



Taking Stock Report
Mozambique

March 2008

**Ministry of Health
for Mozambique**

SCALING UP FOR BETTER HEALTH

**International Health Partnership and related initiatives (IHP+)
Harmonization for Health in Africa (HHA)**

**Inter-Regional Meeting of National Health Sector Teams
Lusaka**

28 Feb - 01 Mar 2008

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Summary

Mozambique is a country which has emerged from a number of years of conflict to build a sound and rapidly growing economy. However, given the low economic base from which progress has been achieved, Mozambique remains poor and highly aid dependent. Approximately, 70% of health sector financing is currently funded by Mozambique's 26 development partners, (based on Javier, M 2006; MOH, 2007 documents). This is despite an increase in government expenditures on health over the years which have, however, been significantly outpaced by that of development partners. This level of dependency on multiple partners requires strong coordination on the part of government if its own vision and objectives for improving the health of the population are to be realized. Whilst good progress has been made in terms of donor coordination, with 14 development partners currently contributing to a pooled funding mechanism for the health sector (PROSAUDE), which provides funding on budget and on plan and against a single agreed performance plan for the sector, a significant proportion of health, especially HIV/AIDS related, aid, is still channeled according to donor defined priorities and through non government organizations.

Whilst there is a well established SWAp mechanism, there is a continued need to actively engage development partners who are not able to pool financing to ensure that funds are provided against the national plan. There remains a significant challenge in trying to both maximize the efficiency and effectiveness of available resources as well as mobilizing the additional funding that will be needed to overcome a number of clearly identified bottlenecks to MDG progress.

Three priorities have been identified by the Ministry of Health in its planning process (PESS):

- 1) the development of human resource capacity;
- 2) improvement of health care infrastructure; and
- 3) increased community engagement and expansion of training and deployment of community health workers.

The lack of human resource capacity has been defined as one of the greatest barriers to overall health sector delivery, and is also a major constraint to disease specific targets such as reducing malaria, tuberculosis, HIV/AIDS and maternal, infant and child mortality. Having one of the lowest health worker densities in Africa, with less than 0.3 health workers per 1000 population, Mozambique also suffers a significant internal brain drain, with many of its trained health workers being attracted by better salaries in the NGO sector, moving out of government service on to project based payrolls, funded in large part by the same development partners that are trying to support health system development through the SWAp mechanism. This has compounded the challenge faced by government in terms of achieving nationally defined priorities and in trying to provide health services in an equitable way, reaching remote and underserved areas and poor and marginalized groups.

Challenges

The key challenges identified for the IHP are:

1. Reducing internal competition for limited human resources and also to increase training, maintenance and retention of a motivated health workforce;
2. To reduce the transaction costs related to managing the health sector, by rationalizing the number of development partners that MISAU has to deal with on a regular basis;
3. To mobilize additional resources, so that a higher level of ambition can be factored into national planning, based on an increase in longer term, more predictable financing;
4. To hold donor groups to account for their commitments;
5. To maximize the effective use of already available resources
6. To address other major health system weaknesses:
 - a. improve physical access to health services,
 - b. sufficiently integrate the HMIS,
 - c. strengthen links between the health strategic plan and annual operational plans
 - d. strengthen linkages between strategic objectives, investments or inputs and

- e. measurable outputs within the Medium Term Expenditure Framework
- e. strengthening capacity for health systems research

Recommendations

Mozambique is looking for the following actions to be taken as a result of the IHP process, which will help strengthen performance and improve progress towards the health MDGs:

1. All partners should acknowledge and respect agreed in-country planning processes, and aim to harmonize and align their support behind these processes.
2. To reduce the transaction costs related to managing and working with multiple funding agencies – encouraging development partners to maintain or increase their financial commitment to the health sector, but to work, wherever possible, through silent partnership or using other funding modalities in order minimize the administrative burden on MISAU.
3. Given the scale of PEPFAR funding, in comparison to other funding for the health sector, it is essential to fully use the flexibility of PEPFAR funding, in order to ensure that HIV/AIDS funds are helping provide the full range of primary care services required by both HIV positive and HIV negative people - by supporting the overall strengthening of primary healthcare.
4. To ensure that GFATM funding remains on programme, on budget and begins to use the single agreed performance assessment framework (PAF). In addition, ensuring that funding is provided in a predictable fashion, in line with principles set out in a newly drafted MOU.
5. To ensure that a bid for GAVI health system strengthening funding contributes to overall health system strengthening, not just immunization services strengthening, recognizing that effective EPI in an integrated PHC system requires a fully operational PHC service. The funding should be provided on budget, on plan, be long term and predictable.

This paper has been drafted by a task force mandated by the Ministry of Health and by its development partners (through the Focal Donor), however it has not yet been presented in full and discussed and agreed, it does not yet, therefore, represent a consensus document. An immediate follow up to the Lusaka meeting will be to have more detailed country level discussions on the papers contents, as the basis for achieving consensus on the current status – in order to have a participative stock taking exercise, where both the government and its partners voice their issues and concerns and achieve an agreement on the next steps needed to further strengthen existing country coordination mechanisms.

Introduction

Objectives of the Paper:

This paper has been produced for two purposes, firstly to satisfy the immediate needs of providing feedback to IHP partners at the international level on the IHP process in Mozambique at the meeting to be held in Lusaka from 28-29 February 2008; and secondly, to be a platform document for both IHP and other partners at the country level to debate the key issues and challenges facing Mozambique as it begins to scale up health action and accelerate progress towards the MDGs.

