timeliness improvements must be sustained, and data accuracy must continue to rise to meet the completeness and timeliness standards | Continued strengthening of data quality audits (DQA), including the use of data to target repeat visits and provide on-site mentorship | NMCP and DPS/SPS |
| Financial and programmatic sustainability of campaign digitization efforts, including expansion to all malaria campaigns | An integrated approach to campaign digitization will yield efficiency gains, however the capital investment required is substantial. Funding for this will be prioritized under this investment where possible, and will require cost sharing from other donors.  To improve programmatic sustainability, NMCP and partners have explicitly made efforts to partner with the Health Information Department (DIS) and IT Department (DTIC) to build internal capacity and improve programmatic sustainability. Additionally, implementing partners for campaigns will play a key role in shared responsibility for the sustained programmatic capacity. | NMCP, DIS, and DTIC – with partners |

1. Financial and fiduciary concerns.

|  |  |  |
| --- | --- | --- |
| **Key Risks** | **Corresponding Mitigation Measures** | **Entity Responsible** |
| Available funding compared to need is a major risk – in this funding request having reached a state of constraint not experienced in the recent past. | Great effort has been expended to optimize the budget and prioritize activities to achieve maximum impact with the limited resources. The MOH and its partners remain confident in this analytical approach to resource allocation – however, several items are constrained and representing great risk to realizing the MSP goals:   * The necessity to place a quantity of ITNs (equal to the variance of found population from INE population) in PAAR which if unfilled will result in inadequate quantities for the 2025/26 distribution * The withdrawal of IRS in Zambezia and Nampula. While hope is given to the provision of PBO-pyrethroid ITNs in 2022/23, and dual-AI ITNs in 2025/26, this is a risk of unknown magnitude. | MOH, GF, PMI, and other partners in resource mobilization |
| Bureaucratic government financial systems are in place to reduce fraud risk, but are risking implementation timeliness | MOH and MEF will continue to work closely to improve timely disbursement of funds for mission-critical activities, but experience to date has been challenging. Support from MOH senior leadership will be sought. | MOH and MEF senior leadership |

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

This checklist only applies to applicants requested to apply using the Full Review application approach.

Refer to the [Full Review Instructions](https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf)[[18]](#footnote-19) for details, applicability and resources.

#### Documents Reviewed by the Technical Review Panel

|  |  |
| --- | --- |
|  | Funding Request Form |
|  | Performance Framework |
|  | Detailed Budget |
|  | Programmatic Gap Table(s) |
|  | Funding Landscape Table(s) |
|  | Prioritized Above Allocation Request (PAAR) |
|  | Health Product Management Template |
|  | Implementation Arrangement Map(s) |
|  | RSSH Gaps and Priorities Annex |
|  | Gender Assessment (if available) |
|  | Assessment of Human Rights-Related Barriers (if available) *[Cabo Delgado Assessment]* |
|  | Essential Data Table(s) |
|  | National Strategic Plans |
|  | Innovative Financing Documentation (if applicable) |
|  | Supporting Documentation Related to Sustainability and Transition (if available) |
|  | List of Abbreviations and Annexes |

#### Documents Assessed by the Global Fund Secretariat

|  |  |
| --- | --- |
|  | Funding Priorities from Civil Society and Communities Annex |
|  | Country Dialogue Narrative |
|  | CCM Endorsement of Funding Request |
|  | CCM Statement of Compliance |
|  | Additional documentation to support co-financing requirements |
|  | Sexual Exploitation, Abuse and Harassment (SEAH) Risk Assessment (optional) |

1. Afai, G., Rossetto, E.V., Baltazar, C.S. et al. Factors associated with knowledge about malaria prevention among women of reproductive age, Tete Province, Mozambique, 2019–2020. Malar J 21, 76 (2022). <https://doi.org/10.1186/s12936-022-04090-0> [↑](#footnote-ref-2)
2. Differential in AS-PY/DHA-P and AL reference prices for APS in PAAR, but no commodities included as “gap” given only the reference price differential vs. the commodity itself [↑](#footnote-ref-3)
3. Raouf S et al; The Lancet Global Health; 2016; <https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(16)30014-6/fulltext#pageBody> [↑](#footnote-ref-4)
4. Chaccour C et al; Malaria Journal, 2021; <https://malariajournal.biomedcentral.com/articles/10.1186/s12936-021-03611-7> [↑](#footnote-ref-5)
5. WHO, RBM Partnership to End Malaria. High burden to high impact: a targeted malaria response. Geneva, World Health Organization, 2019. Report No.: WHO/CDS/GMP/2018.25. [↑](#footnote-ref-6)
6. Sub-national Analysis of Malaria Situation in Mozambique, Updated with 2021 data for all provinces; PNCM [↑](#footnote-ref-7)
7. Cuamba, N.J.B (2003). The bionomics, population structure and roles in transmission of malaria vectors in Mozambique and Angola. University of Liverpool. [↑](#footnote-ref-8)
8. PNCM Relatório Anual de Entomologia, 2016 [↑](#footnote-ref-9)
9. Candrinho B et al.. Quality of malaria services offered in public health facilities in three provinces of Mozambique: a cross-sectional study. Malar J 18, 162 (2019). <https://malariajournal.biomedcentral.com/articles/10.1186/s12936-019-2796-9> [↑](#footnote-ref-10)
10. Manuscript in draft [↑](#footnote-ref-11)
11. Malaria threats map. <https://apps.who.int/malaria/maps/threats/> [↑](#footnote-ref-12)
12. Plucinski et al.<https://journals.asm.org/doi/epub/10.1128/JCM.00875-19> [↑](#footnote-ref-13)
13. PMI, VectorWorks. *Durability Monitoring of LLINs in Mozambique.* December 2018 [↑](#footnote-ref-14)
14. Chaccour et all. Malaria Journal, 2021. <https://malariajournal.biomedcentral.com/articles/10.1186/s12936-021-03611-7> [↑](#footnote-ref-15)
15. 2023-2028 Global Fund Strategy - <https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf> [↑](#footnote-ref-16)
16. Review Criteria of the Technical Review Panel - <https://www.theglobalfund.org/media/3048/trp_technicalreviewpanel_tor_en.pdf#page=15> [↑](#footnote-ref-17)
17. Gender and Social Inclusion Analysis – Mozambique; 8 April 2022; PSI, Unitaid, LSHTM, and RC. [↑](#footnote-ref-18)
18. Full Review Instructions - <https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf> [↑](#footnote-ref-19)