Sector Budget Support in Practice

Case Study

Health Sector

in

Mozambique

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List of Acronyms

ACA	Joint annual review of the health sector
AFD	French Development Agency
AfDB	African Development Bank
BM	Bank of Mozambique
CACM	Account for acquisition of medicines *(Conta para Aquisicão de Medicamentos)*
CCC	Joint Coordination Committee
CF	Common Fund
CIDA	Canadian International Development Agency
CPAR	Country Procurement Assessment Report
CS	Civil Society Actors
CUT	Single Treasury Account *(Conta Unica do Estado)*
DFID	United Kingdom Department for International Development
DAF	Department of Administration and Finance
DP	Development Partner
DNS	National Health Directorate (*Direccão Nacional de Saúde*)
DPPF	Provincial Planning and Finance Directorate
DPS	Provincial Department of Health
EPI	Expanded Programme on Immunization
EWG	Economist Working Group
FCM	Common Medicine Fund *(Fundo Comun de Medicamentos)*
FPC	Provincial Common Fund *(Fundo Provincial Comun)*
GBS	General Budget Support
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
GNI	Gross National Income
GoM	Government of Mozambique
HoC	Head of Cooperation
HoM	Head of Mission
HR	Human Resources
HRDP	Human Resource Development Plan
HSRP	Health Sector Reform Programme
HQ	Headquarters
IGF	General Inspectorate of the Ministry of Finance *(Inspecção Geral de Finanças)*
IMR	Infant Mortality Rate
INS	National Health Institute *(Instituto Nacional de Saude)*
IT	Information Technology
JAR	Joint Annual Reviews
LOLE	Law on State Local Authorities *(Leis dos Orgãos Locais)*
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MICS	Multiple Indicators Cluster Survey
MMR	Maternal Mortality Rate
MoF	Ministry of Finance
MoH	Ministry of Health
MPD	Ministry of Planning and Development
MoU	Memorandum of Understanding
MPF	Ministry of Planning and Finance
MTEF	Medium Term Expenditure Framework
NGO	Non Governmental Organization

NHS	National Health System
ODA	official development assistance
OE	State Budget *(Orçamento do Estado)*
OECD	Organization for Economic Cooperation and Development
PAF	Performance Assessment Framework
PAP	Programme Aid Partners
PARPA	Government's Poverty Reduction Strategy
PATA	Pooling Arrangement for Technical Assistance
PEFA	Public Expenditure and Financial Accountability
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PES	Economic and Social Programme *(Programa Economico e Social)*
PESS	Economic and Social Programme for the Health Sector (*Programa Economico e Social do Sector de Saude)*
PFM	Public Financial Management
PHC	Public Health Care
PMTCT	Prevention of Mother to Child Transmission
PQG	Government of Mozambique five year plan *(Plano Quinquenal do Governo)*
SBS	Sector Budget Support
SDC	Swiss Development Cooperation
SCC	Sector Coordination Committee
SIP	Sector Investment Programme
SWAp	Sector Wide Approach
SWG	Sector Working Group
TA	Technical Assistance
UFMR	Under Five Mortality Rate
UFSA	Functional Unit of Supervision of Acquisitions
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

Executive summary

1. This case study on the sector budget support (SBS) to the health sector in Mozambique is part of a broader study by the Strategic Partnership with Africa Task Team on Sector Budget Support which covers ten sector case studies from six different countries. The study draws together SBS experience and aims at guiding future improvements in policy and practice.

Sector Context

2. The Mozambican health sector has made considerable progress. Service output, coverage and service consumption have expanded since the end of the war in 1992. Between 2001 and 2005 service units in the health system increased by 22%, institutional births grew by 28%, mother and child health consultations by 28%, and vaccine administration by 10%. Important progress has been made in reducing the Infant Mortality Rate (IMR), the Under Five Mortality Rate (UFMR) and the Maternal Mortality Rate (MMR) since 2000.

3. The focus of the government policy in the health sector has been on improving quality and access to basic health care. These priorities are reflected in the poverty reduction strategy (the PARPA II) and in other key government planning instruments, including in the health sector policy document (the Plano Estrategico do Sector de Saúde – Health Sector Strategic Plan or PESS). A Sector Wide Approach (SWAp) has been in place since 2000.

4. Progress in the health sector has taken place in the context of growing emphasis by the Government of Mozambique (GoM) on public sector reform and public financial management (PFM), including through the new public financial management system (SISTAFE) and a comprehensive program of civil service reform. Reforms in government financial management through SISTAFE have contributed to improvement in the timeliness, quality and availability of budgetary information in the sector. However, the 2008 health sector PFM assessment – which established a base line for the sector – highlighted that the health sector is substantially weaker in key PFM areas compared to government as a whole. Nevertheless, the visibility and transparency of the budget has improved, but there are still major concerns related to: the coherence, correctness and completeness of budget and execution data within the sector but also within the government as a whole; the link between allocation of resources and the priorities in the PESS and other planning documents; the tracking of expenditures and budget monitoring; and revenues from within the sector which are not captured and poorly reported.

5. The Health sector budget has been following an upward trend, in absolute terms, but has dropped as a percentage of the Gross Domestic Product (GDP), and Mozambique is moving further away from the 15% target established in Abuja. Also although the share of external funding on budget has increased, significant off-budget aid flows remain. Growing domestic and external budget allocations have contributed to the expansion in service delivery through construction, recruitment of qualified staff and improved availability of drugs.

6. Nonetheless, inequities in access to service and in quality of care provided are still substantial. Some of the poorest and most densely populated provinces receive the least resources. In terms of per capita budget allocation, there is a more than three-fold difference between provinces. While there has been progress in decentralization of funding as part of an overall government focus on decentralization and deconcentration, most of the funds (in particular investment related) continue to be centrally managed. Early gains in increasing utilization, efficiency and quality of services are now levelling off and further progress will likely require additional and more complex efforts to address the capacity, management and decentralization processes of the healthcare system. While there has been progress, the disease burden has grown on other fronts, to a significant

extent related to the high and still growing prevalence of HIV and the burden of AIDS. The health status of the Mozambican population remains lower than average for African countries and below international standards.

The Nature of Sector Budget Support

7. Key development partners (DPs) provide external support in the context of the SWAp which was put in place in 2000. A growing number of donors support the sector – 26 in 2008, of which 15 provide SBS under a Memorandum of Understanding (MoU) signed in July 2008. There are also external projects and vertical funds – namely the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and USAID funding – and several other off-budget funds in the sector.

8. The transition to SBS from the fragmented project support which characterized the sector in the mid 1990's has taken place over a decade. A number of common funds (CF) were progressively introduced and an increasing share of donor funding is provided through CF now largely reflected on budget. Until 2008, three common funds were in place in the Health Sector (the Provincial CF, the CF for Drugs, and PROSAUDE I). In 2008, the first two were merged into PROSAUDE II which became the only joint funding mechanism to the sector.

9. The key features of SBS in support to PROSAUDE II are as follows:

- **SBS Funding and Financial Management Arrangements.** SBS represents significant transfers of $75m and $86m in 2008 and 2009, although slightly lower than common funds before it, in part as a result of the withdrawal of the GFATM from joint funding arrangements. Donors make commitments to provide SBS. In 2008 84% of budgeted SBS funds were disbursed in local currency terms. SBS is earmarked to the sector, and beyond that is discretionary. For PROSAUDE II, funding is provided in two distinct ways – as internal or external budgetary funding. Donors concerned about funding through the State budget being 'lost' to the overall budget at the end of the year, can use a system by which funds are marked at the outset by donors as external funds. At present 10 of the 15 donors have asked for their funds to be coded as external funds. In practice, thus far, both internal and external SBS funding is traceable, and has been allocated to the investment budget in a way similar to previous common funds. Whilst the provisions for tracing donor funds are there, there are no specific requirements for additionality of SBS funding to government state budget allocations in place. SBS is channelled via the Single Treasury Account, and the majority uses government procurement accounting and audit systems, governed by the SISTAFE law. However as an interim arrangement parallel procurement and audit arrangements will be used. SBS does not use government cash management arrangements and instead, when funds are disbursed by SBS donors they are transferred to spending agencies. The MoU for SBS also includes specific conditions with requiring annual PFM assessments which aim at assessing how this area is developing.
- **Conditionality and dialogue.** Disbursements are based on overall 'satisfactory performance' of the sector against agreed indicators. Assessment takes place through the annual joint reviews (the ACA), using a health sector Performance Assessment Framework (PAF) which includes a total of 37 indicators. Satisfactory performance is also linked to performance in financial management for which specific indicators are included in the health sector PAF. The 2010 ACA will be the first Annual Joint Review related to PROSAUDE II.

10. Coordination of the provision of SBS with other aid instruments is carried out via the SWAp. Efforts have been made to link sector dialogue with coordination of General Budget Support (GBS). The schedule of sector review processes has been revised to fit in with the budget calendar and the calendar of meetings with GBS. There are also links between the GBS PAF and the Health sector PAF. GBS working groups share participants with the SBS coordination and dialogue structures.

The Effects of Sector Budget Support

11. It is too early to say what the specific effect of the SWAp is. However, the CF and associated SWAp procedures that preceded SBS made the following overall positive contributions:

- The dialogue and coordination structures associated with the SWAp facilitated the development of a single policy and implementation framework for the sector (the PESS), costing of this plan, and development of a single monitoring framework (the PAF);
- These SWAp structures have led to inclusiveness of partners in policy dialogue through a structured process for discussion which includes the Joint Annual Review process;
- Clearer policies and the SWAp processes facilitated improved alignment by partners with government and sector planning and budgeting processes;
- Harmonisation among donors on policy, financial management, procurement and monitoring and evaluation and use of government systems has strengthened those systems and enhanced confidence in them.
- There has been progressive improvement in budget execution in the sector due to the introduction of e-SISTAFE – this was accelerated as common funds used e-SISTAFE;
- CF have allowed for an increasing volume and share of external sector funding to appear on budget and have increased discretionary funding for the PESS, contributing to government ownership. Flexibility is likely to improve as conditionalities and earmarking by donors continues to decrease;
- Combined this means that CF resulted in increased funding of operational inputs, such as medicines, and infrastructure for service delivery.
- CF have facilitated some additional decentralization of funding to provinces, increasing capacity, confidence, and stakeholder participation at provincial and district level.
- The combination of SWAp coordination structures and the use of common funds have resulted in a gradual reduction in transaction costs for the Ministry of Health (MoH).

12. However, in a number of areas less progress has been made:

- Other plans co-exist with the PESS, fragmenting the policy environment.
- Insufficient progress has been made on key policy decisions, and on establishing clear sector priorities which can guide decision making at central and decentralized levels.
- The comprehensiveness of resource allocation is undermined as vertical funding continues to increase, much of which was off budget and not aligned to the PESS.
- Decentralization of planning and implementation is weak namely for the external part of the investment budget. Central management of CF resources reinforces this.
- On-budget, CF have distorted the structure of resource allocation by channelling significant volumes of operational inputs via the investment budget.
- Issues related to poor predictability of funding have affected GoM planning and implementation capacity. Confidence among partners is still weak in some respects.
- A disproportionate time in the dialogue has been spent on CF issues. Little attention was paid in the dialogue to the downstream systems for service provision, the incentives faced by service providers, and accountability for service provision.

13. SBS in support to PROSAUDE II is likely to consolidate the positive impact of the SWAp and CF. However, it has failed to address many of the weaknesses.

- The allocation of SBS funds continues to be highly centralised, with only a quarter of funding allocated to provinces. Furthermore, SBS remains separately identifiable in the investment budget, and this continues to distort resource allocation. Whilst the intention of the MoU was for SBS to fund both the recurrent and development budget, the practicalities were not worked out. Further progress is undermined as vertical project funding continues to increase. The inclusion on-budget of more donor projects is a positive, but efforts to get big ‘vertical funders’ (GAFTM, the World Bank) to be part of PROSAUDE II have failed for now.

- The SWAp dialogue has remained preoccupied with the design and management of SBS. Vertical funds have also taken up time. A disproportionate time of the dialogue is spent on PFM. As a result, other core service delivery issues remain inadequately addressed in the dialogue.

14. There has been progress on selected health indicators in recent years, indicating a generally positive trend in some areas of health delivery. It is reasonable to assume that the increased sector funding as a result of CF, which peaked at 45% of sector funding in 2007, has contributed to this. However, there are also areas where little progress has been made, or where the situation has worsened, in particular with respect to the burden of AIDS-related diseases on the system. Overall, large numbers of Mozambicans continue to have major difficulties in gaining access to health services.

Conclusions and Recommendations

15. PROSAUDE II provides positive indications of progress. A large number of donors have joined in the common funding arrangements and committed to supporting the SWAp and to providing SBS. There has also been significant improvement in the proportion of discretionary funding provided, dialogue has been streamlined, donor coordination has improved, and there is evidence that this has impacted on various aspects of sector policy, management and monitoring and evaluation.

16. However, SBS in support of PROSAUDE II, does not, yet, represent a departure from previous practices, in essence because:

- SBS is budgeted in the same way as CF, thus recurrent funding is still in the investment budget.
- Systems for financing downstream service delivery have not been given adequate attention. It is unclear what the government framework for financing decentralised service delivery should look like. Consequently SBS has nothing to align to but the fragmented system that exists.
- Complementary technical assistance and capacity development were not adequately factored into the SBS design, and remain fragmented in the sector.

17. Nevertheless, partners to the PROSAUDE II SBS arrangement are positive about the intermediary outcomes, aware of the challenges, and generally committed to the process. A key lesson from this case is that these are issues which need to be addressed in the design phase of any SBS process. An important opportunity has been lost to establish strong systems and procedures for monitoring of service delivery and it will take time to re-focus.

18. Moving forward, key issues regarding the mechanisms for funding service delivery need attention:

- The success of SBS will depend to a significant extent on getting the financing channels for service delivery right so that resources may be used in the most effective and efficient way. Addressing the aforementioned challenges and ensuring funds will be channelled to and accessed by decentralized levels to improve service delivery is crucial.
- SBS would be more effective in supporting financing delivery if SBS inscribed as internal funding were allocated to the recurrent budget, and specifically to existing budget lines service delivery. In this way, the SBS would no longer be traceable. Furthermore, given the fact that the recurrent budget is increasingly reliable, those donors that can provide non-traceable SBS should elect for the funding to be inscribed as internal funds.
- Success of SBS will also depend on further progress by DPs in bringing aid to the sector into PROSAUDE II. This involves letting go of vertical projects and initiatives (a number of partners are moving in this direction) and increasing funding to PROSAUDE as confidence grows. It will also involve developing further confidence in monitoring systems which will allow partners to have some of the information/security which they are still getting through their project portfolio. For DPs there continues to be tension between the official commitment to more aligned means of funding and the reality of being held accountable for results.

- The increase in vertical funding is an important concern and should be a point of action moving forward – at country level and globally at the headquarters of agencies which are as of yet unable to join PROSAUDE II. As PFM, monitoring systems, and confidence all increase, conditions should allow for these partners to join. Alternatively, reluctant vertical funders may be more willing to join if they can play a key role in strengthening the systems that are currently preventing them from participating in PROSAUDE II.
- Donors are focusing strongly on the success in addressing PFM issues as this is what they are ultimately held accountable for. A less than favourable audit in 2010 would represent a significant setback to progress whereas a lack of progress on key outcome indicators is perceived as potentially less damaging. The 'incentives' for DPs need to be reviewed so that SBS does not become skewed as a result of an excessive focus on mechanisms.

19. An equally important group of non-financial inputs needs addressing, key issues being:

- The focus of the overall dialogue and review processes need to be reoriented towards addressing the key challenges to effective and efficient health service delivery. Sector institutions, and systems for service delivery, must be more prominently on the agenda.
- Capacity constraints emerge throughout this study as a key concern. Efforts will need to be made to ensure that funding is brought on board to pay for the additional expenses.
- Attention to the provision of technical assistance and capacity building alongside SBS funding to strengthen downstream delivery, and central management and monitoring of service delivery.
- The development of stronger systems for accountability for service delivery at lower levels, and not just via SWAp arrangements

20. In order to achieve progress on these different aspects, the MoH and the GoM will need to take a stronger leadership role to ensure adequate priority setting. Further progress will need to be made in developing confidence in the systems and processes. This could be helped by:

- Streamlining information flows – ensuring timely and appropriate communication – between partners so that the fora for discussion and reflection can function more effectively. This is essential to ensuring that partners have enough time to react meaningfully to issues.
- The focus, quality and coordination of donor interaction with the government is critical to getting and sustaining commitment on both sides. Ensuring neutrality on the part of the focal point is important in this respect. As was suggested during the study by the current focal donor there may be an added value to 'professionalizing' coordination by establishing a donor coordination unit for the sector. This would reduce the burden on the focal donor, help in ensuring that the right mix of skills is available, and reduce some of the tension and loss of memory which arises from the turnover of staff. More fundamentally, donors need to find ways of balancing the dialogue between their legitimate fiduciary concerns with the need to focus on core service delivery issues which effect the broader development

Introduction and Study Objectives

21. This is a case study examining Sector Budget Support in the health sector in Mozambique. It forms part of a broader study commissioned by the Strategic Partnership with Africa Task Team on Sector Budget Support of SBS which covers 10 case studies in six countries.

22. The overall purpose of the study is to draw together experience of SBS to guide future improvements in policy and practice by partner countries and donors. The additional objective of this case study is to assess the lessons from experience to date in the health sector and to provide the Government of Mozambique and donors with guidance that will help them improve the design and implementation of SBS in future.

1.1 Methodology

23. The case study has been carried out using a methodology (ODI and Mokoro, 2008) which draws from evaluation frameworks of General Budget Support (IDD and Associates, 2006; Lawson and Booth, 2004, Caputo, Lawson and van der Linde, 2007), and the specific requirements of the Terms of Reference for the Assignment. The assessment framework has four levels:

- Level 1: breaks down sector budget support into inputs, both financial and non financial inputs such as dialogue, conditionality and associated technical assistance and capacity.
- Level 2: identifies the immediate effects of SBS inputs on the overall nature of external assistance to the sector.
- Level 3: examines the outputs influenced by SBS in terms of sector policy, budgeting, financial management, institutional capacity, service delivery and accountability systems and processes.
- Level 4: examines the likely influence of SBS on outcomes in the sector, in terms of the achievement of sector policy objectives and service delivery.

24. The assessment framework also recognises the importance of external factors on the effects of SBS, the context within which it is provided, and the existence of feedback loops between and within each of the levels. A diagram of the assessment framework is provided in Annex 1.