This paper is a clear expression of the expectations of health sector partners in Mozambique to both the International Health Partnership and the various initiatives which are helping to mobilize resource for the country's health action. It is an opportunity to ensure the implementation of country led initiatives and processes as well as ensuring that international commitments translate into support that is delivered at the country level in ways which help build and develop country capacity.

For Mozambique, the International Health Partnership represents an opportunity take stock of the progress made to date in terms of donor harmonization and alignment behind nationally identified priorities. It is an opportunity for the Government of Mozambique and its development partners to consider whether the international community has lived up to the commitments made in the Paris Declaration on Harmonization and Alignment, and whether the country and its partners have lived up the various other international commitments made linked to MDG progress. The IHP is also an opportunity for Mozambique to deliver a clear message to the international community on the need to improve communication and coordination between the international level and HQ's of the various IHP partners and their operatives at the country level, to ensure commitments made at the international level are translated into practical action at the country level.

1. Background Information

Despite having one of the world's highest economic growth rates, nearly 54% of Mozambique's population lives in extreme poverty, and the access to health and education services are limited. The illiteracy rate, 60%, is high, especially among females (male 39.4%; female 71.3%). Much of the health infrastructure was destroyed during the long civil war and less than 50% of the population currently lives within 5 km of fixed health services. The country has a severe shortage of trained health professionals.

Health care is provided mainly by the public sector, which relies on a network of about 1100 facilities with 15500 beds, staffed by about 27000 health workers. Private for-profit care provision, which has expanded in the main cities in the last decade, is poorly documented. Private not-for-profit operators, mainly associated to missions and charities, add some capacity, often in collaboration with the public sector. There are many international and national NGOs that contribute to the health sector.

Health status indicators

The country's burden of disease is largely a consequence of the high levels of poverty and a result of infectious and communicable diseases. Poor access to primary health care facilities has made it difficult for government efforts to deal effectively with the health situation. Only 36% of people have access to a health facility within 30 minutes of their homes (PARPA II). About 30% of the population are not able to access health services and only 50% have access to an acceptable level of health care. Among the top contributors to the country's disease burden are malaria, diarrhoea, HIV/AIDS, respiratory infections and tuberculosis. Malaria is considered the major contributor to the country's burden of disease. 30% of the mortality rate in children 7 yrs and below is attributed to malaria. Malaria is responsible for 40% of all outpatients' attendance and approximately 30% of all hospital deaths (RBM situational analysis 2001). The incidence of tuberculosis in the country is very high at 1,025 per 100,000 population (2004). The infant mortality rate has declined from 147/1000 live births (IDS, 1997 and MISAU reports, PESS) to 124/1000 live births (DHS, 2003). According to the latest figures from UNICEF the infant mortality has declined further to 100/1000 live births (UNICEF 2005). The child mortality rate declined from 219/1000 births to 178/1000 births (PARPA II). Child mortality rates are usually considered to be a reflection of the extent and impact of prevailing poverty levels and as a proxy indicator of socio-economic development.

The high levels of poverty and the persistent nature and degree of food insecurity in the country have contributed to the poor nutrition indicators in children under the age of five years. Levels of chronic malnutrition in children under the age of 5 years are currently at 41%, with vitamin A deficiency rates at 69% and levels of anaemia at 75% (PARPA II). The challenge is to develop and implement viable strategies to improve food security at both the household and national levels.

The maternal mortality rate which was once considered one of the highest in the region has over the past five years declined to about 408/100,000 live births. The proportion of deliveries taking place in health institutions varies significantly by province as do most of the health indicators. According to PARPA II only 48% of deliveries take place at health 5 facilities and the index for access to Essential Obstetric Care (EOC) is only 1.23 per 500,000.

"It is estimated that more than one and half million persons are infected with HIV and the national HIV prevalence is recently estimated to be at least 16 % in people over the age of 15 years. The strategic plan for the national multi-sectoral response to HIV/AIDS has been reviewed and revised to take into consideration the changing epidemiology of HIV/AIDS and the introduction of new strategies for prevention, control and treatment. Much of the effort will be directed at prevention and mitigation of the impact of HIV/AIDS at the household and national levels. Programs have been developed to scale up access to Voluntary Counselling and Testing (VCT) and Antiretroviral Therapy (ART) with a particular emphasis on access to paediatric ART."

Progress in establishing a rural primary health care network and management system has

been limited by several factors, which include high rates of infectious disease and malnutrition; a growing prevalence of HIV/AIDS; inadequate access to potable water; limited numbers of trained health personnel; and inadequate funds allocated for basic health care delivery annually. Overall, the health status of the Mozambican population is lower than average for African countries and far below international standards.

2. Overview of national policy framework for the health sector

The health policy framework for Mozambique is articulated in several documents, including the *Five Year Government Plan (2005 – 2009)*, the *Poverty Reduction Strategy Paper (PARPA II)*, the *Social and Economic Plan (PES)*, the *Three Year Public Investment Plan (PTIP)*, the *Medium Term Expenditure Framework (CDFMP, or MTEF)* and the *Health Sector Strategic Plan (2007-2012) (PESS)*. Stated cornerstones of the policy are primary health care, equity and better quality of care. These six documents provide a framework for national planning and programming. The main document in this hierarchy is the *Government Five Year Plan 2005- 2009* which sets its main objectives as, reducing the levels of absolute poverty, rapid and sustainable economic growth, consolidation of peace, national unity, justice, democracy and national awareness, as indispensable conditions for the harmonious development of the country and the fight against corruption, crime and red tape.