25. The primary question posed for the case studies by the terms of reference is as follows:

> *How far has SBS met the objectives of partner countries and donors and what are the good practice lessons that can be used to improve effectiveness in future?*

26. The key purpose of the study is therefore the identification of good practice. It is not an evaluation. Therefore the assessment framework will be used as the basis for the identification of cases of good practice. For the purpose of this study, good practice is defined as:

> *Instances where SBS inputs (level 1), and their influence on the overall nature of external assistance to the sector (level 2), have helped strengthen sector processes (level 3) in areas which have improved, or will plausibly improve, service delivery outcomes (level 4).*

27. The case studies follow four steps in applying the assessment framework:

- The first step involves analysis of the country, sector, and aid environment, in particular evolution of sector systems and service delivery outcomes (i.e. the context from levels 1 to 3).
- The second step involves documenting and assessing the specific nature of SBS provided to the sector, and its effects on the quality of partnership in the sector (level 1).
- The third involves an assessment of the effects of SBS from inputs to outputs (i.e. across Levels 1 to 3). This is carried out along four dimensions:
  (i) Policy, planning and budgeting processes and monitoring and evaluation systems;

(ii) Sector procurement, expenditure control, accounting and audit processes;
(iii) Sector institutions, their capacity and service delivery systems; and
(iv) Domestic, ownership, incentives and accountability (See Figure 4).

- The fourth step involves an assessment of contribution of outputs influenced by SBS to improvements in sector outcomes (level 4).

28. The structure of this report follows the four steps. Under each of the four steps Main Study Questions (SQs) have been identified, as shown in
29. Box 1.

Box 1: Main Study Questions

Step 1: Setting the Country, Sector and Aid Context
SQ1.1: What have been the main national trends in poverty, economic performance, governance, and public sector delivery prior to and during the provision of SBS?
SQ1.2: How have sector processes, institutions, accountability and service delivery outcomes evolved prior to and during the provision of SBS?
SQ1.3: What has been the environment for external assistance at the national and sector level?
Step 2: The Key Features of SBS Provided and its Effects on the Quality of Partnership
SQ2.1: What are the key features of the SBS that has been provided?
SQ2.2: Has SBS contributed positively to the quality of partnership and reduction in transaction costs between development partners, the recipient government and civil society?
Step 3: The Influence of SBS in Practice on the Sector and Lessons Learned
SQ 3.1: What has been the influence of SBS on Sector Policy, Planning, Budgeting, Monitoring and Evaluation Processes, and what are the constraints faced and lessons learned in practice?
SQ3.2 What has been the influence of SBS on Procurement, Expenditure Control, Accounting and Audit Systems at the Sector Level, and what are the constraints faced and lessons learned in practice?
SQ3.3: What has been the influence of SBS on Sector Institutions, their Capacity and Systems for Service Delivery, and what are the constraints faced and lessons learned in practice?
SQ3.4: What has been the Influence of SBS on Domestic Ownership, Incentives and Accountability in the Sector, and what are the constraints faced and lessons learned in practice?
Step 4: The Effectiveness of SBS, and the Conditions for Success
SQ4.1: What are the main contributions that SBS has made to the improvement of sector policy processes, public financial management, sector institutions, service delivery systems and accountability, and what were the conditions for success?
SQ4.2: Have the improvements in sector systems and processes to which SBS has contributed, had a positive influence on sector service delivery outcomes, and are they likely to do so in future?

30. The Conclusion will draw out the answers to the primary questions, and examine how the practice of the provision of SBS to the health sector can be improved in future.

1.2 Activities Carried Out

31. The field visit took place in December 2008 and included meetings with key government officials, donors providing SBS to the health sector, as well as civil society organizations working in the areas of health and/or HIV and AIDS. As part of the methodology a visit was organised to two health posts in Maputo City where discussions were held with selected staff members. A complete list of persons met is provided following the bibliography.

32. This study is limited by the fact that key partners had not been informed of the study prior to the arrival of the lead consultant and that that authorization from the Government for its realization was only received two days before the end of the field work in Mozambique. This affected the capacity of the team to collect data during the field visit.

2. Country, Sector and Aid Context

2.1 Country Context

SQ1.1: What have been the main national trends in poverty, economic performance, governance, and public sector delivery prior to and during the provision of SBS?

Economic Growth

33. Mozambique became independent from Portugal in 1975 and shortly afterwards plunged into a civil war in which the military opposition to the government was supported by the neighbouring apartheid regimes (by South Africa and until 1980 by the former Rhodesia,). The war lasted until 1992 and had a devastating impact on social and economic progress. More than one million people are believed to have died and much of Mozambique's infrastructure was destroyed. Forty percent of the population lost their homes, were internally displaced or became refugees, many of them from the central provinces. By the mid 1980s Mozambique was one of the poorest countries in the world.

34. Today Mozambique – with a population of 20.5 million (2007 census) – is still among the least developed countries in Africa with a per capita GNI in 2005 of USD 310, compared to a Sub-Saharan average of USD 430 (World Bank (2004), GNI tables). Nonetheless it is considered one of sub-Saharan Africa's success stories. Macro-economic growth has been impressive since the advent of peace in 1992. Economic growth has been on average 8% per year during the period 1994-2001, and slightly lower (between 7–8%) from 2002–2008. The volume and percentage of government revenues as a share of GDP has increased steadily, up from 12.6% of GDP in 2004 to 16.4% of GDP in 2007 as a result of reforms to tax administration, increasing foreign investment and progress in tourism and agriculture. This has enabled increased budgetary allocations (Instituto de Estudos Sociais e Economicos, 2008).

Poverty reduction

35. Mozambique's medium term objectives are laid out in the country's poverty reduction strategy document known by its Portuguese acronym PARPA. The country had a first version of the strategy covering the period of 2000 – 2005. It is currently implementing its second version and is also going to adopt a new version of the strategy for 2010 onwards.

36. PARPA II continued the priorities of the first PARPA by focussing activities and resource allocations on education, health, basic infrastructure, agriculture and rural development, good governance, and macroeconomic and financial administration. However PARPA II – compared to its predecessor - puts an increased focus on conditions for sustained economic growth, support to small and medium enterprises, and development of internal revenue collection systems and methods for allocating budget funds. PARPA II also highlights the importance of increasing donor alignment and harmonization. Regarding the health sector this PARPA puts particular emphasis on expanding access to health care services in poorly served areas, aiming at increasing the percentage of the poor with access to health care. The aim is to raise access from 36% to 45% by 2009 by allocating more resources to poorly served provinces.

37. The human capital pillar in PARPA 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 addressing the challenges of malaria, tuberculosis and HIV & AIDS.

38. Information from the 2002-03 household survey and subsequent estimates suggests that poverty is decreasing; the poverty headcount fell from 69% in 1996-97 to 54% in 2002-03 – a

considerable and important achievement. The decline was larger in rural areas (from 71% to 55%) than in urban areas (from 62% to 52%). However, poverty continues to be mainly a rural concern. The majority of the population live in rural areas where there is a high incidence of income poverty and very poor access to social services and economic infrastructure. The PARPA II (2005-2009) aims reduce poverty further to less than 45 percent by 2009. This is broadly consistent with achieving the Millennium Development Goal (MDG) target on poverty eradication, which aims at halving the proportion of people living in absolute poverty by 2015.

39. Mozambique is making progress towards other key MDGs. There have been substantial reductions in the under five mortality rate and the maternal mortality rate as well as large increases in primary school enrolment and completion rates, with improved gender ratios. Nonetheless, and in spite of these areas of progress, it is unlikely that Mozambique will achieve the MDG goals related to hunger, education and gender, HIV and AIDS, malaria, and water and sustainable development by the 2015 target date (Republic of Mozambique, MDG report, 2005).

40. HIV and AIDS are major threats to the economic and social development of the country and in spite of significant (although late) mobilization around the pandemic, the HIV prevalence has risen from 14 percent of the adult population in 2002 to 16 percent in 2007, but is showing some recent early signs of levelling off. Over 1.6 million Mozambicans were living with HIV in 2007 (CNCS, UNGASS report, 2008). The impact of HIV and AIDS is significant in all areas of social and economic life, including in the health sector where the burden of the disease is substantial (as with many other southern African countries the majority of hospital beds are occupied by patients with AIDS-related diseases) and where HIV and AIDS also affect the performance and attrition of health staff from the system as a result of personal or family illness and death.

Governance and public sector reform

41. Mozambique has a multi-party governance system and has successfully held three rounds of legislative and parliamentary elections since 1994. A new round of elections – to be held in November 2009 – is currently under preparation. However, during the last elections held in 2004, many voters stayed away from the polls, and the turnout dropped to 40%[1], down from 88% in 1994 and 70% in 1999.The ruling party, FRELIMO, has won all three rounds. Only RENAMO, the main opposition party, is represented in the Parliament. It is widely expected that the ruling party will be maintained in Government during the forthcoming elections. In 2009, for the first time, the country will see the election of the Provincial Assemblies.

42. Mozambique has enjoyed peace and political and social stability and is considered a successful example of post-conflict transition. The election of a new president, Mr. Armando Guebuza, in 2004 after a long period in power by President Alberto Chissano (from 1986 after the death of President Samora Machel), has provoked some change, however. The new government is more focused on domestic affairs but is also seen as less forceful on anticorruption issues and less committed to economic liberalization reforms.

43. Government is organized in three levels: central, provincial (11 provinces including Maputo City) and district (128 districts which are composed of 393 administrative posts), representing local government. Provincial governors are appointed by the President and governors in their turn appoint the district administrators. In practice, provinces and districts are integral parts of the central government and they are not autonomous government bodies. In the Strategy for Public Sector Reform (2001-2011) they are considered/ defined as de-concentrated rather than decentralised government bodies. According to Fozzard (2002), in the mid 1990s, following the preparation of the National Reconstruction Plan, the Ministry of Planning and Finance (MPF) increased the provinces' share of internal investment financing from 8% in 1994 to 17% in 1997

[1] Costra (2006): Synopsis Cooperation Strategy Mozambique 2007-2011

and introduced a Provincial Public Investment Programme. A number of issues have dwarfed the implementation of these decentralisation initiatives.

44. The approval in May 2003 of the Law of State Local Authorities – 8/2003 (Lei dos Órgãos Locais – LOLE) was an important move in the decentralisation/ de-concentration process. Law 8/2003 gave more administrative powers to the provincial and district levels, in particular in relation to planning, budgeting, expenditure execution and definition of local development strategies. This law also grants greater coordination powers to provincial governors and district administrators over line agencies (health, education, agriculture, etc), potentially strengthening the territorial and multi-sectoral planning and coordination processes, and thus, adjusting the dual subordination system which is in place. Nonetheless, line agencies at both levels (province and district) continue to be accountable both to local government and to their respective line ministries. Importantly, under Law 8/2003 no substantial competences have been transferred to local state entities, the only exception being that the provincial governor is authorized by law to establish new primary health care units and new primary schools. The most significant change introduced by this law is that the districts are now considered by law as autonomous bodies for fiscal purposes – *unidades orçamentais* – and are now eligible for direct budget funding. In line with this the GoM introduced a special investment line in the national budget starting in 2006, allocating investment funds directly to district administrations for their use in local investment initiatives.

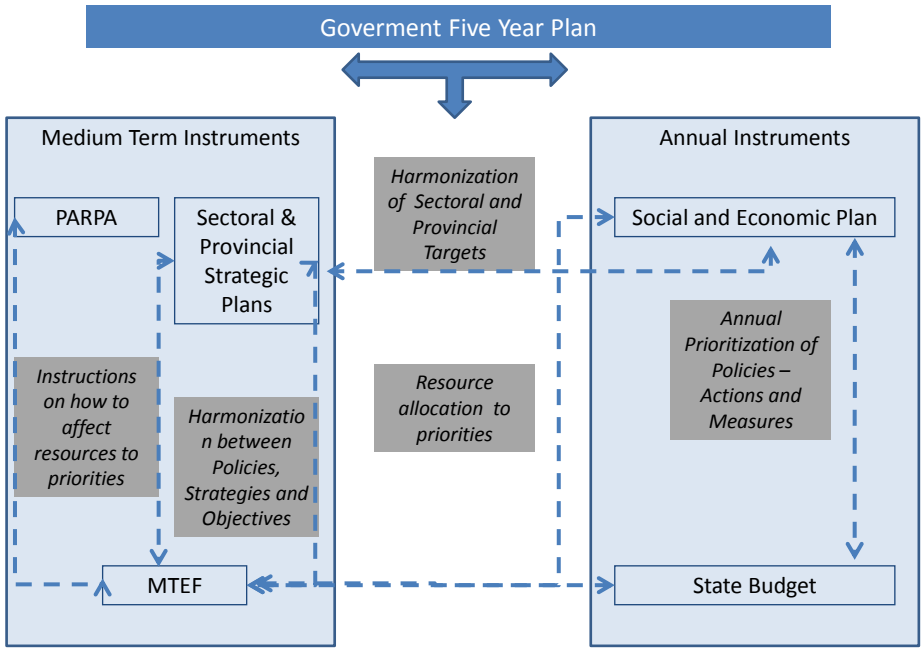
45. The process of decentralization and de-concentration, albeit moving at a very slow pace and having registered important setbacks, has been under way since the mid 1990s. In 1994 a comprehensive decentralisation law was passed, providing for district governance that would be headed by an elected body with a wide range of competencies in education, health care, water supply and roads. The law was rescinded soon after, in 1996, and replaced with a more progressive decentralisation process, through the 1996-97 law. This resulted in the establishment of 43 municipalities with administrative, financial and patrimonial autonomy and elected mayors and legislative representatives (33 in 1997 and 10 in 2008). Municipalities have a specific package of legislation governing all aspects related to their management and functioning. However, they have very limited functions, which include the running of basic urban services (land use, building licences, small-scale water supply systems, sanitation, municipal markets and municipal police). All other services including primary education and primary health care fall under central government competence and are executed through the local government bodies (provincial and district). From January 2010, in Maputo City, primary education competences are to be transferred to the Municipality. Furthermore, municipalities co-exist with local government bodies.

46. This decentralization process has created room for civil society participation, particularly at district and administrative post levels through consultative councils. Decentralization is part of a comprehensive set of reforms, defined in the Government's Global Strategy for Public Sector Reform (2001-2011) which in addition includes public financial management reforms, resource development and salary reform, and aggressive action against corruption. However, overall government institutions are weak and service delivery is not strong. Donors have provided support to improving the public sector civil service through a number of initiatives over the past years.

Planning, Budgeting and Financial Management

47. According to the Mozambican Constitution, after general elections, Parliament has to approve a five-year Government Plan (PQG). This plan and the PARPA guide government long-term planning and are structured along three main pillars, namely: a) governance; b) human capital; and c) economic development. PARPA includes a strategic matrix of key indicators, identified and agreed upon through 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 Government's Economic and Social Plan (PES – see Figure 1 below).

Figure 1: Normative Relationship between the Government's Planning Instruments



Source: Ministry of Plan and Development & PARPA

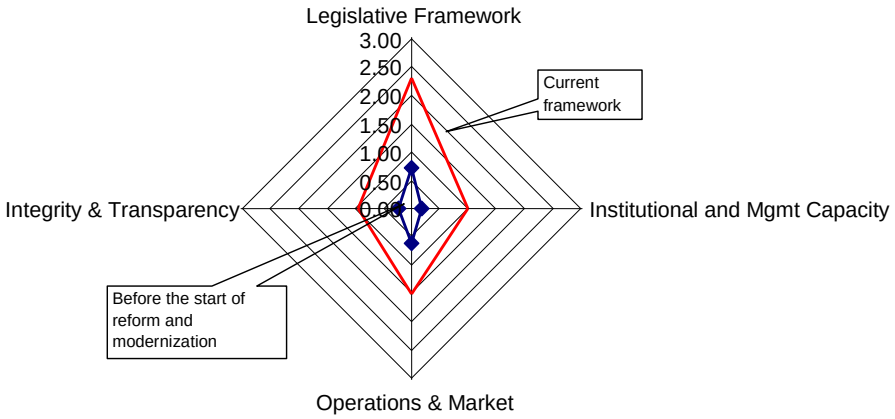
48. In terms of budgeting, the Medium Term Expenditure Framework (MTEF) is the main tool used to outline the available resource ceilings (revenue and expenditures) for the medium term. The MTEF is a three-year rolling tool aimed at identifying available revenues and expenditures foreseen in the budget lines, sector policies, and programmes which are part of the state budgetary system. However, the MTEF has had a very limited role in the planning process and in ensuring that strategic resource allocation takes place in accordance with PARPA priorities (MPF 2004, Hodges & Tibana 2004, Batley et al 2006).

49. In recognition of the weaknesses in Mozambique's fiduciary accountability the Government has been taking measures to improve the system as part of its focus on improved governance. One of the key weaknesses is the weak link between the PES and the health budget, a problem which is found in many other sectors too. A new financial management law with accompanying regulations has set the basis for modern accounting procedures and procurement reform. An assessment of PFM performance at the end of 2007 (focusing on the budget cycle ended in 2006) showed that improvements in financial management of public money across a number of areas, in particular in terms of revenue collection and management, cash management, and policy based budgeting are being felt (Lawson, 2006).

50. In general the budget is considered to be credible. Budgetary institutions have been working on establishing solid links between government policy, resource allocation decisions and final service delivery. Reforms which have contributed to these gains have included the development and rolling out of e-SISTAFE – a new Information Technology (IT) based integrated public financial management system. e-SISTAFE has focused on key areas of public expenditure management (i.e., treasury, accounting and budget). Rollout of e-SISTAFE began with the establishment of a single treasury account (the *Conta Unica do Tesouro* – CUT) from which direct disbursements to spending agencies are made. Combined with a system of several daily transfers of funds this has reportedly speeded up the release of funds to Provincial Departments of Finance (DPPFs). All DPPFs and the Ministry of Finance (MoF), as well as other Ministries now use e-SISTAFE. Specific complementary actions to the work around e-SISTAFE have also been important, such as the

census of public servants. Despite this progress, there is little assessment of the efficiency and effectiveness of the expenditure by sectors. The last Public Expenditure Tracking Survey (PETS) is dated 2002 (in the Health Sector) and a second PETS exercise has not yet been concluded after multiple delays. It was not yet available at the time of writing of this report.

Figure 2: Mozambique: OECD Methodology Comparative Analysis (2002-2008)
Rating of Base Line Indicators



Source: Updated CPAR 2008

51. Since 2002, Mozambique has made significant progress in establishing the foundations of a sound procurement system based on international best practice. The findings of an updated Country Procurement Assessment Report (CPAR) carried out in 2008 are captured graphically in Figure 2. In particular, Mozambique has made notable progress in the area of developing the legal and regulatory framework for public procurement with more opportunities for improvement in the areas related to institutional capacity, oversight, integrity and transparency of the systems. In addition to continuing to improve its systems, the study recommended that Government should now focus its attention on the implementation and performance of the systems. The most significant advances were recorded after the drafting of the 2005 Regulations for Public Procurement Regulations (Decree 54/2005) and the creation of the regulatory body (Functional Unit of Supervision of the Acquisitions or UFSA) for reform supervision. Progress is undermined by the fact that currently more than 50 percent of donor funds are not channelled through the Single Treasury Account. A key issue in this is the lack of harmonization of procurement rules.