The *Poverty Reduction Strategy Paper II (PARPA II)* is the operational plan for the government's Five Year Program (2005–09) which includes a strategic matrix of key indicators, a joint effort by the government, development partners and civil society. These indicators are fully integrated into and monitored through the annual instruments of the Economic and Social Plan (PES). The *human capital* pillar provides, *inter alia*, for the development of good health and hygiene and a reduction in the incidence of diseases that affect the most vulnerable population groups, focusing particularly on the battle against malaria, tuberculosis and HIV-Aids. Health contributes to human development, and directly and indirectly to a reduction in poverty.

The objectives for the health sector are laid down in the *Health Sector Strategic Plan (PESS 2007-2012)* and the PARPA II. The Health Sector Strategic Plan also takes into consideration regional health initiatives within the SADC and global initiatives such as the Millennium Development Goals. Success factors addressed include the mobilization and efficient use of resources, increasingly harmonized planning and budgeting processes, improved management, the availability of competent professional staff, the availability of essential supplies and community participation/collaboration with various stakeholders in health development.

The PESS ensures that the plans are tools to serve the sector, tools to indicate direction, objectives and strategies and, at provincial and district levels, to articulate the means by which these objectives and strategies can be achieved. The plans also serve as tools for monitoring the achievement of targets and indicators. Expected outcomes from the PESS include:

- Increased access to health services;
- Consolidation of the PHC approach and integrated service delivery;
- Strengthened referral system and continuity of care;
- Improved quality of services delivered at all levels;
- Improved functioning and performance of health care facilities at all levels of care;
- Guaranteed, adequate and early response to Emergencies and Epidemics;
- Strengthened Community Participation approach;
- Promotion of a collaborative approach with other health providers;
- Improved inter-sectoral collaboration.

Progress towards MDG goals

MDG Indicator	1990	1995	2000	2005
Children 1 year old immunized against measles	59%*	61%	71%	77%
Infant Mortality rate / 1000 live births	158*	145	122	100
Under five mortality rate / 1000 live births	235*		178	145
Contraceptive Prevalence Rate (modern method)		5.1%		11.8%
Births attended by skilled health personnel			47.7%	48%
Maternal Mortality rate / 100000 live births	1500*		1000	408**
Prevalence of tuberculosis / 100000 population	296*	520	580	597
Tuberculosis detection rate under DOTS		46%	44.4%	48.7%
Tuberculosis death rate / 100000 population	33.7	77.9	115	123.8
HIV Prevalence in 15-49 age group				16.2%

Source: Database: MDG Info.2007.mdb; 08-02-2008)

* Other sources, MOH data.

** According to the Maternal Death UN report 2005, the estimate for Mozambique is 520, ranging 360-680

maternal deaths/100000 live birth.

Progress towards attaining the health MDGs has been slow mainly as a result of the following reasons:

- Weaknesses in linkages between: strategic plans and annual operating plans;
- Weaknesses in linkages between the health sector and broader development processes;
- Difficulties in coordinating international initiatives;
- Staffing and systems limitations,
- Inadequate monitoring systems for resource flows, progress and outcomes;
- Limited progress in transferring global commitments into concrete action at country level (e.g., the provision of predictable, long-term financing);
- The lack of a multi-sectoral approach to achieving health outcomes.

3. Health sector Strategic Plan and program specific plans

The PESS is seen as both a statement of policy and outlines the major strategies for medium-term action within the sector. The PESS articulates both the mission statement and guiding principles for the sector.

Several health systems related and program specific strategic plans have been developed, which present a more detailed outline of strategies and areas for action, in line with the broad national health policy and strategic directions. Valuable information has been obtained from the evaluation of health sector sub-systems such as the pharmaceutical sector, TB, malaria, EPI and disease surveillance program as well as and the impact of global initiatives.

	Plans and main initiatives	Remarks
Health system strengthening	1. HRDP 2009-2015 2. Pharmaceutical review/plan 3. Roadmap for HMIS 4. Service availability mapping 6. Laboratory evaluation and draft plan 7. GAVI proposal for HSS	Completion: May 2008, including costing Costing being finalized Draft under review Analysis of data in process
Program Specific	1. Malaria business plan 2. TB five year plan of action 3. PEN HIV 4. Roadmap to accelerate maternal and neonatal mortality reduction 5. Policy and strategic plan for newborn and child health 6. EPI 5 year plan of action 6. CMYP 2007-09 for EPI, GAVI proposals for new vaccine introduction	Till 2009 Being costed

Summary table of health system and program specific plans and main initiatives

1. Major challenges and bottlenecks

Area of Human Resources

Training

- Expansion of the training network (priority – Institute of Health Sciences of Nacala, new Institute of Health Sciences in Tete, new Institute of Health Sciences in Maputo Province (after building the General Hospital - HG) and in Gaza, training institutions in Chokwe or Chibuto)
- Development of capacity for distance training;
- Allocation of sufficient quantity of qualified teachers in training institutions (IdF's in Portuguese)
- Regular and periodic evaluation of training quality in the Training Institutions (IdF's)
- Stimulate the participation of Elementary Polyvalent Agents (APE's) in the health promotion for communities.