52. Overall several weaknesses and challenges remain. There is still poor monitoring of aggregate fiscal risk. Follow-up to external scrutiny and auditing is very poor and irregular. There are also serious weaknesses in internal control systems, including in terms of controls over expenditure commitments and procurement processes. High levels of off-budget spending – from departmental revenues but mostly from external project finance – make it difficult to ensure budget integrity and to manage treasury resources effectively. One of the results of this is that off-budget balances continue to exist which are not being used while Mozambique borrows money from the domestic market at a high cost. This has also affected the capacity to plan strategically and to cater effectively for recurrent costs.

53. Finally, in spite of the ongoing decentralization process, budget execution is still very centralized, and in reality only 25 per cent of the total public expenditure is decided upon at local level by the provincial, district and municipal governments (Instituto de Estudos Sociais e

Economicos, 2008). And reporting on spending at local levels is still problematic, contributing to reduced accuracy of the available information.

2.2 Sector Context

SQ1.2: How have sector processes, institutions, accountability and service delivery outcomes evolved prior to and during the provision of SBS?

54. This section provides an overview of how the health sector in Mozambique has evolved in terms of its objectives, organization, accountability and outcomes. Because SBS has only become a reality very recently (with the signing of a new MoU between the Government of Mozambique and development partners in July 2008) most of this section will concern developments prior to the provision of SBS. Thus any changes noted below in the sector context (overall and specifically in terms of planning, processes, ownership, and outcomes, among others) actually took place as the sector was moving towards SBS, and therefore were not influenced by SBS.

Health Sector Outcomes

55. Trends in health sector outcomes are shown in Table 1. There has been a significant improvement in indicators such as infant mortality (IMR) which declined from 147 in 1997 to 100 in 2005 and under-five mortality (UFMR) which is down to 145 per 100 live births from 219 over the same period. Both IMR and UFMR have declined most rapidly in rural areas. However, a comparative analysis of the 1997 and 2003 health demographic survey results shows that in some provinces these indicators have worsened: for instance, the IMR went up in 3 provinces: Niassa (from 134 to 140), Cabo Delgado (from 123 to 178) and Manica (from 91 to 128). Maternal mortality (MMR) has also declined to 408 per 100,000 live births in 2003.

Table 1: Progress on Key Health Indicators

MDG Indicators	1997	2003	2005	2008
Children fully vaccinated	47%	63%		
Infant mortality (per 1,000 live births)	147	124	100	94
Under-five mortality (per 1,000 live births)	219	178	145	138
Contraceptive prevalence rate (modern methods)		5.1%[a]	12%	
Coverage institutional deliveries	44%	48%		58%
Maternal mortality rate/ 100000 live births		1000[a]	408	
Prevalence of tuberculosis/ 100000 population	78[b]	115[a]	123.8	
HIV prevalence in15-49 age group			16.2%	

Source: IMR, UFMR, children fully vaccinated and deliveries 1997 and 2003 data from Inquérito Demográfico e de Saúde (Demographic Health Survey). 2008 data from the Multiple Indicator Cluster Survey (MICS).
(a) data for 2000 and (b) data for 1995.

56. Recent data from the Multiple Indicator Cluster Survey (MICS) confirms the overall downward trend of some of the key indicators. According to the MICS results (which covered 14,900 households) the UFMR has now dropped to 138 (2008) and the IMR to 94. Progress has also been made with increasing coverage of institutional deliveries (Instituto Nacional de Estatisticas, 2009).

57. Despite this progress Mozambique has not performed as well in child mortality reduction as countries with a similar Gross National Income per Capita. Although the MMR has decreased it remains high. Malaria is the main cause of death among children. The disease burden has grown, on other fronts, to a significant extent related to the high and still growing prevalence of HIV which was at 16% in 2007 (with significant regional variations within the country). Mozambique ranks 18th on the WHO list of high burden tuberculosis countries. Overall the health status of the Mozambican population is and remains lower than average for African countries and far below international standards.

Sector Policies, Planning, Budgeting and Reporting

58. Directly after the end of the war in 1992 the focus of the Government of Mozambique (GoM) was on re-establishing the services destroyed during the war. As was the case across sectors, the health needs were immense and the resources very limited. The focus was therefore on rehabilitating the health network to pre-war levels and on ensuring that services returned to areas that had been made inaccessible by the war. There was a need also to address efficiency and organization as health service delivery had fragmented into vertical silos with few linkages and little communication between them. In addition, the National Health System (NHS) had become increasingly aid dependent with a proliferation of emergency oriented projects which – although necessary at the time – contributed little to the development of a comprehensive vision, to the identification of longer term strategies, and to the definition of priorities.

59. In the post-war efforts to re-establish infrastructure and services, the MoH launched the Health Manpower Development Plan 1992–2002 and in the same year, a post-war strategy for rehabilitation and sustained development was published. The development of these strategies was very significant and played a major role in steering the recovery efforts in the health sector in the right direction. It also allowed donor activity to begin to turn to longer and more development oriented programmes.

60. In terms of policies 1992–95 saw the development of the Health Sector Reform Programme (HSRP), and a WB-supported Sector Investment Programme (SIP) was launched in 1996. In parallel, movement towards developing a SWAp started, spearheaded by the MoH and some of its key development partners, and in this context the first steps towards developing a common fund for financing certain areas of the health sector were taken.

61. The first Sector Wide Health Strategic Plan – PESS I – covered a ten-year period 2001 to 2005/2011 (the plan deliberately included a mid-term review with the intention of reshaping/reformulating based on the first years of implementation) and put the emphasis on moving from crisis management to a SWAp, at a time when there was increasing pressure on the system as a result of drains in human resources, and the challenges of institutional reform and HIV & AIDS and other endemic diseases (Martinez, 2006). PESS I built on priorities identified by the Government in its PARPA I and in the Programa Economico Social (the PES or the Government's Economic and Social Plan). PESS I aimed at taking the sector beyond reconstruction planning to strategic growth and development, by focusing on internal reorganization and institutional development within the health sector to address issues such as decentralisation, separation of financing and delivery functions, and provincial capacity building in planning and budgeting. PESS I was broadly regarded as an important document but without a sufficient level of detail and analysis to guide priority setting and accountability. The focus of PESS I was on improving the quality of health services for the poor, strengthening the pharmaceutical sector, advocacy for health, improving financing and supporting institutional capacity building (in particular in the areas of policy analysis, planning, management and systems administration).

62. Drafting of a new PESS started in 2005. PESS II – with a five-year window (2007-2012) continues the line of work of the first PESS. The overall focus of PESS II is on two main areas: a) the improvement of the health status of the population and the provision of quality health services, and b) on strengthening the capacity of the sector for service delivery. A total of 20 overall objectives are identified in the document under these two broad headings. For each of these objectives the main strategies and targets are identified.

Box 2: Outcomes of the PESS II

The PESS II (2007-2012) guides the sector – it indicates direction, objectives and strategies. It also aims at ensuring that provincial and district levels articulate the means by which these objectives and strategies can be achieved. The PESS constitutes a tool for monitoring the achievement of targets and indicators. Expected outcomes from the PESS include:

- Increased access to health services
- Consolidation of the Primary Health Care (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

63. While the drafting process for the first PESS was very participatory, this has been less the case for PESS II which has been developed largely through an internal process. There are various degrees of reservation among external stakeholders around PESS II. It has been criticised for being too detailed, and for lacking clarity on strategic priorities and choices. PESS II is also seen as not linking sufficiently with other key strategic documents in the sector such as the recently launched Human Resource Plan (MoH, 2008), the HIV and AIDS Strategy and Plan, and the multi-year Expanded Programme on Immunizations (EPI). There is concern too that the PESS II does not take sufficient account of the financial requirements to meet the MDGs. Development Partners have been debating the need to develop a unique plan which brings the different sub plans together and on ways to make this work more efficient and more operational. However, a clear solution has yet to emerge.

64. Equally critical is the recent introduction of the programmatic classifier for the external component of investment for 2009 and overall expenditure in 2010, for the MTEF and Budget Proposal. This has been done by both the Ministry of Planning and Development (MPD) and the MoF; however, it too is not contributing to clear sector level planning consistent with specific sector needs. This is because the definition of the programme was decided by the Ministry of Planning and Development (MPD)/MoF without involvement of other sectors. Three pilot sectors were selected in 2008 (not including Health) but the findings of the exercise were not shared. Additionally different donors working in the sector understand this .

65. As part of the national planning and budgeting process, every year a Social Economic Plan (PES) is prepared by the MoH. This is a process which involves key managers at national and provincial levels. The provincial involvement is officially seen as crucial but the plans still continue to be rather theoretical. This is partially explained by the poor capacity at provincial and districts levels in reporting on achievements from previous periods to serve as the basis for future planning and budgeting.

66. Coordination in the health sector takes place internally and externally. Internal coordination meetings include: a) twice yearly meetings between the MoH and the provincial health directorates; b) periodic management meetings of the Consultative Council of the Minister; c) meetings of the technical and scientific council which supports the MoH in taking technical and scientific decisions related to improving health care; and d) meetings of the Hospital Council. External coordination with all stakeholders and as part of the Government's overall planning process is discussed in more detail under Section 2.3., and includes Joint Annual Reviews (JAR) and monitoring of progress against an agreed framework of indicators. This process links in with the national planning and budgeting processes of the government.

Sector Institutions and Capacity

67. Over 95% of Mozambique's health care is provided by the public sector. In rural areas health care is provided through a formal district health care system which consists of district hospitals with a network of health centres and health posts, as well as a community-owned facilities and traditional healers. Private medicine has grown somewhat in the past decade and half but continues to represent only a small percentage – it is essentially for those who have the means to pay for it and are located exclusively in large urban areas. Many doctors work both in public and in private practice, though some have moved exclusively to private practice.

68. The network of facilities in the country is unevenly distributed. The government has taken major steps to reduce this. Nonetheless over half of the country's medical doctors work in the capital Maputo, and the staffing variations between provinces are substantial, with 168,637 inhabitants per medical doctor in Zambézia and 5,092 in the capital (Ministério da Saúde 2006 - ACA findings).

69. The central MoH manages the NHS which is in charge of establishing goals and norms, and fixing targets, and for inspection of the quality of service provided. The MoH has in recent years undergone a restructuring process which left it with five directorates (Planning and Cooperation, Administration and Finance, Human Resources, Medical Assistance, and Health Promotion and Disease Control). These five directorates fall under the responsibility of the Minister, the Vice-Minister, the Permanent Secretary and National Directors. Internally, in terms of planning and budgeting, these areas are treated as cost centres. The Minister directly controls the Account for the Acquisition of Medicines (CACM), the National Institute for Health (INS), the Institute for Traditional Medicine, and the Regulatory Authority for Drugs, Vaccines, and other biological products and the Health inspectorate.

70. In line with GoM commitment in this area, PESS II includes actions aimed at decentralizing health delivery. The provincial health directorates are involved in the allocation of resources within provinces. This process is guided by the MoF, as part of a gradual process of allocation of resources, decision making, planning and management functions to decentralized levels. This has meant that the central MOH is no longer involved in establishing the provincial health budget ceilings and only takes an observing role when provinces present and debate their budget with the Ministry of Finance. It should be noted, however, that imbalances are not the result only of projects. State budget is allocated in an incremental basis and its distribution has historical biases, even when MoH had full responsibility for its allocation. However, the MoH could use the Provincial Common Fund to reduce some of the imbalances.

71. The capacity of sector institutions is fragile. Capacity is clearly a critical issue, however, for the implementation of the PESS affects both access to and quality of basic health care services. A key problem is related to the low ceilings which are currently placed on public salaries in the country which make it difficult to make systemic changes related to increasing wages, expanding the workforce, employing more qualified staff, and offering more competitive working conditions. Many health workers are dissatisfied with their jobs and report serious problems in the health service system, including poor working conditions, lack of career structure, inadequate incentive policies, staffing deficits, lack of access to in-service training, weaknesses in bio-safety compliance, delays in processing staff documentation, and inequalities between provinces and districts.

72. As mentioned above, the MoH developed a comprehensive Human Resource Development Plan (HRDP) in late 2008, in order to address these challenges. This plan analyzes existing capacity in light of what is needed to reach the MDGs and puts forward an ambitious proposal for the progressive training of 20,000 staff. However there is an enormous funding gap for its implementation.

Public Financial Management

73. PFM and Procurement assessments are being concluded at sector level as part of the ongoing dialogue with external partners under the new MoU for PROSAUDE signed in July 2008. A Public Expenditure and Financial Accountability (PEFA) inspired methodology for National PFM assessments was used and has tried to maintain similar standards of rigour in the way in which scores for each of the indicators have been assigned. The national PEFA methodology is based on international standards of public finance management: thus the practices and the qualities which are identified as required in order to merit "A" or "B" scores are those that one would expect to find in a well run Public Administration system within an OECD country. Table 2 shows the distribution of scores for the 23 indicators assessed in the Mozambican health sector. As may be seen, only 7 of the 23 indicators (30%) scored "A" or "B", while 9 indicators (39%) scored "D" or "D+". Overall the assessment shows that SISTAFE introduction and the direct budget execution feature of the system have contributed to improvement in the timeliness, quality and availability of budgetary information at all levels (central, provincial and district). However, substantial improvement is still needed in a number of areas including:

- Health sector expenditure out-turn compared to budget;
- Transparency of obligations and liabilities for health care user charges;
- Timeliness of health sector procurement processes;
- Inventory management in the health sector;
- Effectiveness of internal controls for non-salary expenditure;
- Effectiveness of internal audit in the health sector;
- Availability of information on resources received by district level;
- Quality and timeliness of in-year budget reports;
- Scope, nature and follow-up of external audit in the health sector.

Table 2: Summary of ranking of Health PFM & Procurement Systems, Preliminary Report 2008

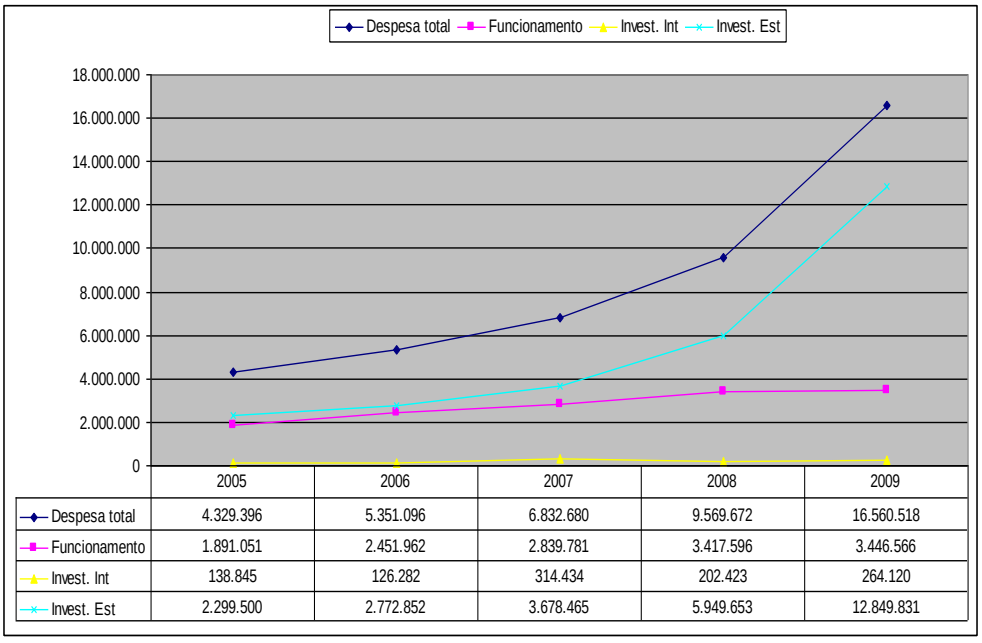
Indicators		D	C	B	A
A. PFM OUT-TURNS: Credibility of the Budget					
SI - 1	Health Sector expenditure out-turn compared to original approved budget	D			
SI - 2	Composition of sector expenditure compared to approved budget				A
SI - 3	Aggregate health sector user fee collections compared to original approved budget		C		
B. KEY CROSS-CUTTING ISSUES: Comprehensiveness & Transparency					
SI - 5	Classification of the Health Sector budget		C		
SI - 7	Extent of unreported government operations in the Health Sector		C		
SI - 8	Tranparency of rules & procedures for Provincial & District Health budgeting			B	
SI -10	Public access to key fiscal information on the health sector			B	
C. BUDGET CYCLE					
C(i) Policy-based Budgeting					
SI-12	Multi-year perspective in planning & budgeting for the Health sector		C		
C(ii) Predictability & Control in Budget Execution					
SI-13	Transparency of obligations and liabilities for health care user charges	D+			
SI-16	Predictability in availability of funds for commitment of health expenditures		C+		
SI-18	Effectiveness of payroll controls in the health sector			B	
SI-19 a)	Quality assurance processes in Procurement of Pharmaceuticals			B	
SI - 19b)	Price competitiveness in Procurement of Pharmaceuticals				A
SI - 19c)	Timeliness of Health sector Procurement processes	D			
SI - 19d)	Competitiveness & Transparency in Health sector Procurement		C		
SI - 19e)	Inventory management in the Health sector	D			
SI-20	Effectiveness of internal controls for non-salary expenditure in the Health sector	D+			
SI-21	Effectiveness of Internal Audit in the Health sector	D+			
C(iii) Accounting, Recording and Reporting					
SI- 22	Timeliness and regularity of accounts reconcilitaion in the health sector			B	
SI - 23	Availability of information on resources received by district health facilities	D			
SI-24	Quality and timeliness of in-year budget reports for the health sector	D+			
SI-25	Quality and timeliness of annual financial statements for the health sector		C+		
C(iv) External scrutiny and Audit					
SI-26	Scope, nature and follow-up of External Audit in the Health sector	D+			

74. In addition, a comparison of the sector assessment with the 2007/08 National PEFA assessment suggests that PFM and procurement systems in the health sector are significantly weaker than overall PFM systems at national level – in fact, the scores for the health assessment were on average 25% lower than the equivalent national level indicators in the PEFA one year earlier. There are therefore real reasons for concern regarding financial management in the sector and it will come as no surprise to see this reflected in the manner in which SBS has been taking shape. It is also interesting to note from the table that indicators related to the procurement of drugs score very high, which is a reflection of the fact that separate systems are in place for drug procurement and management – and under the new PROSAUDE II arrangement will continue to be separate for some time to come until systems are strong enough to ensure a smooth transition (this is further explained in Chapter 3).

Health Sector Expenditures

75. The total State Budget (recurrent and investment) for the Health sector has been following an upward trend, in absolute terms, but has dropped as a percentage of GDP and of the total budget. This budget includes some funding for HIV/AIDS, although without a programmatic classifier it is difficult to say how much this represents specifically. However, the majority of external funding for HIV/AIDS goes directly to the National AIDS Council or is managed by donors (e.g. PEPFAR) and is not reflected in the budget. Figure 3 shows the evolution of the state budget over time.