Management

- Speed up the process of pensions fixing for retired staff to enable absorption of new staff;
- Development of an incentives policy, exploring new ways to increase retention of health staff.

These priorities are being incorporated in the Human Resources Development Plan to be finalised in March 2008.

Area of Medical Assistance

- Definition of levels of responsibility for Sanitary (Health) Units (U.S in Portuguese), updating information on current responsibilities and functions and making a projection of needs for further development of U.S. Given urgency of this task, it is suggested that projected needs be based on a sampling of need from a number U.S, and then make the extrapolation of the results.
- Clearly define the training and the remuneration package for APE's as it is not clear if these would be part of the National Health System (SNS) or work at the Municipal level. This issue is expected to be discussed within the National Directorate for Health Promotion and Disease Control and then after at the Minister's Consultative Meeting.

Area of Prevention and Disease Control

Main challenge is decentralisation of some programme activities. However for the effectiveness of this decentralisation there is a need to take into account the following aspects:

- a) Review the policy for allocation and retention of staff because the Provincial Health Directorates are given the staff who arrive without experience. Once they have gained experience they are invited to work at Central Organs (OC's) or even out of the National Health System (SNS), representing a loss of expertise from Provincial Directorates.
- b) Create conditions for career development at District level in view for staff retention;
- c) Define the level of competences because the Central Institutions are continuing to plan and execute activities that should be done at district level;
- d) Involvement of other sectors in bringing solutions, taking into account that the health problems are requiring a multisectoral answer;
- e) Strengthening institutional and environmental hygiene and cleanliness.

Area of the Directorate of Finance and Administration (DAF)

- Allocation of staff for accounts, procurement and maintenance at provincial level;
- Building of regional and provincial warehouses; the health facilities at district level should have a small warehouse to keep consumption stock (10 provincial and 2 regional)
- Building of new offices for DPS (Provincial Health Directorate) which are only in Tete and Maputo Provinces;
- Creation of a stock management software.

In the area of research

- Need to reinforce the technical capacity
- Building a reference laboratory for TB, Malaria, Microbicides and Immunology

Expansion of the Health Network

- Amplification of all the HPC and provincials. In Niassa Province a new HP (Provincial Hospital) with the current one to become a HG, a new Central Hospital - HC in Inhambane and in Maxixe a HG;
- One hospital with 100 beds capacity in each district;
- Health Centre of type II in rural areas till an average of 1 health unit (CS) per 10000 habitants; We would like the country to have a capacity for building 60 CS/year, with initial plan being for 20 in Nampula and Zambézia and in eight each other 5 provinces (except in Maputo City);
- Building in each provincial headquarters one HG with capacity for 200 beds with the objective to alleviate the pressure on central and provincial hospitals.

3.2. Health Sector Priority areas (PESS):

- Development of Human Resources;
- Development and strengthening of health Infrastructures and Equipment;
- Community participation, with emphasis, in training of APE's

Proposed solutions to scale up targets/achieve MDGs

Considering that a needs assessment and costing of the implementation process to achieve the MDGs in Mozambique the MOH is currently implementing the following strategies:

- Fine tuning the resource implications the PESS, sectoral long range policies, plans, targets and monitoring and evaluation frameworks to those of the MDGs.
- The planning and budgeting processes are being strengthened in order to facilitate effective and efficient resources mobilization and utilization at all level of the health system.
- One of the objectives of the current PESS is to strengthen and increase the collaboration between the Ministry of Health and the private sector (including NGOs) within the existing SWAp mechanisms.
- The MOH program development and implementation continue to be based on locally relevant international best practices and cost effective health interventions – e.g. malaria, HIV/AIDS and TB policies and strategies, IMCI strategy, maternal, neonatal and child health roadmap, safe motherhood initiatives, etc.
- Planning and budgeting for the procurement of goods, services and development of the necessary infrastructure
 - o Improved availability and rational use of medicines & supplies
 - o Expansion and maintenance of health infrastructure in line with available human resources capacity
 - o Increased training, employment and retention of skilled health professionals in line with the country's HRDP.
- Increased mobilization, efficient and effective use of financial resources necessary to archive the set targets – both internal government resources and external donor funds to close the financing gap (development of a financing strategy for the MDGs).
- Health system strengthening - especially management capacity at all levels, financial management, drugs and supplies management, the collection, consolidation, analysis and use of health information in the decision making process.

4. Health Financing

Financing mechanisms

The NHS in Mozambique is financed by public and external funds. About half of the recurrent expenditure is financed by external funds. Including investment, the share covered by the international community surpasses 70%. State Budget and donors financed the health sector to an estimated US\$ 9 per capita in 2002. To this, the contribution of private users, unknown, but reckoned substantial and on the rise should be added. Total health expenditure per capita increased from US\$ 4.6 in 1997 to US\$ 7.5 in 2000.

User fees are charged for most health services, and while exemption mechanisms exist (for some vulnerable groups and for specific illnesses) they are not well understood by the majority of health sector clients. The findings of a study to evaluate the impact of abolishing user fees for primary health care are currently being looked into.

Health insurance schemes exist for public sector employees managed by the Ministry of Planning and Finance. With the continued expansion of the private sector, a more comprehensive scheme has not been ruled out in the future.

Health expenditure 2001-2007 (2008) (US\$ x 1 million)

Source	2001	2002	2003	2004	2005	2006	2007	2008
Government Budget	70	82	96	105	104	108	127	138
Common Funds	17	20	37	63	106	99	125	74
Vertical Funds	75	75	75	85	130	141	150	300
Total Expenditure	165	178	209	253	340	276	402	512

*For 2008: figures refer to financial commitments, not yet expenditure
Based on Javier M, (2006) & MOH documentation*

Different aid modalities

External funding of the health sector has always been substantial in Mozambique. For 2008, 73% of the health budget is financed by a total of 26 partners, comprised of bilaterals, multilaterals, global funds and development banks. Twenty percent of all external aid is channeled through the common funds, a pooling mechanism in the context of a SWAp approach. The common funds are supported by 58% (15) of health partners. Other funding modalities consist of direct support to the Ministry of Health, support through UN agencies or for the majority, through NGOs. Only a small percentage of partners manage part of their funds themselves.

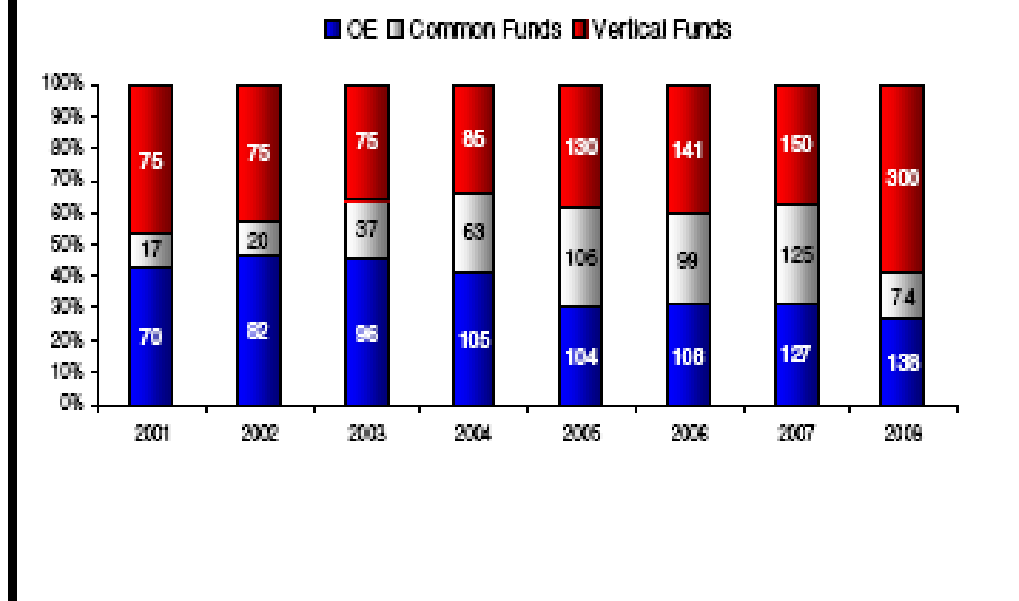
Increase in vertical funding

Health financing through vertical funding is becoming more important. The amount doubled in the period 2003-2007 and has doubled again to 300 Million US\$ in 2008. As a result vertical funding is the single biggest source of funding and accounts for 58% of the total health budget in 2008. This increase is mainly attributed to a considerable increase of USAID/PEPFAR funding.

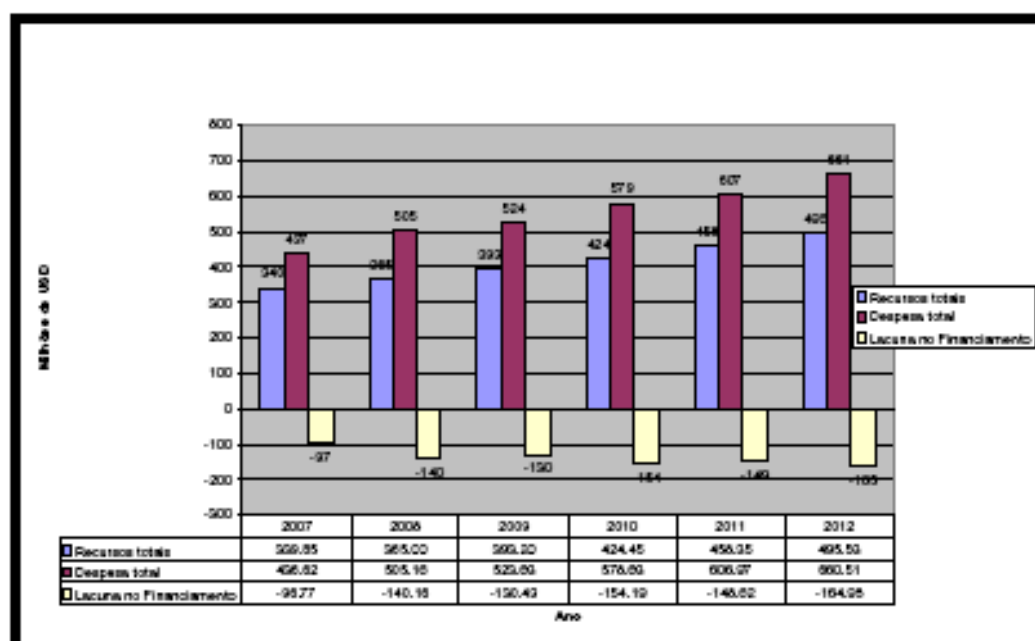
Nearly 80% of health partners have some proportion of their budget allocated to vertical initiatives, mainly through projects implemented by a varied range of NGOs. Only one fifth (n=5) of the partners commit all their financial support to the common funds (2008). A mapping exercise of vertical funding by all health partners in 2007 revealed that less than half (48%) supported projects which were "on plan". Information regarding integration in the budget cycle ("on budget") was incomplete and inconclusive but there are strong indications that most projects are off budget.