Figure 3: Growth in Recurrent and Investment Expenditure (2005-2009)[2]



	2005	2006	2007	2008	2009
Despesa total	4.329.396	5.351.096	6.832.680	9.569.672	16.560.518
Funcionamento	1.891.051	2.451.962	2.839.781	3.417.596	3.446.566
Invest. Int	138.845	126.282	314.434	202.423	264.120
Invest. Est	2.299.500	2.772.852	3.678.465	5.949.653	12.849.831

Source: Annex 2

76. The main sources of financing of the health sector are the government budget and on-budget donor support. There are also external projects and vertical funds (namely Global Fund and USAID) and several other off-budget funds in the sector. User fees are also collected and a significant trend in the collection of this category of financing has been observed in recent years (as reported in Government accounts).

77. According to the JAR 2009 (which quotes REO IV 2008 and *Documento de Fundamentação do OE 2009*), the health sector overall funding (state budget and external funding) as a proportion

[2] Translation to key – Despeso total = total expenditure; funcionamento = recurrent; investment int = domestic investment; investment est: external einvesthment.

of the total government expenditure (external funding included) has been decreasing in the last four years. The health share went down from 13.4% in 2006 to 13.0% in 2007 and to 12.2% in 2008; for the planned funds for 2009, this proportion went down further to 11.9%. The report concludes that the heath sector budget allocation is getting further away from the 15% Abuja target. The declining trend has been a source of concern in the past; whereas the state budget for health as a proportion of total expenditure increased from 6.5% in 1993 to 14% in 2002, from 2003 onwards it has declined, falling to10.6% in 2005. According to the JR 2006, *"The government budget allocation for health expenditure as a proportion of overall expenditure continued the downward tendency registered in the last three years, from 11% in 2004 to 10,6% in 2005"*. External funding accounted for the most of the increase. Available information refers to the high level of dependence of the government on external support – at present over 70% of funding to the sector is provided by 26 health donors (IHP 2008c).

78. Table 3 shows a major increase in sector budget allocations in 2009. For 2009 the State Budget proposal for the sector is 17,151,413 million Meticais, meaning that 17.8% of Total Government Expenditure is going to be spent in the sector. This is a substantial increase compared with the 2008 budget where the sector budget was of only 12.2% of total expenditure. The external funding of the sector budget almost doubled between 2008 and 2009. This increase is substantially explained by the moving of the sector common funds and other projects on budget, and not by an increase in overall funding to the sector. This included PEPFAR funds, which were inscribed in the budget for the first time in 2009. Of concern is also the fact that the amount of vertical funding has been increasing, mainly as a result of the substantial amount of money which comes in for HIV/AIDS from the Global Fund. According to the JR 2009 report, in 2008 around 56% of the overall health budget was provided through vertical funding.

79. All on-budget external funding earmarked to the sector is classified as investment expenditure in the budget, even though it often includes expenditures which are recurrent. This is illustrated by the pale blue line in Figure 3. Furthermore, most of this is allocated to the MoH investment budget. Table 3 shows the amounts of funding allocated to different levels in the health system. The moving of donor project funding on budget meant that the share of the sector budget allocated to the Ministry of Health increased from 61% in 2008 to 76% in 2009.

Table 3: Evolution of the State budget over time

Description (Sector \ Institutions)	CGE	CGE	CGE	State Budget (OE)	State Budget Proposal
	2005	2006	2007	2008	2009
	Total Expenditure	Total Expenditure	Total Expenditure	Total Expenditure	Total Expenditure
HEALTH	**4,683,391**	**5,838,999**	**7,215,081**	**10,207,398**	**17,151,413**
Health System	**4,329,396**	**5,351,096**	**6,832,680**	**9,569,672**	**16,560,518**
Ministry of Health	2,923,644	3,613,625	4,721,663	6,252,483	13,000,747
Provincial Directorate of Health	1,100,472	1,362,958	1,647,053	2,214,185	2,468,958
Provincial Hospitals	0	0	0	217,138	218,315
General Hospitals	0	0	0	126,516	63,914
General Hospitals	0	0	0	0	50,243
Central Hospital of Maputo	197,861	244,173	319,176	502,914	541,581
Other Central Hospitals	107,419	130,340	144,788	235,468	169,623
Psychiatric Hospital	0	0	0	20,968	22,590
General Hospitals	0	0	0	0	24,547
HIV/SIDA	**353,995**	**487,903**	**382,401**	**637,726**	**590,895**
National Council to Combat HIV/AIDS	353,995	487,903	382,401	637,726	590,895

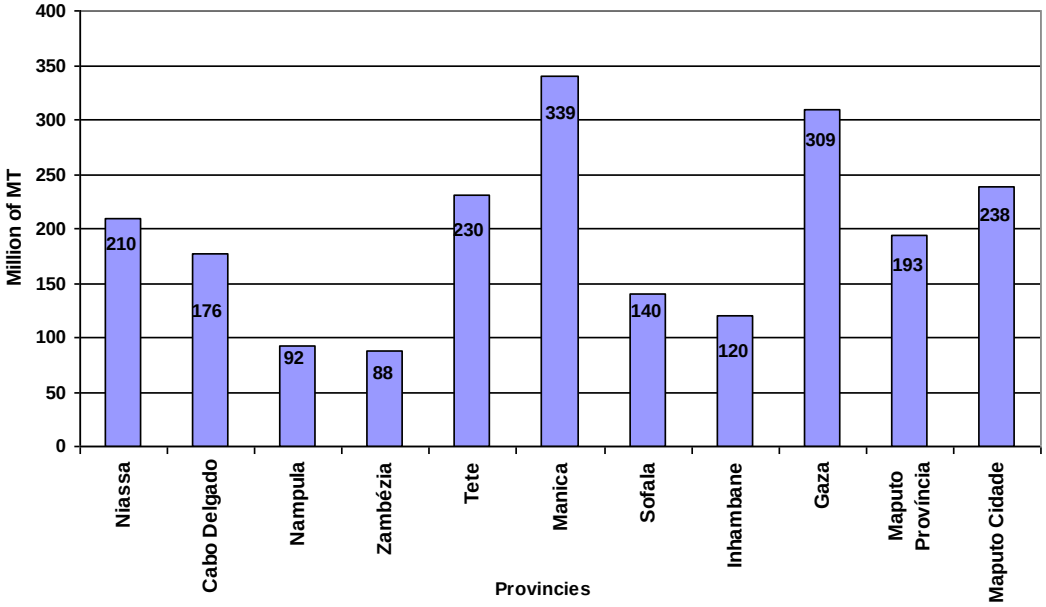
Million of MT

Source: Annex 2

80. The majority of recurrent funding is allocated to service delivery; there has been slow progress on the official Government policy to decentralize the management of recurrent expenditure. Out of the total recurrent budget, MoH managed 37% and 32% in 2005 and 2008 respectively. Care must be taken in drawing conclusions from these data. In fact, although the percentage of the funds being directly managed by provincial directorates of health has increased slightly (from 48% to 52%) it clearly shows that this is only applicable for some recurrent expenditure. In fact, in this period, the proportion of funds for goods and services managed at this level did not change (34% in 2005 and 32% in 2008) and the percentage of allocated capital budget went down from 57% to 27%.

81. Overall for the 2009 budget, 82% of the funding will be managed at central level and only 18% at provincial level. It is difficult to ascertain the share of Ministry of Health budget allocations transferred to provinces. It is however clear that the health sector budget is, in effect, highly centralised.

Figure 4: Per Capita Provincial budget allocations 2009

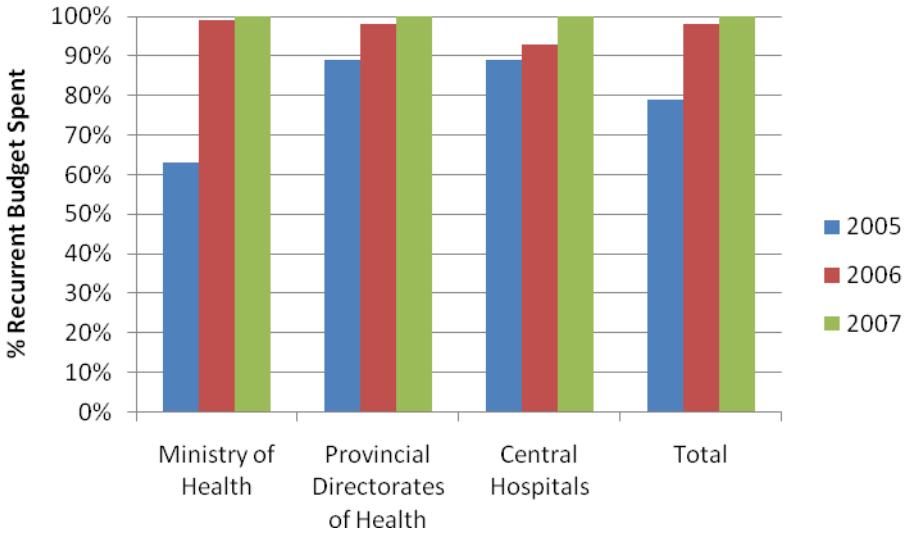


Source: OE 2009 and INE, Projecções Anuais da População Total Actualizada 1997-2015. NB: The Maputo Cidade per capita figure likely does not include Maputo Central Hospital which serves mostly (80-90% probably even more) urban dwellers from Maputo City. The per capita funds including only the State Budget for Maputo City is 561MT.

82. Funding to provinces suffers from considerable equity issues (McCoy, S., Cunamizana, I., 2008). Some of the poorest and most densely populated provinces receive the least resources. In terms of per capita budget allocation, there is a more than three-fold difference between provinces (with Gaza receiving 309 Meticais per capita, and Zambézia only 88). There is also some evidence that intra-provincial variations in funding to and within districts are even larger than those between provinces (Health Sector Expenditure Review, 2003).

83. Finally it is important to note that the reliability of the recurrent budget has improved in recent years, as shown in Figure 5, with execution rates reaching 100% in 2008. The domestic investment budget also appears reliable, with an execution rate of 96% in 2008 for the Ministry of Health. There are, however, worrying issues related to the very low actual execution of the external component of the investment budget that is having a negative impact on overall performance of the sector. For example execution rates were only 42% for the Ministry of Health in 2008 (Ministry of Finance 2008).

Figure 5: Increasing Reliability of the Recurrent Budget



Source: Annex 2

The contribution of policies and expenditures to service delivery and to sector outcomes

84. In terms of service delivery the health sector has made considerable progress in the past years. Service output, coverage and service consumption have expanded since the end of the war and have contributed to reductions in geographical inequities. This is a reflection of the high levels of economic growth in the country and the direct investment by the government and partners in the health sector. The progress is illustrated by the fact that between 2001 and 2005 the number of service units[3] in the health system increased by 22% and the number of institutional births grew by 28%. Over the same period the number of mother and child health consultations increased by 28%. Similar results were seen in vaccine administration which also grew by 10%. The significant reduction in child mortality (highlighted in Section 2.2 under Health Sector Outcomes) testifies to this progress.

85. However, in spite of progress, Mozambique still has low levels of coverage and faces considerable constraints in improving access to and quality of service delivery. Geographical inequities in access to services and in quality of care provided are still substantial. Efforts over the past years to correct regional differences in staffing have had some effect but not enough, and significant regional differences persist. There is evidence that the early gains in increasing utilization, efficiency and quality of services are now levelling off. Challenges to health service delivery are in many respects still considerable and include the fact that:

- Only two thirds of the population are reached by health services.
- Inhabitant/doctor ratios are very high.
- Most of the qualified senior practitioners are found in urban areas.
- Leakage of staff to private sector and Non Governmental Organizations (NGOs) is considerable and substantial numbers of staff are lost to AIDS each year.
- Management capacity is still worryingly weak and concerns exist about channelling high levels of funding to a sector which has limited capacity. Efficiency and effectiveness are poor.

[3] The indicator of Service Unit is an estimate of the global output and is the following weighted sum: ∑ (inpatient days x 9) + (hospital deliveries x 12) + (Vaccination doses x 0.5) + (Outpatient consultations x 1) + (MCH consultations x 1)

- Funds are being re-oriented to curative care and large urban hospitals and there is a slowdown in the reduction of inequities between provinces in terms of access to goods and services.
- Less than half of births are attended by skilled health staff, and this percentage is even lower in the northern and central provinces and in rural areas.
- The AIDS pandemic is threatening many gains, including the achievements in child mortality reduction because paediatric AIDS treatment and prevention of mother to child transmission (PMTCT) coverage, although improving, are still largely insufficient
- Around 50% of the deaths of children under five are related to malnutrition. Neo-natal mortality is high.
- Malaria and tuberculosis are still very serious problems, and insufficient progress has been made in addressing these diseases
- Under the table payments are often required for services and for drugs.

86. The expansion of service delivery has undoubtedly contributed to improvements in terms of reduction in IMR, UFMR and MMR. The increases in state budget and external funds have contributed to this expansion through a focus on construction, recruitment of qualified staff (7% between 2001 and 2005) and improved availability of drugs.

87. However, further progress will require additional and more complex efforts to address key constraints and bottlenecks in the health system's capacity, management and decentralization processes. Human resources are a key challenge. The quantitative and qualitative deficits in health workers put at risk some of the key achievements that have been made in the past years in reducing infant mortality for example, and create challenges to making progress in areas which have yet to be addressed.

2.3 Context for External Assistance

Trends in external assistance in general and in development aid

88. Official Development Assistance (ODA) has been very important to Mozambique over the past years, both for the funding of its fiscal deficit and for development efforts in a variety of areas. In terms of aid per capita and ratio of aid to GNI, Mozambique is one of the most aid-dependent countries in the world. Over 50% of the overall state budget in Mozambique comes from external funding, and aid counts for about two thirds of public investment.

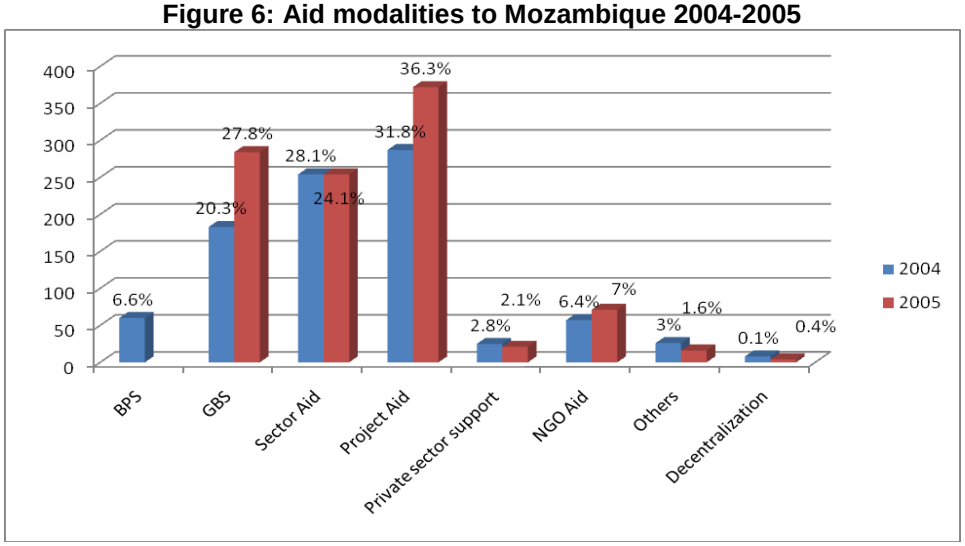
89. Mozambique has an exceptionally large number of donors. The country has a high political profile in southern Africa, and its poverty and humanitarian needs are substantial. Mozambique has enjoyed good relations with its partners and its track record of making effective use of aid is relatively good.

90. Currently 19 donors – known as the Programme Aid Partners (PAP or G19) – are providing general budget support (GBS). A MoU governs the principles and processes of the GBS process in particular with respect to public expenditure and overall governance performance. A new version of this MoU was signed in March 2009.

91. Assessment of performance under GBS is made annually in March/April in joint reviews with all partners. The results of these reviews guide decision making by donors on the following year's funding. In order to allow for smooth planning by the Government of budget ceilings the decision on donors' inputs into the budget must be provided before May. Direct budget support has increased from 22% of ODA in 2005 to 31% in 2008 (representing an increase from 242 million US$ in 2005 to 385 million US$ in 2008).

92. Obtaining information on donor support modalities is a challenge in Mozambique but the available information (based on reports from 18 donor agencies and shown in Figure 6) indicates that there was a considerable shift in aid modalities from 2004 to 2005. Figure 6 shows that GBS has increased in importance from just over 20% to almost 28% of all aid. Data from the GBS evaluation shows that the GBS share of the GoM budget went up from 2.5% in 2000 to around 17% in 2004. As a share of the external budget it increased from 5% to 32% over the same period (Batley et al 2006). It still falls far short, however, of the government's target to have 75% of all aid disbursed as Programme Support of which at least 40% should be GBS, as stated in JR 2009 report: *"GBS increased from 36% to 38% [between 2007 and 2008], against a target of 40% and the programme support increased from 61% to 66%, against a target of 75%."* In this context it should be noted that project aid has continued to constitute a substantial proportion of the funds and the absolute amounts have recently even grown further.

Figure 6: Aid modalities to Mozambique 2004-2005



93. In the context of the EU Fast Track Initiative on the Division of Labour (DoL), EU countries have carried out a mapping of their activities in Mozambique and have also gone through a process of determining where each donor's comparative advantage lies. As a result, selected EU donors, have started limiting the number of sectors in which they operate – in some cases 'exiting' from sectors where they have been operating for a decade or more. Although the principle of the EU DoL rests on the idea of complementarity and rationalizing technical support, in practice decisions on donor disengagement are being made internally within agencies and are being guided by other factors, including the economic downturn in many of the countries and the fall in budgets for development aid.

Health Coordination Structures

94. Mozambique adopted a SWAp for the health sector in 2000. At this time support and funding to the sector were very fragmented with an abundance of programmes and projects and very little on-planning and on-budget external funding.

95. The establishment of the SWAp was a result of an incremental and progressive process. In the aftermath of the war, several coordinating schemes along with original financing mechanisms took place; these pre-dated the reform and paved the way towards a sector-wide approach. These included:

- The Swiss budget support (1990) backed by policy discussion on service goals and agreements on financial allocations with the strengthening of provincial management in the context of decentralisation.

- Donor coordination (1992) with Swiss Development Cooperation (SDC) appointed as the focal donor.
- PATA (Pooling Arrangement for Technical Assistance – 1996) becomes the first Common Fund to be established in the health sector. In fact, the evaluation of General Budget Support (Batley et al., 2006) considers that early cases of donor harmonisation at sector level were in health, through the establishment of this pool. It was managed by the MoH, administered by the United Nations Development Program (UNDP) and funded by the governments of the Netherlands, Norway and Switzerland. This arrangement ceased in 2000, when it was taken over by GoM.
- Common Fund for Medicines (1998) is established following the successful initiative in this area launched by SDC a few years earlier.
- A common fund for developing and launching the health strategy is created (1998).
- Progressive integration of selected vertical programmes in the National Health Directorate (DNS) with some difficulties experienced in prioritizing and implementation (1998-1999).
- The Provincial Common Fund is formally established following the successful Swiss budget support initiated in 1990. Resources are allocated on the basis of the Provincial Health Planning process adopted by all provincial health authorities in the mid 1990s.