Relative weight of vertical funds

Relative weight of vertical funds



Financial requirements (projected) for implementation of Strategic Plan (PESS) 2007-2012



There is general agreement that only through sustained national action and coherent international cooperation to fully mobilize new and existing medical, technical and financial resources, can Mozambique strengthen health delivery systems and reach beyond traditional approaches to attain the MDGs. According to the financial projections based on the PESS, the projected resources available to the sector on a year to year basis for the implementation of the PESS range from USD 339 million in 2007 to USD 495 million in 2012. On the other hand projected expenditures for the same period range from USD 436.62 million in 2007 to

USD 660.51 million in 2012. These figures translate into an annual financing gap that ranges from 22% in 2007 to 25% in 2012.

5. Health Development Partners and Sector Wide Approach

Overview of Sector Wide Structure (SWAp) and coordination mechanisms

Currently 26 donors finance more than 60 percent of health expenditures, 14 of them through the “Common Funds” (PROSAUDE, Provincial Common Fund, and Pharmaceutical Common Fund). The intention is to merge these three funds. Some donors provide overall budget support to the Ministry of Health (MOH) while others finance more specific sub-sectors or provinces. A significant proportion is channeled through NGOs. There is more recurrent-cost support than infrastructure financing.

The trend to operate through projects led to increased fragmentation of the country’s national health system. As a result the Mozambique SWAp was established within the above context. The SWAp initially emphasized an incremental and progressive process, focusing on developing an open, inclusive arrangement where the MOH and its development partners share a set of common principles, objectives and working arrangements, which characteristically include:

- **A health sector strategic plan (PESS)**, endorsed by all development partners with a set of agreed indicators to evaluate policy implementation and health sector progress;
- A **code of conduct** signed in 2000 (revised in 2003) which sets the basic rules of engagement between the MOH and its partners;
- **SWAp ToRs**;
- **Working arrangements that enable structured dialogue and consensus building** between the MOH and development partners
 - The Sector Coordination Committee (CCS): which meets twice in a year, is chaired by the health minister and comprises his/her cabinet, selected provincial health directors (on a rotating basis) and the representatives from development partners active in health. The forum endorses key reports and recommendations (such as those emerging from the joint annual reviews of the Strategic Plan), informs development partners of significant issues or decisions relating to health sector policy, especially focusing on MOH Annual Operation Plans for the following year;
 - The Joint Coordinating Committee (CCC): replaced the former SWAp MOH Partners Working Group, provides a good opportunity for a small group of representatives from MOH and the community of external partners to deal with some critical issues in a more informal manner.
 - SWAp-related thematic working groups: Working groups (and ad-hoc task groups) which provide an opportunity for development partners and the MOH to jointly review or oversee specific areas of health policy where a more in-depth analysis is required prior to their adoption or consideration by the broader SWAp Forum. All of these have their own jointly agreed ToRs.
- **A sector financing framework (MTEF)** which;
 - Forms part of the health strategic plan, the MoU, and the code of conduct
 - Highlights the expectations of the Government in relation to aid modalities and financial instruments to be used by development partners in the health sector
 - Points to the need to increase the government health expenditure,
 - Points towards donors increasingly placing development assistance for health into common funding and budget support mechanisms;
 - Needs to be improved as an instrument as well as in its content
- **The Performance Assessment Framework (PAF)** has been developed to serve as the basis both for monitoring progress of the PARPA, and to inform future developments within the General Budget Support (GBS) programme. Other objectives identified for the PAF include:

- Greater transparency and predictability in the link between policy, implementation, and the level and timing of GBS flows, thereby facilitating improved planning and management;
- Reduced transaction costs through increasing harmonization of donor conditions.

The PAF indicators enable PARPA monitoring to be explicitly linked to budget instruments reviewed by Parliament, thereby increasing accountability parliament and the population, and of donors to the people of Mozambique. At the 2003 Consultative Group meeting, partners, including the World Bank, pledged to link their long-term commitments to release GBS to achievement of PAF indicators.

- **A set of review mechanisms** to evaluate health sector progress and commitment to the objectives of the strategic plan operationalized through a joint annual reviews and biannual meetings of the Sector Coordination Committee (CCS).