96. The SWAp has aimed at improving the performance of the sector, strengthening government leadership, and also puts an important emphasis – at least in theory – on policy and strategy development and on lowering the transaction costs of foreign assistance. The 26 partners use the Health SWAp structure to enhance strategic dialogue among partners and between the Ministry of Health and partners on sector policies, priorities and performance. This dialogue takes place in the context of the PARPA and delivery of the health sector strategic plan (PESS).

97. The dynamics of the Health SWAp are evolving and new challenges are present, among which a major one is the incorporation of global vertical health financing initiatives. Significant and continuous efforts are being made to improve the efficiency and the effectiveness of the health SWAp in harmonizing and aligning partners to government systems, strategies and plans, in line with the Paris Declaration on Aid Effectiveness.

98. Donor and partner coordination is relatively well elaborated in the health sector in Mozambique. The rules of engagement between the MoH and its partners are set down in a code of conduct (known as the Kaya Kwanga agreement, after the place where it was signed) which was signed in 2000 and revised in 2003.

99. Dialogue within the sector takes place at three levels. The manner in which dialogue is organized has been reviewed a number of times in the past years in order to streamline the work for the MoH, reduce transaction costs for all parties, ensure fair representation and, importantly, to link with the process and timing of the national budget cycle and the main government decision-making processes.

100. The first level of organization concerns the Sector Co-ordination Committee (SCC) which take place twice a year and which are chaired by the Minister. The first yearly session examines the performance in the sector looking at the annual PES and budget implementation. The SCC is timed to take place immediately following the internal health meeting and the Joint Annual Review which brings together all partners. The second annual SCC meeting discusses the draft annual plan and the budget. A major task for this meeting is to get commitment from the donors on their contributions for the budget process in September.

101. The second level of coordination takes place in the form of monthly meetings of the Joint Co-ordination Committee (CCC) and is chaired by the Permanent Secretary of the MoH. A total of eight CCC meetings take place each year. Development partners are represented by the focal point, UK Department For International Development (DFID). Lead donors were initially appointed for one year. This was changed to two years beginning with the current mandate of DFID. An

enlarged CCC is held at the beginning of each planning cycle and exceptionally extraordinary sessions are also held.

102. A third level of coordination takes place through working groups that have been established under the SWAp, with terms of reference which have to be approved by the CCC. The working groups are of varying size and importance. They may be permanent or ad hoc in nature and focus essentially on technical issues. Each working group is led by a relevant MoH official and has a donor co-chair. The current working groups include monitoring and evaluation, medicines, investments, human resources, finance and audit, major endemics, gender, emergency preparedness, health systems development, and sexual and reproductive health. Working groups may contribute to certain aspects of the planning process, such as to the development of the recently launched human resource plan. However, working groups are not necessarily involved in or consulted about the key decisions in the sector and there is no requirement for this.

103. Annual Joint Reviews provide an opportunity for assessing progress against a common monitoring and evaluation framework. The joint annual review (or ACA as it is known) takes place in February each year to fit with the GoM planning cycle and uses a health sector performance assessment framework (PAF). The PAF is a detailed matrix of indicators with key targets including input, output, impact and process indicators (for a summary of the matrix see Table 5; a full version of the PAF matrix can be found in Annex 5). The Joint Reviews monitor progress against a list of 38 indicators linked to the PESS (revised in December 2002). Of the 36 indicators, 14 cover the key areas of the Health Sector Strategic Plan, 10 cover functions of the health system and the remaining 12 are general and impact indicators. The Joint Reviews also look at performance against the previous year's annual operational plan and at the recommendations from previous Joint Annual Reviews. Joint Reviews are based on reports produced by teams of consultants, including both ministry staff and independent consultants. The report produced by the consultants is first discussed informally at the SWAp forum, and then formally presented and eventually endorsed at the June meeting of the SCC.

104. A selected number of the health PAF indicators are also part of the annual PAP evaluation process. A broader PAF for the country as a whole – which integrates a selection of the health PAF indicators, as well as indicators for other sectors and key areas of macro-economic activity – provides the link to the PARPA, and informs future developments within the GBS programme. Importantly, the overall PAF also aims at:

- 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.

105. A sector financing framework (MTEF) is also in place 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 government health expenditure.
- Points towards donors increasingly placing development assistance for health into common funding and budget support mechanisms.

106. The partners have agreed, under the new MoU for PROSAUDE II, to make use of the Government's audit system for funds which are made available to PROSAUDE. This audit system is controlled by the General Inspectorate of Finance and the Administrative Tribunal.

107. A number of other instruments are in place. One is a common agenda which aims at ensuring that consultations and missions are held at the right time. This consists of a document which circulates among partners and the MoH. In practice it has proved difficult to make this tool work, as is evidenced by the difficulty which this mission had in contacting key partners because of the number of other parallel missions going on in Maputo at the same time.

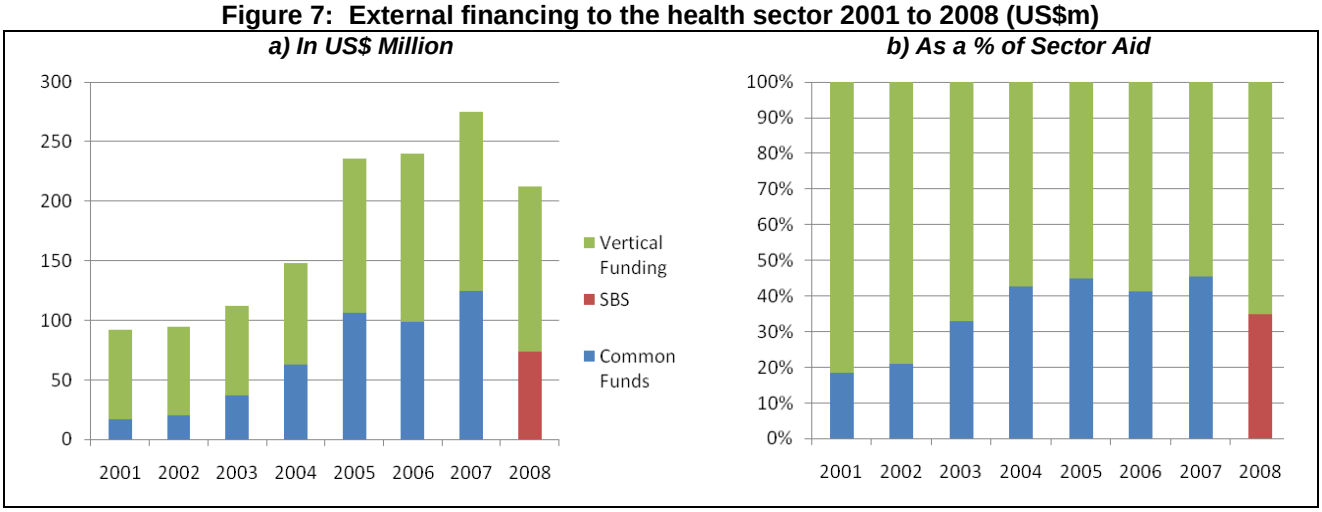
External support to the health sector

108. A shift in donor funding away from traditional project support to sector programme aid has taken place in the past years. An increasing share of donor funding is thus provided through common funds now largely reflected on budget. Until 2008, three common funds were in place in the Health Sector (the Provincial Common Fund, the Common Fund for Drugs, and PROSAUDE I – a general common fund). In 2008, the first two common funds ceased to exist and a MoU was signed between the GoM and development partners for the provision of SBS to PROSAUDE which became the only joint funding mechanism to the sector.

109. Funding to the sector has been considerably streamlined and has become much more integrated with government systems as a result of the MoU which was signed in July 2008. This MoU includes a single financing system, which is inscribed in the State budget. Funds from donors are made available to this system through the single treasury account (the *Conta Unica de Tesouro* or CUT). Donors have the option of marking their contribution to the sector as either external funds (funds which must remain in the sector at the end of the year) or internal funds (which are treated the same as the general state budget and therefore any end of year balances revert to the overall budget and do not necessarily stay in the sector). e-SISTAFE is able to keep track of the origin of the resources financing expenses and thus the balance of external funds can be re-inscribed into the budget for the next year. This solution has addressed one of the key concerns that donors had with providing sector support. A major achievement of the new MoU is that it is consistent with the MoU signed between the Government and the PAP in April 2004 for the provision of direct balance of payments support.

110. Figure 7 illustrates the sources of external financing to the sector over the past eight years.

Figure 7: External financing to the health sector 2001 to 2008 (US$m)



111. Over the period shown in Figure 7, the proportion of vertical funding has decreased substantially: from 82% in 2001 to 55% in 2007 over external funding. In 2008 the shift was made to SBS in support of PROSAUDE II, at slightly lower levels than previous Common Funds. Although increasing at a slower pace than Common Funds, the absolute amount of vertical funds continued to increase. Together common funds reached a level close to domestic budget allocations in 2007, but were still much less than vertical funds. The high level of vertical funding is a reflection of the continued proliferation of projects, including by SBS donors. In 2006, there were:

- 59 projects
- 21 Technical Assistance (TA)
- 6 studies

- 12 SWAp (meaning the various pre-SBS common funds)
- 3 GBS

112. This illustrates just how fragmented aid continues to be, in spite of commitments by donors to harmonise funding. It should also be noted that Government has consistently asked for a decrease in vertical funding. Nonetheless vertical funding has been increasing. In addition, a significant amount of health financing is not being captured in the budget. This includes substantial funds which donors are giving directly to NGOs.

113. Predictability of disbursements of external funds has been a concern over the years for both common and vertical funds. Funds are often disbursed late in the year with the requirement that they must be spent before the next year. This poses considerable challenges to the MoH in terms of planning and implementation of its core activities. A concern for donors is the extent to which they can influence an equitable distribution of resources to provinces. In the past this issue was addressed by donors by channelling funds to the provincial common fund and enforced through the Integrated Planning Exercises.

Donor Support to Technical Assistance and Capacity Building

114. There is no specific approved capacity building strategy for the sector and there is no specific coordination mechanism for capacity building support in the context of the SWAp. However, until the mid 2000s capacity building and TA were an integral part of two common funds. Common fund for drugs: It had a built-in institutional support component which aimed at improving the planning and management of the pharmaceutical sector at national, provincial and district level and this was funded by a specified proportion (about 10%) of the funds disbursed by some donors into the drug pool. Provincial common fund: the Integrated Planning Exercises were the main tool for capacity building mainly at provincial and district level.

115. As mentioned in Section 2.2, the Ministry of Health presented an ambitious human resource development plan for the sector to the partners in 2008. The plan was based on a comprehensive assessment of needs in the context of the MDGs and aims at addressing some of the issues which are at the core of poor capacity at present (including salary differentials and issues related to staff training). At the time this study took place no common position of donors had emerged regarding this plan. Some donors commented that it was too ambitious and expensive and that it was hard to see how the presentation of this plan in the middle of the year was supposed to fit with the overall cycle of review and coordination which is in place for the sector. Pooling of technical assistance has been on the agenda a number of times since the earlier days of the SWAp and partially abandoned because the process of developing joint terms of reference was seen as very time consuming. Recently technical assistance has again become part of the discussion and new mechanisms are being considered.

116. In recognition of these challenges, development partners (DPs) have, through programmes and projects which are financed as vertical initiatives, invested in strengthening management and capacity building, including through the provision of TA at provincial and central levels. TA has been substantially reduced, however, since 2007 when the then new Minister of Health decided to rapidly phase out the substantial number of TA who were occupying line positions. According to donors this has impacted on the quality of the work that has come out of the MoH, and the situation has been made worse by national staff also leaving the service for other opportunities.

117. However, most of these challenges underscore the need for putting in place an effective capacity building programme which is developed in close dialogue with sector budget support mechanisms and processes to improve aid effectiveness. Late 2008 the MoH did just that by presenting donors with a comprehensive Human Resource Development Plan. This was drafted after PESS II was costed in 2007 and therefore highlights the need for additional funds. Under the current MoU DPs already pay for all the additional salaries/staff – by 2010 these will need to be on

budget and on GoM payroll using the funds that already exist. The plan tackles many of the main root causes of issues underpinning the Human Resource (HR) crises in the sector (such as low salaries, incentives, unclear career paths and de-concentration of HR to provinces and districts). GoM is starting a medium term salary reform in 2009 and Health is one of the sectors benefiting from this.

3. The Key Features of SBS Provided and its Effects on the Quality of Partnership

3.1 The Key Features of SBS Provided

SQ2.1: What are the key features of the SBS that has been provided?

118. This section provides a description of SBS to the Health sector and gives information on: the type of SBS provided; the level and predictability of SBS funding; the financial management arrangements; earmarking and additionality; conditionality and dialogue; and future evolution of the support. In complement to this section an overview of the type of SBS provided to the health sector in Mozambique is provided in the inventory in Annex 4. This section also examines the effect that SBS has had on the quality of the partnership between donors and GoM in the health sector. It should be noted that in a number of respects this analysis is limited by the fact that SBS 'in the true sense' has only been in place since the signing of the MoU for PROSAUDE II in July 2008.

The evolution of SBS and its objectives

119. For the purpose of the overall SBSiP study[4], SBS is defined as those aid programmes where:

- *Aid uses the normal channel used for government's own-funded expenditures. Aid is disbursed to the government finance ministry (or treasury) from where it goes, via regular government procedures, to ministries, departments or agencies (MDAs) responsible for budget execution.*
- *The dialogue and conditions associated with aid should be predominantly focussed on a single sector.*

120. The sector case studies which are part of this series do not, however, limit themselves to only these two criteria, but also look at hybrids which display some of the features of SBS. Currently there is only one aid programme in the Mozambique health sector which would fall under the broad definition of SBS – the PROSAUDE II Programme. This is the result of a transition which took place mid 2008 from a situation where three common funds were in place to one common SBS programme. The three common funds that were in place prior to 2008 were:

1. **A common fund for Drugs** *(Fundo Comun de Medicamentos or FCM),* established in 1998 and modelled on the SDC experience. This fund enabled MoH to procure and supply drugs centrally. Initially the fund was managed by SDC. Between 2005 and 2008 the Fund was on-plan and inscribed in the state budget. However, the funds were transferred to a bank account managed by the MoH and the audit and monitoring arrangements were separate from those used for state funds. In 2008 this fund was still recorded in Government accounts and still being used as before.

2. **A Provincial Common Fund** *(Fundo Comun Provincial or FPC*), established in 1999 and also building on an SDC initiative (Martínez J. 2006). The funding was initially aimed at current costs of the health sector at provincial level but gradually its scope was broadened and it covered all expenses. Resources to the provinces were allocated from this fund on the basis of Provincial Integrated Health Planning Processes which had been in place since the mid 1990s and which had received support from a number of donors. This funding had a key role in addressing funding imbalances existing among and within provinces after the state budget and available tied funding in the health sector had been allocated. An

[4] See SBSiP Inception Report (2008, p. 7).

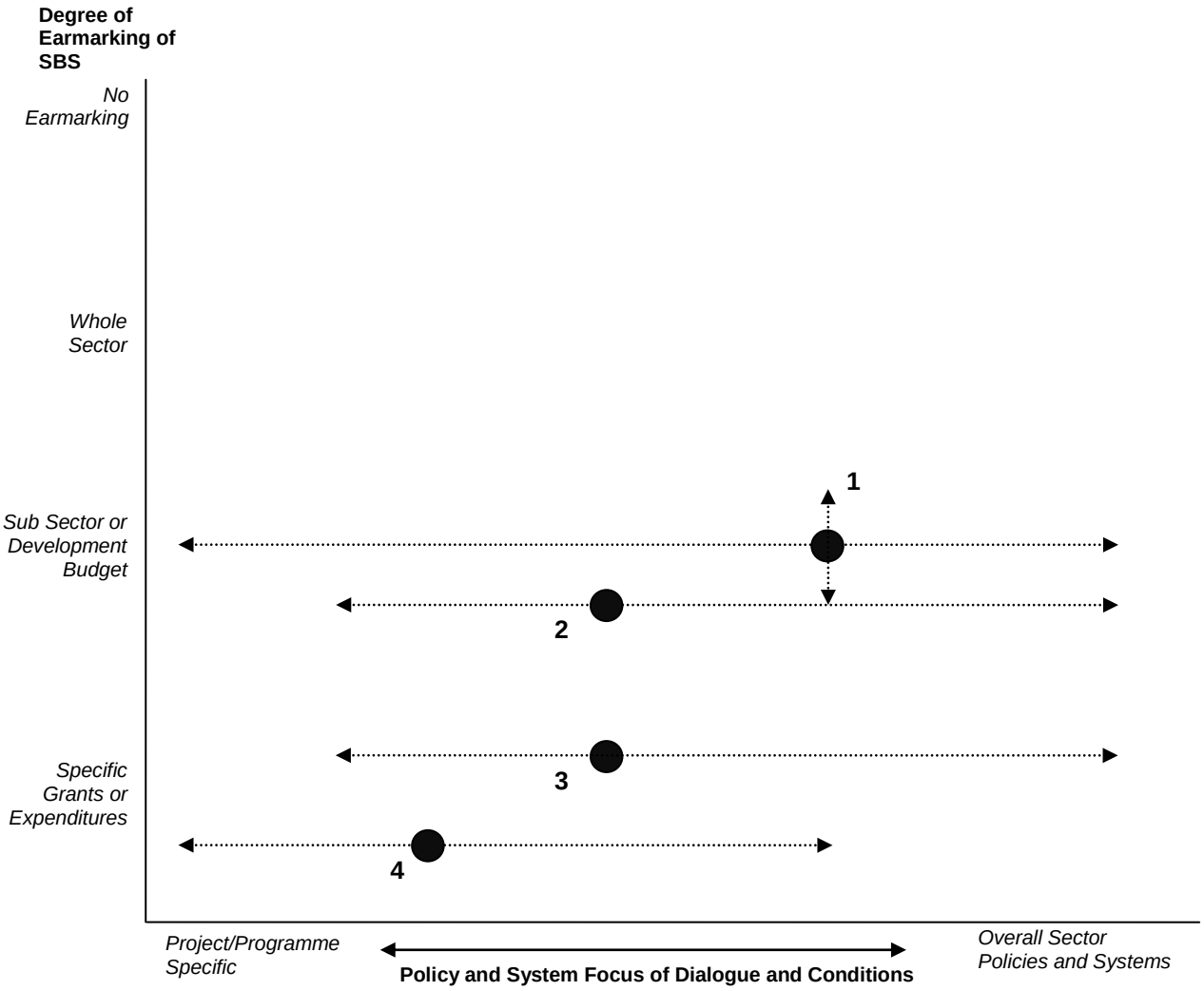
allocation formula was developed for this purpose and had been adopted by MoH. For a long period, the fund was also important in addressing the frequent liquidity crises that threatened the flow of essential health funding to provinces. The fund was managed by SDC until 2003; from that year until its integration in PROSAÚDE II in 2008 the funds for the Provincial Common Fund were transferred by the DPs to an account held by MoH which had its own specific monitoring and auditing arrangements. Although there was no legal basis, this arrangement was in practice justified as a transitional measure for transferring its management from SDC to government authorities, while putting in place necessary measures for its complete integration in PROSAÚDE. In 2008 this Common Fund (CF) was merged with the general CF in the sector.