Health Development Partners

Donor agencies, despite some similarities, are governed by very different rules and regulations, in some cases very cumbersome and strictly adhered to. In this context, Mozambique has several development partners supporting the health sectors and they include multilaterals such as:

- The WHO – World Health Organization
- UNFPA – United Nations Population Agency
- UNAIDS – Joint United Nations Program for HIV/AIDS
- UNICEF – United Nations Children’s Fund,
- WB - World Bank
- UNDP – United Nations Development Program
- ADB – African Development Bank,
- EU- European Union,
- OECD - Organization for Economic Cooperation and Development
- Global Fund

On the bilateral list of partners are:

- DFID, the UK Department for International Development
- JAICA, the Japanese International Cooperation Agency, and the Japanese Ministry of Foreign Affairs;
- NORAD, the Norwegian Agency for Development Cooperation;
- EC, the European Commission;
- IA, Irish Aid;
- DANIDA, the Danish International Development Agency;
- The Direzione Generale Cooperazione Allo Sviluppo, Italian Ministry of Foreign Affairs;
- USAID, the US Agency for International Development;
- GTZ, BMZ, the German Ministry for Economic Cooperation.
- Several NGOs

Achievements in implementing the SWAp

- Funds flow through a Common Fund and use a harmonized financial management and accounting system
- The depth and breath of participation has meant that most key stakeholders are well informed and involved.
- There is high level support an engagement within the Ministry of Health
- There is regular and committed involvement from external partners
- There are opportunities for cross fertilization and harmonization across Ministry of Health Departments and within the external partner group

- New MoU and the amalgamation of three common funds into one, using GoM PFM rules and regulations, and aligned with the state planning and evaluation cycle.
- A PAF (Performance Assessment Framework) of 40 jointly agreed indicators and targets across the continuum of the sector
- The health partners have agreed on a HPG (Health Partner Group) ToRs that define the modus operandi of collaboration in a harmonized partnership

Challenges in Implementing the SWAp

- To ensure that all partners are on board the SWAp.
- To get all partners in the SWAp to abide by the rules set in the MOU.
- To allow space for the government (MOH) to exercise its leadership role without over burdening it.

Coordination mechanisms for National HIV Response

In Mozambique, the first sign of political commitment dates from two decades ago when, for the first time, a concerted response against the disease was established, in compliance with the recommendations of the WHO that emerged from a meeting which urged member countries to set up national committees in response to AIDS.

In 1986, the first body in response to AIDS in Mozambique was set up, the National AIDS Commission, based inside the National Health Institute (INS). In 2000 the Council of Ministers set up the National AIDS Council (CNCS), a coordinating body at the highest level for the national response against the pandemic, chaired by the Prime Minister, and including representatives of the government, civil society and prominent individuals. This step marked the recognition that the scale of the epidemic went beyond the health context and required a multi-sectoral approach that could deal with the sociocultural, economic, and political and health dimension in their broader context.

The Ministry of Health provides leadership on all technical and policy-related issues, including developing national plans, coordinating implementation of the health sector response and managing finances. The National AIDS Council takes the lead in coordinating the multi-sectoral response to HIV/AIDS. The Ministry of Health and the National AIDS Council also provide leadership in antiretroviral service delivery, whilst on the other hand the National Health Department and the Human Resource Department of the Ministry of Health coordinate training and capacity-building activities. The Medical Care Unit within the National Health Department of the Ministry of Health coordinates procurement and supply-chain management of antiretroviral drugs, supported by the National Centre for Medications and Medical Supplies and the parastatal procurement agency MEDIMOC. The National Health Department also provides leadership for counseling and testing activities and laboratory services.

6. Aid Effectiveness in Mozambique

Coinciding with the signature of the Paris Declaration on Aid Effectiveness (OECD, 2005), donor countries and the government of Mozambique as an aid recipient government have been working to bring official development assistance (ODA) on budget. That is, to channel, to the extent possible, ODA through existing planning, budgeting and public financial management systems, with the aim of aligning aid with country-led programmes, strengthening local government systems and, ultimately, increasing aid effectiveness. Despite the growing importance of multilateral aid, there continues to be a very large number of donor organizations operating in Mozambique, with up to 26 multilateral and bilateral donor agencies providing aid to the country in one form or the other.

There are important institutional developments in the area of aid management which include the institutionalization of a sector-wide approach (SWAp) in several sectors, including in the health sector, arrangements in priority sectors, the creation of the Joint (government-donor) Review mechanism and the creation of the Programme Aid Partners (PAP) scheme, which groups all donor agencies providing programmatic aid to the government of Mozambique.

The most significant development in terms of creating an institutional framework for aid management has been the creation of the PAP. This 'partnership' is a coordination scheme currently integrated by 18 international development agencies providing programmatic support to Mozambique. This arrangement was set up to provide greater alignment, consistency and efficiency in donors' funding initiatives to directly support the government's poverty reduction efforts, in line with the principles of the Paris Declaration on Aid Effectiveness.

The PARPA-II is the government's main medium term planning instrument which now constitutes the main reference document for delivering aid, as a result providing for greater consistency and alignment of donor programmes with government poverty reduction policy efforts.

Programmatic aid disbursements and donor and government commitments in this area are governed by a Memorandum of Understanding (MOU) between PAP agencies and the government, clearly stating both parties' commitments and responsibilities. The MOU includes a common Performance Assessment Framework (PAF) in which the government identifies its policy priorities and, jointly with the PAP, annually assesses performance against these priorities. It is important to note that progress in areas captured by these indicators influence donors' decisions regarding commitments for budget support and other forms of programmatic aid for the following year. Furthermore, since 2006, this instrument has been revised and harmonized to ensure consistency with the PARPA-II policy framework and with the government's own monitoring and evaluation system.