3. **The PROSAUDE Health Common Fund** – or General Common Fund (also known as PROSAUDE I) – was established in 2003 and aimed at funding priorities across the sector in accordance with the priorities of the PESS. A total of nine partners supported PROSAUDE I in the pre-July 2008 phase. Funding to the fund consisted of a combination of earmarked and un-earmarked funding. The fund had separate audit and monitoring arrangements. The current PROSAUDE II has followed from this first experience and has a total of 15 signatories out of the 26 donors in the sector, including two United Nations (UN) agencies. This makes it the largest group of donors being considered in this series of studies.

121. In this study, these three common funds are discussed, alongside a detailed examination of the relatively new SBS programme in support of PROSAUDE II. Figure 8 shows the situation of the current PROSAUDE II Programme and the three Common Funds, along two dimensions. The horizontal axis reflects the focus of the dialogue and conditions while the vertical axis refers to the level of discretion of funding.

122. As can be seen from the diagram the Common Fund for Drugs had the narrowest scope of dialogue being focused on issues around provision of drugs, the sector drug policy and strengthening of the pharmaceutical department institutional capacity and the funds being exclusively earmarked for drugs. The Provincial Common Fund was put in place to address concerns around geographical equity of access and quality of service and was mainly used to pay for contracted staff. The dialogue around the Provincial Common Fund was conducted in the context of the overall sector policy and the systems used were partially those of the government. However, the funding could only be used for provinces and the level of discretion of funding was therefore not complete. Finally PROSAUDE I (as it is labelled in the diagram to avoid confusion with the current PROSAUDE II after July 2008) was the most 'liberal'. Dialogue around PROSAUDE I took place in the context of the SWAp and the funding could be used for the priorities in the PESS. However, some of the funds were earmarked for specific priorities. The graph shows that PROSAUDE II has the least earmarking and broadest focus of dialogue and conditions of the four aid modalities, but it still is *de facto* earmarked to the investment budget. This is explained further in this chapter.

Figure 8: The Spectrum of Sector Budget Support Covered by the Study



1. **PROSAUDE II (SBS from 2008)**
2. **PROSAUDE I (Common Fund up to 2007)**
3. **Provincial Common Fund (Common Fund up to 2007)**
4. **Common Fund for Drugs (Common Fund up to 2007)**

123. Reflecting back on the ten years since the first Common Fund was established, a number of factors can be identified which influenced the move to SBS. These include:

- Increasing control, authority and ownership exercised by the Government of Mozambique over external resources.
- Strengthening of government systems through the civil service reform, the introduction of e-SISTAFE, the new procurement regulations and other measures.
- Strong agenda of some development partners for promoting budget support (BS) at sectoral and country levels and progress at country level in harmonization and alignment through the PAP process.
- Introduction of mechanisms for joint monitoring at sectoral and government level, as well as mechanisms to monitor the compliance of DPs with provisions of the Paris Declaration and other agreements. Over the years these have drawn attention to the fact that DPs were developing new structures and following procedures and mechanisms which were undermining national efforts to work toward integrated systems and have pushed for change among DPs in the way in which they work.

- Development of a shared position by a key group of development partners in the Health sector who were able to clearly articulate the importance of the SBS agenda, and who supported government plans and priorities in this field.
- Evidence of a learning process by which, for example, PROSAUDE I's accounting rules and monitoring and evaluation indicators and processes were gradually improved and created confidence in systems and procedures. This process helped generate confidence among partners that SBS might be a feasible option.
- An important lesson emerging from the Mozambique experience is the role of leadership and of individual personalities in influencing the success of these endeavours.
- The provision of GBS to the country and related efforts to strengthen government systems and processes generated a climate of confidence for donors who wanted to take a similar step but without letting go of their sectoral focus.

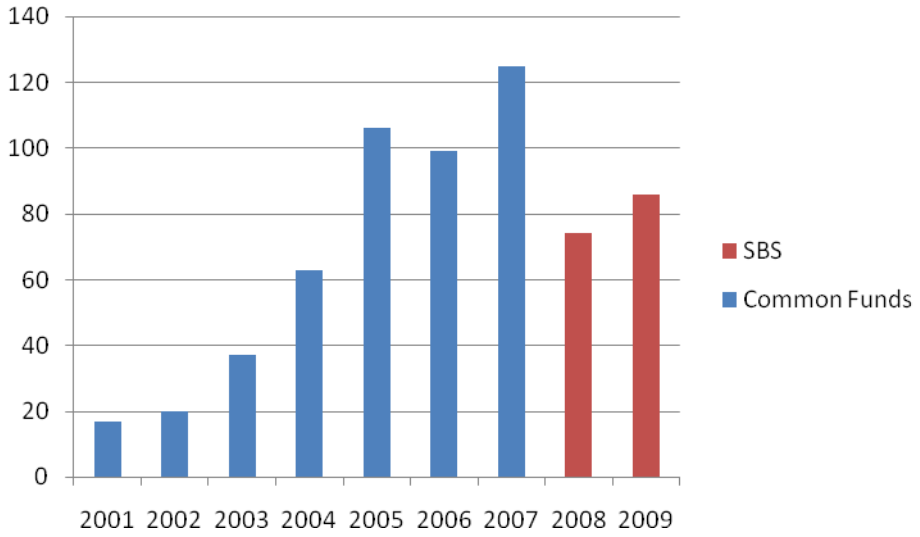
124. A number of big bottlenecks had to be addressed in moving from the three Common Funds to a single fund which only uses government systems. Stakeholders interviewed in the context of this study highlighted that this had been a long and cumbersome process – during which for some time it looked unlikely that there would be a breakthrough. The following is noted in a 2008 review of the sector: *"However full integration of these CFs into Mozambique's national systems and the merging of these funds into one programme aid modality e.g. sector budget support appears to be at least as difficult as it was in the case of traditional projects"* (Williamson et al. 2008). These difficulties resulted in a number of derogations from country systems being agreed, as discussed in Section 3.2.

125. In 2004 the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) decided to adhere to PROSAUDE I, in what was widely seen as a major success story given that this was the only country in the world where GFTAM money is placed into a common funding, on-budget arrangement. However, by 2008 the on-going challenges in trying to align GFATM procedures with those of the government (and the delays in disbursements which were resulting) led to a decision by MoH that GFATM would not be part of PROSAUDE II. However at the time of writing of this report, the situation with GFATM had yet to be solved. GFATM has made further transfers of money conditional on proper accounting of the funds that were transferred through PROSAUDE I. However, because these funds are common funds, it is not possible for the Mozambican government to provide accounts by donor.

Levels of funding

126. Over time common funds in support of the SWAp attracted more and more donors with increasing amounts of funding as confidence grew, as illustrated in Figure 9. The common funds within the health sector received varying levels of funding. From 2005 onwards the common funds saw an increased flow of funds; in 2005 year total common funds were higher than the State budget. In 2007 a total of 53 million US$ was allocated by DPs to PROSAUDE I, the Common Fund for Drugs received a total of 45 million US$ and the Provincial Common Fund 27 million US$. Allocations to Common Funds increased significantly in 2005, with much of the increase a result of the integration of GFATM into PROSAUDE I. Similarly, a major reason the level of SBS since 2008 has been significantly lower than Common Funds is because GFATM was not included in support to PROSAUDE II.

Figure 9: Volume of Common Funds and SBS (US$m)



127. A major achievement under PROSAUDE II has been that donors will be making commitments in the financial year prior to the provision of aid (year n-1). This should improve predictability of funding and allow for the government to improve its planning process. A major on-going concern however comes from delayed disbursements which have affected implementation for the past four years. The reasons for the late disbursements have been varied but each time these have had serious repercussions in terms of results and outcomes. In 2005 a problematic audit report which leaked to donors without MoH comment, resulted in a number of donors making late disbursements while awaiting clarification on the issues that had arisen. In 2007, 20 million US$ from GFATM was only disbursed in December of that year because of delays related to the process for requesting these funds. 2008 started well but there were further delays because of specific donor procedures (signing of bilateral agreements) and some donors (notably the EU and France) finally disbursing a total of 17 million US$ only in December of that year. The delays were in part due to the fact that the MoH has to send out a formal request for funding to each individual donor and that each donor has a different procedure for this (for example GFATM has a 14 page request form). And by October 2009, as was mentioned above, GFATM had not yet transferred funds because it was awaiting financial reporting on the funds which it had channelled through PROSAUDE I.

Earmarking, Additionality, and Financial Management Arrangements

128. Under the terms of PROSAUDE II MoU funds are not intended to be earmarked. In fact, the MoU, in paragraph 4.2, specifically guards against earmarking by stating that:

"PROSAUDE II funds will be used to cover all eligible expenditures, defined as being:

- *Consistent with the PESS;*
- *Consistent with the Annual Economic and Social Plan of the Health Sector (Health Sector PES), that has been formally presented and discussed with the CPs before sending it to MPD; and*
- *Reflected in the budget approved (or legally revised) by the Parliament (Assembleia da República).*

Under no circumstances *(emphasis by the author) should the CPs earmark their contributions within PROSAUDE II for specific activities. PROSAUDE II funds can be used for all budgeted expenditures within the sector, and need not be limited to the financing of expenditures classified as investment."*

Box 3: Earmarking, Traceability and Additionality

Earmarking is a requirement that all or a portion of a certain source of revenue, such as a particular donor grant or tax, be devoted to a specific public expenditure. The *extent* of earmarking can vary. It involves the *ex ante* assignment of funds to a particular purpose and can range from the very broad and general to the narrow and specific.

Traceability refers to whether donor funds are separately attributable to a specific use. Funds are either traceable, or not:

(i) **Traceable**, whereby allocation, disbursement and spending of funds is via specified and separately identifiable budget lines. This bypasses the normal procedure by which revenue is pooled with all other revenue in a general fund and then allocated among various government spending programmes. *De facto*, a traceable aid instrument must involve a degree of earmarking, although this may be very broad – this is often referred to as *real earmarking*.

(ii) **Non traceable**, whereby external funding is not identifiable by separate budget lines. If earmarked, the allocation of funds is justified against budget allocations to pre-agreed institutions or budget lines, and is pooled with other government revenues in the general fund. When non traceable SBS is accompanied by earmarking – this is often referred to as *notional earmarking*.

These two dimension combine to form three main types of SBS funding:

	Earmarked	**Un-earmarked**
Non Traceable	Non-traceable Earmarked SBS	Un-earmarked SBS
Traceable	Traceable Earmarked SBS	

Additionality refers to requirements from the donor that the provision of external funding earmarked to a set of expenditures leads to an increase in total expenditure allocations to those expenditures. Additionality attempts to address the problem of fungibility, which arises because government resources can be substituted for aid resources. If aid finances any activity that the recipient would otherwise have financed itself, the resources that the recipient would have spent on that activity become available to finance something else.

Source: SBSiP Literature Review

129. This was intended to represent a clear move away from the earlier common fund modalities – two of which were earmarked to specific priorities, and within which donors could earmark contributions for specific sub-priorities. Overall, within common funds, DPs in Mozambique have moved away over the past years from specific to broader earmarking. Donors mention that the Paris Principles and the monitoring of donor performance on harmonisation and alignment in Mozambique have played a role in this change.

130. For PROSAUDE II, funding is provided in two distinct ways, as mentioned previously. In order to address donor concerns about funding through the State budget being 'lost' to the overall budget at the end of the year, a system has been put in place by which funds are marked at the outset by donors as either internal or external funds. The MoU (July 2008) specifies that:

"The Ministry of Finance will treat the balances, i.e. the non-executed funds, in Meticais that have already been entered in the CUT, differently according to the coding of the funds following the indication of the different Cooperating Partners, accordingly:

1. *Those funds that were coded as internal funds on entry in CUT will be treated in the same way as the State Budget as they have become part of it;*
2. *Those funds that were coded as external funds on entry in CUT will be reinscribed in the budget of the health sector for year n+1 as additional external funds for the sector".*

131. As can be seen from the paragraph above there are a number of donors who do not want the unused end of year balances to be re-inscribed as treasury funds. The re-inscription is thus a way of appeasing these donors and to make sure that despite the fact that the balances are going

to be accounted differently, the funds will be managed through national systems and procedures. The PROSAUDE II external funds are recorded on budget under the external component of the investment budget but that it is also used to pay recurrent expenditure. With the new MoU the plan is to classify these funds as is done in the case of GBS. However, there are still problems of how to deal with unspent balances at the end of the year and this is still under discussion.

132. At present 10 of the 15 donors have asked for their funds to be coded as external funds. These donors are CIDA, the Catalan Agency for Development Cooperation, Irish Aid, SDC, Royal Danish Embassy, The Finnish Development Cooperation, the Flemish Ministry of Foreign Affairs, the Dutch Ministry of Development Cooperation, the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA). Five donors have indicated that their funds can be coded as internal funds, including the European Commission, the French Development Agency (AFD), the Spanish International Cooperation Agency, DFID, and the Norwegian Ministry of Foreign Affairs. For 2009 internal funds represent a total of 29 million US$ (roughly 30% of the funds so far committed to the sector).

Table 4: Disbursement Plan for Prosaude II (2009)

Partners	Currency	Commitment			Disbursement on 1st quarter 2009				Disbursement 3rd quarter of 2009
		Amount in Original Currency	Exchan ge	Amounts in USD (exchange rate of 15/12/08)	Amount in Original Currency	Exchan ge	Amounts in USD (exchange rate of 15/12/08)	disbursed until March 10	Amount in Original Currency
Canada (CIDA)	CAD	8,000,000	1.23	6,504,065	**3,000,000**	1.23	2,439,024.39	2,326,844	1,000,000
Canada (CIDA)**	CAD		1.23		**4,000,000**	1.23	3,252,032.52		
Comissão* Europeia**	EUR	8,000,000	0.74	10,810,811	**0**	0.74	-		8,000,000
Cooperação Flamenga****	EUR	3,000,000	0.74	4,054,054	**2,000,000**	0.74	2,702,702.70	2,699,174	1,000,000
Dinamarca	DKK	25,000,000	5.51	4,537,205	**12,500,000**	5.51	2,268,602.54	2,154,466	12,500,000
Espanha	EUR	3,000,000	0.74	4,054,054	**0**	0.74	-		3,000,000
Finlândia	EUR	6,000,000	0.74	8,108,108	**0**	0.74	0		6,000,000
FNUAP	USD	500,000	1.00	500,000	**500,000**	1.00	500,000.00	500,000	-
França	EUR	3,000,000	0.74	4,054,054	**3,000,000**	0.74	4,054,054.05	3,800,469	-
Generalitat de Catalunya*****	EUR	500,000	0.74	675,676	**0**	0.74	-		500,000
Holanda	USD	3,500,000	1.00	3,500,000	**3,500,000**	1.00	3,500,000.00		-
Irlanda	EUR	17,600,000	0.74	23,783,784	**17,600,000**	0.74	23,783,783.78		-
Italia	EUR	-	0.74		**-**	0.74			-
Noruega	NOK	-	6.88	0	**-**	6.88	-		-
Reino Unido (DFID)	GBP	7,000,000	0.66	10,606,061	**3,000,000**	0.66	4,545,454.55	8,464,200	4,000,000
Suíça	CHF	4,000,000	1.17	3,418,803	**2,000,000**	1.17	1,709,401.71	1,727,115	2,000,000
UNICEF	USD	1,200,000	1.00	1,200,000	**1,200,000**	1.00	1,200,000.00	1,200,000	-
Total	**USD**			**85,806,675**			**49,955,056**	**22,872,268**	

* MISAU to determine the distribution of funds between Forex Account in Mozambique and Credit Suisse Account in Switzerland

** CIDA can disburse CAD 4M in the first semester after the signing of new bilateral agreement.

*** The European Commission (EC) can only spend in 2009 after signing the Financial Agreement of the new program (1 quarter 2009). All disbursements of EC are conditional on the3 eligibility criteria for budget support: 1) there is a strategic plan of the health sector formally approved, responding the challenges and health problems in the country, 2) a macro-economic policy is implemented with attention to private sector development, 3) that Mozambique shows a progress in implementing reforms in public financial management.

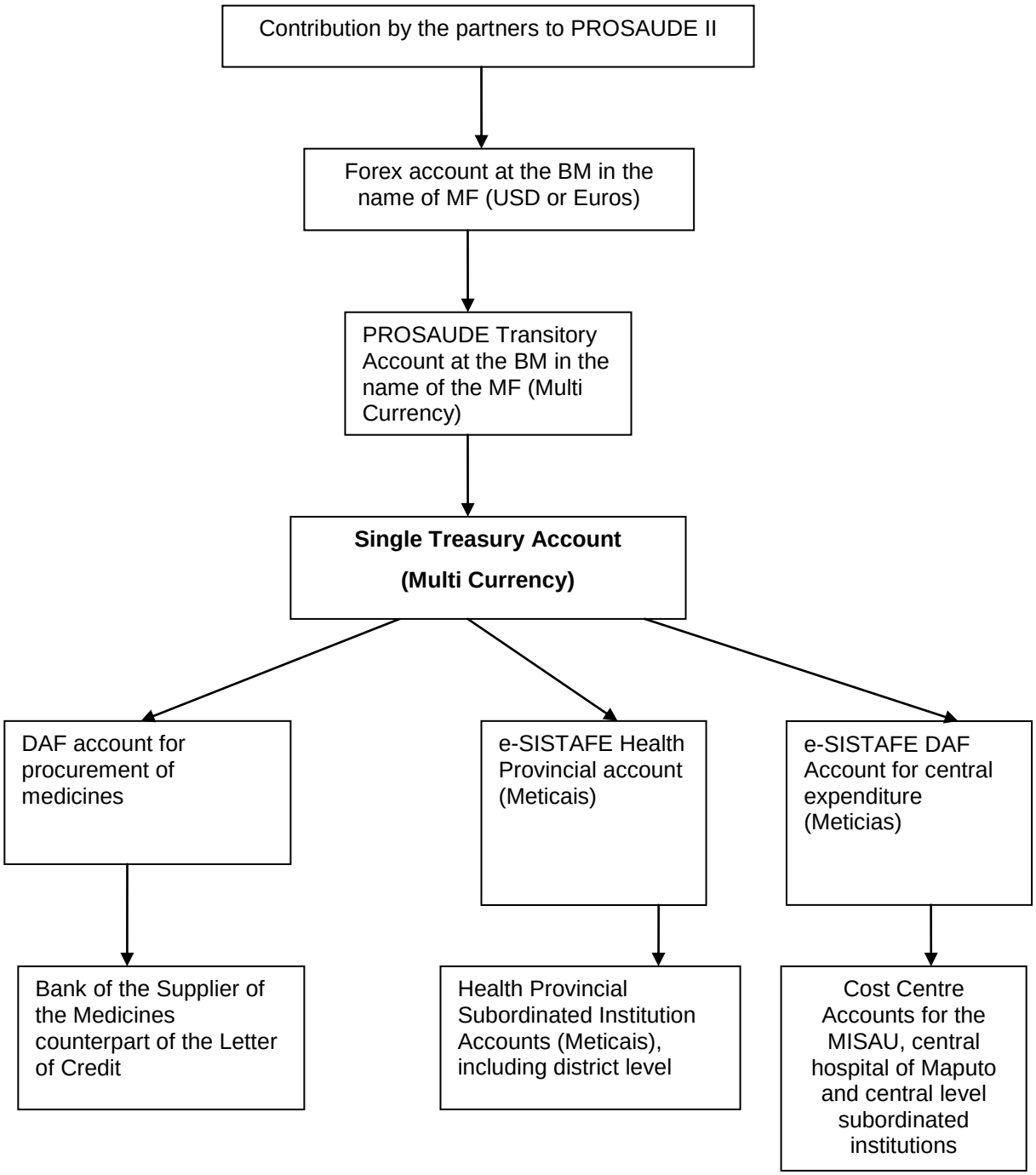
**** The 2nd release of Flanders / FICA is conditional to the beginning of the implementation of the Plan of Development of Human Resources (FICA needs to receive a formal letter of MISAU)

***** A Generalitat de Catalunha can disbursed in April / May after the signing of the new Arrangement

133. Whilst the provisions for tracing donor funds are there, there are no specific requirements in place for additionality of SBS funding to government state budget allocations.

134. However, the MoU has yet to be implemented in the spirit in which it was planned. In both the 2008 and 2009 budget both internal and externally classified SBS funding were still classified and separately identifiable in the investment budget. Therefore, *de facto,* SBS is traceable and earmarked to the investment budget – in a very similar way to the Common Fund in support to PROSAUDE I.

Figure 10: Diagram of the Final Financial Flow Mechanism for SBS Funding to the Health Sector in the Context of Mainstream Budgetary Channels



(From PROSAUDE MoU July 2008)

135. PROSAUDE uses the national public financial management system, the SISTAFE Law and Regulation (Law 9/2002 and Decree 23/2004). Under PROSAUDE II all funding from donors is channelled from a Foreign Exchange Account through a transitory account to the Single Treasury Account (known by its acronym CUT) and from there to the Ministry of Health using e-SISTAFE (the electronic management system for government funds). In 2008 84% of SBS budgeted SBS funds were disbursed (Ministry of Finance 2008 – in MT terms). Table 4 (above) provides an overview of disbursement plans to PROSAUDE II for 2009.

136. The financial procedures were intended to be aligned "as much as possible" (MoU, 2008, p.6) with the Government's financial management system. This includes three key aspects:

- Annual joint monitoring and evaluation of performance of MISAU and the CPs against agreed targets for the implementation of the PESS and the annual PES;
- Common procedures for commitment and disbursement on the part of the CPs;
- Procedures for planning, budgeting, reporting and auditing.

137. Under the current arrangement there is still a parallel channel for the purchase of medicines internationally (not reflected in Figure 10 above). The July 2008 MoU explicitly foresees that these for now still parallel channels will be integrated into one flow of funds which will follow GoM normal procedures, via the Single Treasury Account. Therefore Figure 10 illustrates the situation as it will be once procurement of medicines also takes place via CUT.

138. Procurement will be done through the MoH Management and Execution Unit for Procurement (UGEA) using the Procedures Manual on Procurement developed by the Ministry of Finance based on Decree 54/2005 and related administrative instructions. In practice this means that procurement will follow strict government procedures and regulations. The exception to this is for the procurement of drugs.

139. The MoU foresees that for specific issues, which are not part of the existing regulations and documentation, the MoH may develop its own complementary norms on procurement which would be approved through a Ministerial Decree. The MoU specifies that the drafting of these norms *"will be the responsibility of MISAU with support from the CPs, and (that) the approval of the Ministerial Diploma will be the responsibility of the MoH and the Ministry of Finance"* (MoU, 2008, p.11).

Conditionality and dialogue

140. Disbursements are based on an overall 'satisfactory performance' of the health sector against the agreed indicators. Assessment of performance takes place through the annual joint reviews (the ACA). In this context the July 2008 MoU specifies that:

"Targets for the health sector's performance in year n+1 will be agreed between MISAU and the CPs as part of the year n planning process, and progress against them will be assessed through the ACA process, including the Health Sector PAF, in year n+2. The Signatories will attach the agreed Health Sector PAF to this MoU annually as an updated annex (see Annex 2)."

141. The health sector PAF includes a total of 37 indicators, which fall in 14 broad areas of focus. Table 5 provides an overview of the summary of these indicators and their corresponding objectives (for the complete Framework see Annex 5). A detailed technical document has been drafted providing details of each of the indicators and how these will be measured.

Table 5:Summary of the PAF Framework for the Health Sector

Objective	Indicator
Reduce child and youth mortality	Rate of child and youth mortality
Reduce the acute malaria incidence rate amongst children below the age of 5 years	Acute malaria incidence rate amongst children below the age of 5
Reduce the rate of acute malaria incidence amongst children below the age of 5 years	% of pregnant women and children below the age of 5 years that sleep protected by REMTILD (Mosquito Net Treated with Long-Lasting Insecticide)
Reduce the tuberculosis prevalence rate	Tuberculosis prevalence rate
Reduce the risk of mother to child HIV vertical transmission	% children below the age of 2 years infected with HIV
Increase the nº of patients receiving antiretroviral treatment	% of adults eligible to treatment receiving combined ARVT according to the country's protocols
Contribute to reduce the HIV prevalence rate amongst the youth aged between 15 - 24 years	Average HIV prevalence rate amongst female pregnant youth aged between 15-24 years
Increase the access to healthcare and reduce the iniquity in its consumption	% of the population with easy access to one health facility (< 30 minutes on foot)
Increase the access to healthcare and reduce the iniquity in its consumption	Ratio of external consultations per inhabitant between the rural and urban districts
Improve the availability of resources that contribute to enhance the quality of the health services offered to the population at all levels	% of Health Facilities that have water and electricity supply services
Strengthen and improve the health sector planning processes and instruments	% of teams (collective boards in districts trained and with capacity building in planning)
Strengthen and improve the financial management in all its components and at all levels in the health sector	Expenditure executed as a % of the approved budget for the health sector
Strengthen and improve the financial management in all its components and at all levels in the health sector	% of audits conducted with UNQUALIFIED OPINION
Improve the predictability of the external funds for the health sector and promote the harmonization between MISAU and the cooperating partners	% of bilateral and multilateral partners with multiannual financial commitments (at least 3 years)

142. Satisfactory performance is also linked to performance in financial management for which specific indicators are included in the health sector PAF. The 2010 ACA will be the first Annual Joint Review related to PROSAUDE II. This will be a critical moment and will make it possible for stakeholders to assess specifically how pertinent and helpful these indicators are in practice, and in particular to what extent the arrangements make it possible to reach a consensual judgement on performance. It should be noted in this context that the interviews conducted for this study highlighted that there was considerable variation among donors as to what would constitute a reason for concern with respect to performance, and at what point this would trigger decisions to revise funding commitments to PROSAUDE II.

143. The EC is the only donor which has specific conditionalities and these are specified in Annex 1 of the July 2008 MoU. The conditionality consists of a split response system for its financial contributions with a fixed and variable part. The financial commitment for the year n+1 will be based on performance in the year n-1. The variable contribution is related to two specific targets selected from the PAF and agreed with the MoH, namely:

1. The rate of coverage of institutional births.
2. The rate of budget execution of funds under MoH management.

144. Both targets will be measured through the joint annual health sector review (the ACA) and the assessment of the implementation of the PESS. They do not involve separate monitoring mechanisms.

145. The agreement further specifies that achievement will be based on a scoring system, where '1' will be for a target that has been fully met and '0' for a target that has not been met. The weight of each of the two indicators is 50 percent. The total score for the indicators can thus be 2, 1 or 0.

146. The MoU includes specific conditions with respect to the conducting of annual PFM assessments which aim at assessing how this area is developing. This is an area of critical concern to donors. A baseline assessment is ongoing. A draft Action Plan to strengthen PFM is also being prepared and annual follow-up studies will be conducted. The PROSAUDE II MoU foresees that these annual assessments would feed directly into the ACA. Depending on the results of the PFM assessment, rapid situational assessments may also be carried out, the results of which would feed directly into a financial management strengthening plan to ensure follow-up can be monitored on an on-going basis. The MoU also contains a provision that any donor can request an additional audit if there are good arguments to do so.

147. A number of donors expressed particular concern about weak financial management and considered it likely that such extra studies would necessary. However, they also highlighted a weakness of the MoU, namely that it does not specify whether and how the MoH would have to move forward on the recommendations of such studies.

Links to TA/Capacity Building

148. PROSAUDE II (and the common funds that existed before it) has no in-built capacity building components, nor does it have explicit links to TA and Capacity Building programmes. It was designed in the absence of a detailed analysis of human resource capacity needs. The DPs who were interviewed during this study acknowledged that this had been an issue which had been temporarily left aside because of the complexities in reaching consensus on other issues. This has now been addressed through the drafting of the HRDP.

Harmonisation and Links to other Aid Modalities

149. Harmonisation has however been successful in some respects:

- Common funding has allowed the MoH to cover gaps in resource allocation. This has gone hand in hand with a strengthening of operational plans and budgets.
- There has been agreement on a set of common indicators for assessing progress against the PESS.
- Procurement has been harmonised (with the exception of medicines) to follow the government procedures.
- Audits have also been harmonised, again using government procedures.

150. As part of harmonisation efforts DPs have established a technical position of health SWAp coordinator (for the donors). This person is funded by DFID and has an office within the Netherlands Embassy. Her duties are to support the coordination of dialogue among donors.

151. Links have been developed with other aid modalities, in particular with GBS. As was mentioned earlier, for GBS there is an elaborate structure of dialogue fora linked to an agreed annual calendar of events which includes annual joint review of progress and which is designed to fit GoM's annual planning and budgeting cycle. In the context of GBS, meetings with the government take place twice a year and are timed to coincide with the government's annual budgetary cycle. In March/April the Joint Review takes place to look back at progress and plan for the next calendar year, and in August the meeting reviews indicators and make necessary adjustments. The sector review processes (and this is the case in the health sector) have been revised to fit in with this calendar and this provides one important means of linking SBS dialogue with GBS.

152. The PAPs' structure for dialogue comprises the Heads of Mission group (HoMs), the Heads of Cooperation group (HoCs) and the Economists Working group (EWG). Additionally, there is a PAF coordination group, chaired by the troika HoCs and formed by the representatives of Sector

Working groups (SWG) and cross-cutting reform groups relevant for assessing PAF performance. The Troika plus at HoCs level has the mandate delegated by the HOMs group to represent the group as necessary, and prepare and facilitate the PAPs' decision making process associated with the implementation of the MoU. A secretariat is in place to assist the PAPs in the dialogue between them and with the government through provision of supporting services and facilitating information sharing.

153. The overall PAF is a second instrument for linking SBS with GBS. Through it progress is monitored against 40 indicators under main headings including procurement, audit, macro-economic developments, governance, health, education, water, and crosscutting issues. This PAF serves as the shared instrument for dialogue, for assessing government's performance in the previous year and for donors' support commitments for the following year. It captures government priorities across the PARPA into measurable indicators for each of the pillars and sectors. The overall PAF contains a selection of indicators for the health sector (a total of five indicators).

154. The third instrument for linking SBS and GBS is through the working groups which fall under GBS – akin to the system of working which exists in the health sector. The working groups are the core mechanism for analysis, technical dialogue, monitoring, assessment and reports. The participants at technical level include representatives of the respective Ministry/Ministries or relevant GoM agency/agencies responsible for that sector, and of the donor agencies providing support to that sector. The working groups are chaired by the relevant Ministry or GoM agency, and co-chaired, on the basis of rotational selection, by one of the donor agencies providing Programme Support to the sector. The working group for health thus includes participants who are also part of the SBS coordination and dialogue structures.

155. Nonetheless, the process is not yet working entirely smoothly. In practice there are deficiencies in how the dialogue functions between SBS and GBS. This may be in part because some of the provisions relating to the linkages between GBS and SBS have only recently been formalized in the revised MoU for GBS (March 2009) and therefore will need time to produce effects. Issues noted during the present study include, for example, that at GBS level senior agency representatives participate (heads of mission and/or heads of development cooperation). However, various stakeholders interviewed for this study highlighted that the level of information sharing between agency staff working on SBS and the heads of mission was not always optimal resulting in conflicting positions being taken with respect to the two aid modalities. Also, as noted by the evaluation of GBS in Mozambique (Batley et al., 2006), sector support programmes remain managed largely in isolation from GBS, further contributing to the lack of information and dialogue between these. Nonetheless, the same study also noted that there has been a level of learning from sectoral experiences to GBS and vice versa as shown for example through the sharing of MoU and the adaptation of these to ensure they are in conformity with each other.

Prospects for the future provision of SBS

156. It is too early to say what the prospects are specifically as SBS has only just started. Although vertical funding is seen with some concern, due to its substantial amount of funds which continued to increase, some positive trends in regard to SBS were observed. Although the absolute amount of vertical funding is higher then that of common funds, available data show that from 2001 to 2007, while the amount of vertical funds only doubled, the common funds increased seven times. Moreover, the number of donors joining common funds increased from only nine in 2003 to 17 in 2009. It also has to be noted that some donors may decrease their participation or even quit the SBS as a result of their increased participation in GBS.

157. Attempts to get GAFTM to integrate into PROSAUDE II failed because GAFTM is unable to do away with the in-year triggers which are at odds with the requirements of SBS (in 2007, for example, this resulted in other donors having to front load their commitments to fill gaps because

the GAFTM funds had not yet been transferred) and as a result GAFTM is not a signatory of PROSAUDE II. As Mozambique did not qualify in the GFATM Round 8 for new AIDS money, there is a serious concern as to how Anti-Retroviral Treatment (ARVs) will be paid for from 2010 onwards. This underscores the need for and importance of having flexible funding available and makes it even more critical for SBS to continue to be in place.

158. For donors, future provision of SBS will depend on progress with PFM and progress against the agreed indicators. In this context, the first audit of PROSAUDE II will be available in 2010. Many donors see this as an important moment.

3.2 Derogations from Country Policies, Systems and Processes

SQ3.2: To what extent have SBS inputs derogated from country policies, systems and processes and are these a result of country specific concerns and/or headquarter requirements?

159. The Common Fund arrangements included a number of derogations from country systems, in particular in relation to funding and financial management arrangements. Some requirements associated with the SWAp and common funds which were initially derogations from government systems have become part of the annual planning and budgeting cycle. The most obvious one is the ACA, the Joint Annual Review which is now planned in such a way that in terms of timing, structure and focus it allows for Development Partners (DP) to participate in the assessment of progress and to make clear their commitments for the next year in time to feed into the planning and budgeting process of the government.

160. There were a number of issues of concern to donors during the process leading up to the signing of the July 2008 MoU for PROSAUDE II SBS. These included:

- The need to ensure that the funding provided to PROSAUDE II would stay in the health system, rather than revert to the overall government budget as a 'left-over' at the end of the year.
- The weak financial management systems and the lack of insight into, and influence over, how these could be improved.
- The weak capacity of the government's internal and external auditing systems.
- The need to protect funding for essential medicines and to protect other priorities such as an equitable budget allocation to different provinces.
- Low absorption capacity which – although gradually improving – has highlighted that the sector needs much more than just funding to be able to make substantial progress in access and quality of basic health care.
- Concerns around capacity and human resources in the sector.
- The lack of prioritization in the PESS which as a policy document essentially lays out the situation but does not provide sufficient prioritized strategic guidance for implementation.
- The poor quality of the indicators and of the data generated within the health system, making monitoring of outcomes, results and impacts a substantial challenge.

161. A number of these issues have been addressed in the MoU for PROSAUDE II, through the creation of specific derogations. These include:

- Funds for medicines and medical supplies do not yet pass through the Single Treasury Account and there are specific external audits over the procurements process by an independent firm. This is in order to minimize disruption of stocks and to guard against possible corruption.
- Bilateral agreements prevail over the MoU, but donors agree to eliminate exceptions over time.
- Internal funds are treated the same as the State Budget (OE), and externally labelled funds are treated as sector funds and are inscribed back into the budget in year n+1.
- In exceptional circumstances donors may undertake independent evaluations and audits.

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162. As mentioned earlier the EC is the only agency that has conditions separate from the overall SWAp/SBS process, using a split response mechanism, with fixed and variable portions and with a financial commitment for year n+1 which is based on performance in year n-1.

163. As will be further explored below, a lack of understanding among some of the agencies on what SBS is and on the specific position of their HQ with respect to the mechanisms for providing SBS appears to have led to unnecessary derogations and has made the dialogue more difficult than it might otherwise have been. Furthermore, it is important to note that the MoU has not been fully implemented as planned. Most notably SBS inscribed as government funding still appeared in the investment budget in 2009, which has meant that in practice the changes have not been significant from PROSAUDE I.

164. Nevertheless, in other aspects SBS inputs have been well aligned with national systems and processes, both in terms of the financial aspects such as budget preparation, execution and monitoring, as well as on non-financial dimensions such as the planning and overall monitoring and evaluation process. The relatively long history of working towards SBS and GBS has generated increasing commitment among donors to greater harmonisation and to a corresponding reduction of transaction costs.

3.3 The Effects of SBS on the Quality of Partnership in the Sector

SQ3.2: Has SBS contributed positively to the quality of partnership and reduction in transaction costs between development partners, the recipient government and civil society?

Quality of the dialogue

165. Overall coordination and dialogue between partners works reasonably well. Civil society has been involved more actively recently, although a number of civil society actors (CS) interviewed for this study highlighted that they often felt their participation was rubber stamping (as evidenced by receiving invitations and documentation for key events in the sector very late, making it difficult to comment and contribute) and that their effectiveness in being part of the dialogue is limited by lack of capacity and coordination among CS itself. CS also noted that their participation is less effective because information on meetings and related documentation is received late, making it difficult for them to work towards a common position. Dialogue has also increasingly involved other government sectors, and in particular the Ministry of Planning and Finance.

166. Some donor partners also noted difficulties in participating in discussions because of delays on the MoH side in providing necessary documentation (specific provisions on minimum times for sending out and reviewing documentation are part of the MoU but do not seem to be followed). Partners who are not involved in the Sector Coordination Committee (SCC) also note that their capacity to engage is limited because their only reasonably frequent area of interaction with the MoH is their participation in the working groups. Recently a discussion has been started among the donors on the number of working groups, with some arguing in favour of reducing these because of excessive time spent in meetings, and a disproportionate burden on the government. However, on the government side, observations from this study made it clear that transaction costs for government have reduced as a result of the streamlining of coordination and the reduction overall in the number of meetings. The MoH in particular noted that working groups have been important, although to a varying extent and with varying levels of input.