Government and donors' performance under this MOU/PAF framework is formally examined and assessed in two sessions: the mid-year review, an exercise mostly aimed at setting targets for the following year, which also includes a limited assessment of performance during the first half of the year; and, more importantly, the Joint Review, a more exhaustive annual review of these issues, which serves to monitor and evaluate government and PAP's performance in the implementation of their respective programmes.

The outstanding challenges for improving aid effectiveness in Mozambique have been identified as follows:

- There are multiple stakeholders and agendas in the health sector making the prioritization process difficult for MISAU
- The rapid increase of a varied number of implementing partners (academic institutions, international NGOs) require a stronger stewardship role from the MOH in order to rationalize and harmonize aid and optimize use of available resources to the priorities of the health sector.
- Links between the health strategic plan and annual operational plans are weak. With the perspective of developing an effective Medium Term Expenditure Framework the link between strategic objectives, investments or inputs and measurable outputs needs to be strengthened.
- There are major health system weaknesses which are as yet insufficiently addressed (i.e. physical access still low, low number of health workers, problem of distribution, internal brain drain, HRH salary and compensation, HMIS insufficiently integrated, ...)
- Multiple international agendas and initiatives add to the challenge of coordination at the country level. Communication between partners at country level and at centrally needs to be strengthened.
- There are multiple financing mechanisms, with the majority of funds to health and HIV/AIDS being provided off budget and off plan. This has led to misalignment of donor disbursements with government planning and budgeting cycles, making it difficult to report on the budget.
- The changing trends towards more project funding from donors with a flag-showing approach requires a rethink of the functioning and mechanisms of the SWaP coordination structure.
- Cooperation and coordination mechanisms need to consider ways of integrating projects – often with limited time span and limited scope- within the general health sector development plans.

- Insufficient predictability and sustainability of financing, both of off budget funding, but there have also been problems with GFATM funding which has not been fully aligned with national financing and reporting systems.
- Coordination of multiple partners and funding channels creates large transaction costs for government.
- There is insufficient information on composition, efficiency and equity of health spending.

7. Development of a Compact

Since the Ministry of Health and its partners have already established a solid basis for cooperation, with the development of a Memorandum of Understanding, a Code of Conduct and there being an agreed process for supporting a nationally developed and costed plan for the health sector, the main objectives of the compact for Mozambique will be to define the timelines and to set out a clear road map for further strengthening harmonization and alignment.

The Ministry of Health and its partners are committed to receive aid through the use of Sector-Wide Approach and Multi-donor Budget Support (MBS) mechanisms. The MOH in Mozambique expects that the compact will bring about a signed commitment from all development partners to a clearly articulated process for strengthening the existing SWAp mechanism. The compact will identify how donors should support and use nationally led health sector planning processes such as the PESS II, annual PESs and budgets, an annual review document (Balanço de PES) focused on the sector PAF, as well as engaging in other processes of cooperation such as working groups. An overarching objective will be to increase the transparency and predictability of support including notifying financial commitments or projected financial commitment to the rolling MTEFs, to allow planning against a more predictable financing framework than has hitherto been possible. There should be a jointly agreed vision of building blocks in place, and collaboration processes that all should commit to, with each agency showing maximum flexibility within their system constraints to achieve the milestones that will be set out in the compact.

Apart from the harmonization processes expected to be achieved through the implementation of the compact, the government of Mozambique expects concrete commitments as to the resources that will be made available to implement the various priorities articulated in the PESS.

Top of the priority, *inter alia*, list being;

- Implementation of the Human Resources strategy
- Scaling up the health sector response to HIV/AIDS
- Implementation of the maternal, neonatal and child health roadmap.

The challenge is to bring together all policy documents into a comprehensive and consistent planning instrument, where policies are clearly prioritized and linked to resources.

Road Map: Lusaka Towards Signing of a Compact

- Dec 2007-Jan 2008: Synthesis and Situation Analysis (stock taking exercise);
- Jan 2008: Performance Based Assessment Framework for the Health Sector (Health PAF) finalized;
- Feb 2008: Finalisation MTEF 2009-2011-Start work on MTEF 2010-2012;
- 28 February- 1 March 2008 : IHP+ meeting in Lusaka;
- March 08: Joint Annual Evaluation of the Health Sector's performance in 2007 (ACA);
- March 13th 2008 : high-level Health Coordination Committee meeting (CCS)
 - o Approval of Report of the Joint Annual Evaluation of the Health Sector's performance in 2007 (ACA)
 - o Signing of the Memorandum of Understanding of PROSAUDE II
 - o Change of focal partner
- March 2008: De-briefing IHP+ meeting in Lusaka;

- March 24-28, 2008:: National Coordination Council of Ministry of Health (CNCS);
- April 2008: Annual Joint Review of GoM and all cooperating partners (government-wide);
- May 2008: Draft HR Development Plan;
- May 31st, 2008: Donors inform MOH about financial indicative commitments for 2009;
- July 2008: high-level Health Coordination Committee meeting (CSS)
 - o Compact signed by all partners
 - o Draft Economic and Social Plan for 2009 presented to health partners
 - o Donors confirm financial commitments for 2009

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