167. Specifically on the donor side interviewees noted that an important barrier has been the lack of consensus around terminology, in particular with agencies having very different interpretations of SBS. And on a related point, for a number of agencies there was insufficient clarity at field level on procedures and processes and on what would constitute an acceptable

'formula' of support. These issues were highlighted as having considerably delayed and complicated the process of moving towards SBS.

168. In general, parties interviewed for this study felt that the quality of dialogue had improved. However, it was also noted that the nature of the dialogue had changed, with the MoH claiming more time for internal reflection and discussion than it used to (this reflects a change in senior management of the MoH and within GoM as a whole – see also the case study on the Agriculture Sector which presents a similar finding). The discussion with donors through the focal point (i.e. having meetings with the focal point rather than the full group of donors) is seen by the MoH as a very useful development which has reduced the amount of time spent on discussions and also improved the balance of power (previously the dialogue with donors would be with the full group, compromising the leadership of the MoH). The system was also seen as helpful because it obliges donors to take a position on issues (in donor meetings prior to the meetings of the SCC) and therefore promotes greater alignment. On the other hand, some development partners were critical about the focal point system. The rotating nature was seen as problematic because it can lead to changes in quality and engagement over relatively short periods of time[5]. Also the 'privileged' position of the focal point can lead to this donor using the position to advance its own agendas because it has access to those in power. A number of recent examples of this were given by DPs interviewed during this study.

169. There is a generalized perception among development partners and MoH officials that mechanisms for dialogue have not always worked to desired standards. An important recurring concern (signalled in the review of the SWAp in 2004 but also mentioned during the current study) is the lack of consistency between official commitments and behaviour both on the side of the MoH and on the side of the donors. For the MoH the most frequent concern mentioned is the failure to follow up on recommendations made in reports and reviews. And this has become more critical in the past two years now that the MoH has become more internally focused. On the side of development partners, a frequently mentioned issue is the lack of follow up on official commitments to improve predictability of aid. Harmonization was also mentioned in 2004, but is seen as less of an issue now.

170. Another important point that was brought forward by stakeholders on all sides is the strong focus of the dialogue over the past few years on the technicalities of the mechanism for SBS rather than on policy and substantive issues related to implementation and to progress. This means that dialogue remains stuck in operational issues around CFs in particular and in the more recent period around mechanisms for moving from the three CFs to SBS. This was also noted in a recent three country study on the effectiveness of Aid delivery at the sector level (Williamson et al., 2008).

171. The comprehensiveness of the dialogue has evolved to become more inclusive. Participation by civil society has reportedly improved in general, with civil society now being part of key consultation and discussion fora. However, there are still considerable challenges to full-scale civil society participation.

Transaction costs

172. Government and civil society actors interviewed for this study spoke consistently of a reduction in transaction costs. In particular the number of meetings that needed to be held by GoM with donors was cited as having gone down. Mechanisms for consultation were considered more efficient (for example, various agencies 'share' economists).

[5] The focal point position has recently been expanded from one to two years to address this concern and outgoing focal points are expected to continue participating in the monthly meetings with the MoH and in other consultation fora to ensure a smooth transition.

173. On the other hand, it appears that there have also been increases in transaction costs, for example those related to the functioning of the SWAp working groups. The message around the working groups was thus not a consistent one. Donors considered them important for staying involved and for being able to influence certain priority agendas. But not all working groups are equally efficient and there is nothing that binds the MoH to following up on the advice of the working groups. GoM also mentioned that working groups were very important, in terms of technical input and to allow all the partners to keep a finger on the pulse.

174. In addition, donors who have wanted to continue placing emphasis on certain priority agendas and concerns have also done so through continuing to fund specific parallel projects and programmes. In fact most of the main PROSAUDE donors to the health sector continue to have parallel programmes and projects, although a number of these will be closing down in the next year or two (e.g. for DFID and Norway).

175. A number of reasons for continued affinity to separate projects/programmes were mentioned during the interviews and include:

- The need for the donor agency to inform its own understanding of reality on the ground.
- The importance given by specific donors to addressing concerns which they feel might otherwise be neglected, in particular because of the lack of clear strategizing and prioritization in the PESS (this is the case, for example, of Danida's support to capacity building).
- Generating innovative practice that can feed into the overall reform of the health system.
- Visibility – providing something to 'show' at home, and to share with visiting dignitaries.
- Ensuring that funding goes to civil society organizations to strengthen their capacity as a partner for dialogue and implementation.

176. The bilateral consultations in the context of these projects take up government time and energy. Donor behaviour in this context is still rather problematic. Donors continue to field separate missions in a way that is not always coordinated.

Lessons learned

177. A number of lessons emerged from the process of moving towards SBS, including:

- The importance of ensuring that there is a joint understanding of concepts and principles – in practice in Mozambique agencies and other actors have had very different understanding of what SBS means and this has held back the process.
- The need for donors to learn about HQ position and rules. Donors often do not understand procedures and processes, not even their own internal ones. SBS processes therefore require close dialogue and consultation between field offices and HQ – this needs more time and deliberate effort.
- The move towards measuring performance, rather than considering in-year triggers as conditions for disbursement, represents an important shift in the way in which donors function and was very difficult to achieve.
- Framing of issues is very important. For many donors handing over responsibility for audits to the administrative court was a major sticking point. It was necessary to present the advantages of doing this – i.e. allowing for a full vision of the sector rather than a partial (and possibly distorted one) and linking this clearly with other efforts by DPs to strengthen government systems.
- The Government's capacity and willingness to hold donors accountable is critical, both with respect to their financial commitments, and also with regards to their behaviour.
- Examples from other countries can be useful in reflecting on how to move forward.

- Hard decisions need to be taken at times to move processes forward. Striving for inclusiveness of all partners may lead to a 'lowest common denominator approach'.

178. Challenges:

- The number of donors has been a challenge – for government it has been difficult to understand and navigate donor differences and it has been a steep learning curve for the government.
- The preparation process and actual implementation of the new MoU for SBS has been very slow and has dominated dialogue in the SWAp.
- The turn-over of staff within agencies has affected progress toward the current MoU because the dynamic was lost.
- Many agencies' representatives are not necessarily experts in the key areas that are being discussed in coordination fora around the SWAp and SBS, as well as in the working groups.
- Visibility of the results of aid contributions through SBS continues to be a major challenge for a number of donors, including those who are very committed to budget support.
- Late disbursements are a major issue and dramatically affect the planning and implementation capacity of the MoH and have a direct impact on the achievement of results.
- Effective exchange of information is essential to good dialogue and confidence between partners. The importance of this appears often to be underestimated by partners.

4. Sector Budget Support and its Effects in Practice

179. This section of the report is intended to examine the effect of SBS in practice on a number of important dimensions of policy, planning, budgeting, monitoring and evaluation, procurement, accounting, auditing, service delivery, ownership, incentives and accountability. 'Full' SBS to the health sector in Mozambique had not yet completed a first year cycle at the time interviews were conducted and analysis of the effects is therefore premature. This section of the report therefore focuses primarily on the effects of the SWAp, and associated Common Funds during the period running up to the signing of the PROSAUDE II MoU in July 2008. In doing so this section draws on earlier assessments cited in the bibliography (including Martinez, 2006; Vinard & Muquinigue, 2008; and Williamson et al., 2008) as well as on the interviews done for this study in December 2008. It also attempts to identify whether the SBS programme design responds to the weaknesses of common funds and SWAp in the areas assessed.

4.1 Influence on Sector Policy, Planning, Budgeting, Monitoring and Evaluation Processes and Sector Expenditures

SQ 4.1: What has been the influence of SBS on Sector Policy, Planning, Budgeting, Monitoring and Evaluation Processes, and what are the constraints faced and lessons learned in practice?

180. Working towards SBS has impacted on planning and budgeting processes and on monitoring and evaluation. The impact has been less on policy where the lack of clear prioritization, and the absence of integration of the various national and sector plans in the sector continue to be a challenge.

Sector policy

181. An achievement at the sector policy level has been the institutionalisation of channels for joint policy dialogue between GoM and donors, which are closely linked to the structures for national dialogue and decision making. These have helped to develop a common vision for the sector on certain issues – such as the desirability of providing SBS over individual donor funding – and have begun to tackle the problem of coordination of development interventions by government and donors. These channels are for all SWAp donors, and not just for donors providing budget support, and have contributed to bringing a large number of donors on board in the SBS process.

182. However, overall, there has been too little systematic attention to policy issues. There are various reasons for this. An important one is certainly that the focus of much of the dialogue in the past two years among the stakeholder group as a whole has been on procedures and mechanisms for funding flows, and on putting in place a framework for monitoring progress. Other reasons – cited by persons consulted during this study – include shifting capacities within donor agencies (more generalists, fewer technical staff), and capacity, willingness and leadership issues within the MoH.

183. Working groups are supposed to be the main vehicle for technical work in the context of the SWAp. Although some working groups function reasonably well, there are issues of linking the work of these groups to processes for policy refinement and decision making. In addition, many donors – with the exception of the former and current focal points – expressed the opinion that they do not have as much interaction and 'power' of discussion with the MoH as they would formerly have had under bilateral arrangements. The current management of the MoH is less open to sharing policy dialogue and has limited the frequency, scope and duration of policy discussions

with DPs This creates challenges for donors who find themselves with limited options for influencing policy and priority setting in the sector while still voicing considerable concerns about issues such as policy choices, centralization of decision making, and equity issues. There are a number of examples of key decisions that are made by the senior MoH officials without any real dialogue with key partners.

Planning and budgeting

184. The SWAp process has overall contributed to some modest improvements in planning and budgeting processes. There has been substantial progress from the time when the SWAp was first established – when it was characterized by a proliferation of vertical programmes and projects and very little on-planning or on-budget external funds – to a more cohesive system.

185. Overall there has been a clear effort by Common Fund and now SBS donors to align with national processes for planning, budgeting, reporting and monitoring performance. This has not been the case for those that continue to provide vertical funding, although the GFATM is credited with having tried. Also, predictability has improved through alignment of donor and GoM planning cycles, allowing for greater clarity on funding. There has also reportedly been progress towards better inter-ministerial dialogue, for example on when to inform disbursements for n+1 in year n, on processes and times when such information must be updated, and also on the provision of information for the national MTEF.

186. The timing has also been worked out so that donor commitments can fit into the national planning process, allowing for a longer term vision by the government on planning and budgeting priorities. The national PES and Budget are now prepared at the same time and the Annual Review in the Health Sector happens when the PES and the state budget (the *Orçamento do Estado* or OE) need to be informed of the commitments of donors. These changes represent significant improvements with potential impact on progress in the sector. The extent to which this will happen remains to be seen.

187. The PESS is considered very broad and not sufficiently prioritized. In many ways this PESS II is as much a first generation health sector strategy as the first one (Martinez, 2006). The plan provides a medium term agenda but is very broad and insufficiently distinguishes desirable actions from the priority ones. The plan has also been criticised for focusing too much on central level priorities, and for giving too little guidance and scope for provincial implementation.

188. The Plan is still, however, a key reference document and has helped guide discussion on planning and budgeting. The recent budgeting exercise of the PESS points this out but also highlights the limitations of the document by stating: *"the results (of the budgeting exercise) lead to the conclusion that an evaluation of the plan's practicability needs to be carried out, taking into account existing limitations at various levels which may affect the implementation of activities"* (Tyrrell and Warrell, 2007).

189. A major step has been made also with the costing of the PESS in 2007. However, this costing exercise has highlighted the need for a more realistic assessment of capacity in the sector. The costing exercise shows a large and growing shortfall in the coming years, increasing from 97 million US$ in 2007 (the first year of the PESS) to over 165 million US$ in 2012. These estimates do not include the considerable costs of the recently launched human resource development plan.

190. This raises another problem – that there are still too many health plans co-existing with PESS II. The existence of various planning documents exacerbates the lack of clarity on priorities for the sector.

191. In spite of some of the positive developments with respect to budgeting, the national health budget (which is part of the state budget) continues to suffer from systemic weaknesses, as a result of which:

a. Input-based budgets cannot be related to plans and the new programmatic classifier is difficult to link to existing plans;
b. Ceilings for goods and services in the recurrent budget are based mostly on estimates derived from previous year's allocations;
c. The domestic budget allocations, which are dominated by recurrent budget allocations, appear unrelated to the investment budget which comes mostly from DPs;
d. DP funding earmarked to the sector, including common funds and SBS, appears in the investment budget, but supports significant volumes of operational spending.
e. Linkages between approved budgets and actual expenditure is weak.

192. Another area of concern is that planning and budgeting at provincial level are in practice very difficult. In spite of the decentralization process the MoH (as is the case with many other sector ministries) continues to be very centralized (especially with respect to the investment budget) and much of what happens at provincial level is therefore a result of orientations received from central level. At provincial level, PROSAUDE I has paid a part of personnel costs (recurrent expenditure) but this has been a centrally managed process. Weak capacity at provincial level (namely on procurement issues) exacerbates this problem. Furthermore, a lot of funding is provided outside of provincial plans (e.g. by NGOs, but also by the same DPs who are part of PROSAUDE II), which continues to create incentives for provincial authorities to engage with donors rather than government in order to meet immediate needs for inputs or funds.

193. In general, therefore, there has been some progress in improving the planning process, in particular in linking it to the national processes. Budgeting also has improved. However, significant areas of challenge remain which will need to receive priority attention by government and partners in the coming years.

Monitoring and reporting

194. Monitoring and reporting processes have been streamlined. Progress has been made from highly fragmented project-based monitoring to common processes for the sector as a whole.

195. Monitoring of the SWAp and of PROSAUDE II is based on the health sector PAF framework which has represented a move away from how things were done previously. Reporting now takes place against a common set of indicators and based on a dialogue between sector and DP. The health sector PAF matrix includes key targets and input, output, impact and process indicators. Efforts have also been made to integrate HIV/AIDS indicators into the PAF (until now seen as a cross cutting issue in the matrix). The process is seen as quite robust by DPs and as representing significant progress.

196. SBS donors use the ACA as the main instrument to assess performance in the sector and in order to take disbursement decisions for the following year. The ACA, which started out as a donor requirement, has been integrated in the national budgeting process. Progress has also been made towards establishing good linkages with national planning processes through the PAF.

197. Nonetheless, a problematic issue has been that between Joint Annual Reviews issues that are identified as requiring attention are not necessarily followed up. In part this is because of the sheer number of recommendations, and the lack of prioritization of the numerous recommendations which emerge from each annual review.

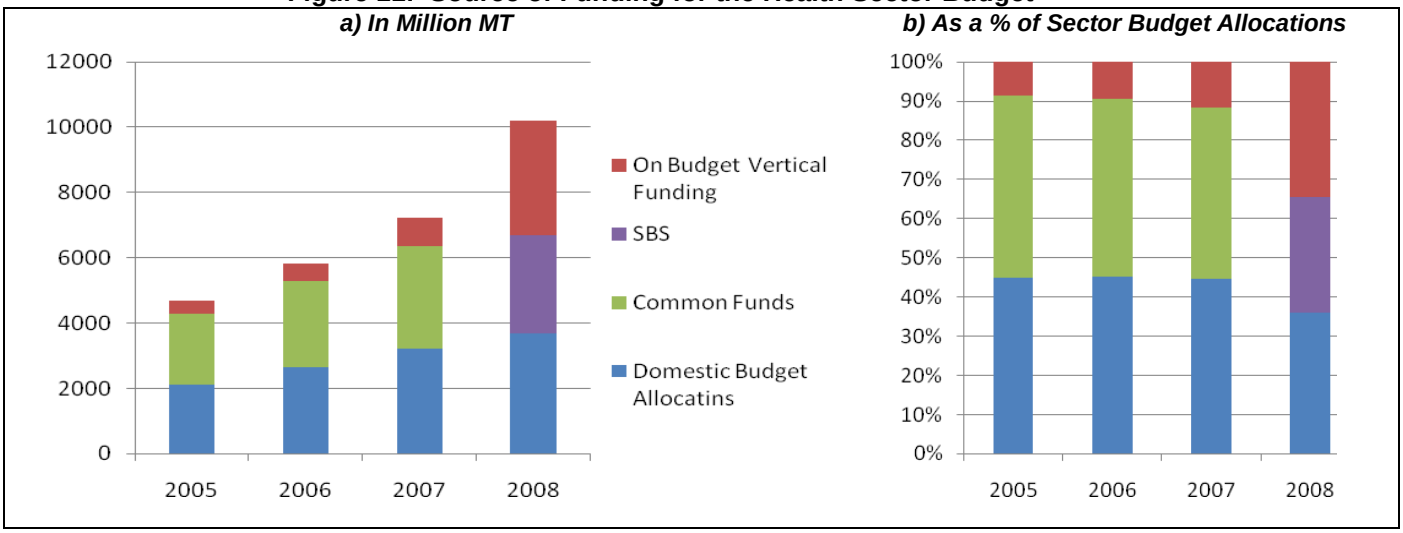
Sector Expenditure

198. The sector is considered to be a priority sector under the GoM and PAP dialogue and is the second biggest sector in terms of funds absorbed (after education). Common Funds contributed to a rapid increase in sector resources between 2001 and 2005, increasing from US$17m in 2001 to a peak of US$125m in 2007. At that point SBS represented 45% of the sector budget allocations. Common Funds undoubtedly contributed to major increases in on-budget sector funding. The introduction of SBS represented a switch in aid instruments from the Common Funds. SBS levels are lower than Common Funds in absolute terms (US$ 74m in 2007) and relative to the sector budget (30% in 2007); this does not represent a decline in sector financing, partly because of the GFATM not being included in SBS.

199. In spite of donor commitment to shared forms of funding, and government insistence on scaling this up, the absolute amount of vertical funds has continued to increase over time as detailed in Section 2 of this report. This is due in no small measure to the funding for HIV/AIDS by the GFATM and the US PEPFAR initiative. It is also related to the fact that many DPs continue to finance projects and programmes in parallel with their contributions to PROSAUDE II. If one examines external funds which appear on the budget, the picture is more stark. Vertical funding as a percentage of the state budget increased from 9% in 2005 to 12% in 2007. It then leapt to 34% as significant volumes of vertical funding were brought on budget. Whilst bringing vertical funding on-budget is an important positive development for overall resource allocation, it means that SBS represented only 30% of sector budget allocations in 2008 – less than on-budget vertical funding.

200. It is also important to point out that domestic budget allocations have also been buoyant. Between 2005 and 2007 health expenditures increased by 57%. Before the inclusion of vertical funding on-budget this represented 45% of the state budget, after which the share of domestic allocations declined to 36%. Nevertheless, in the context of rapidly increasing on-budget external financing, domestic allocations have continued to increase rapidly. It is clear that external funding overall, including Common Funds and SBS, have contributed to increased sector funding, even in the absence of additionality requirements relating to Common Funds or SBS.

Figure 11: Source of Funding for the Health Sector Budget



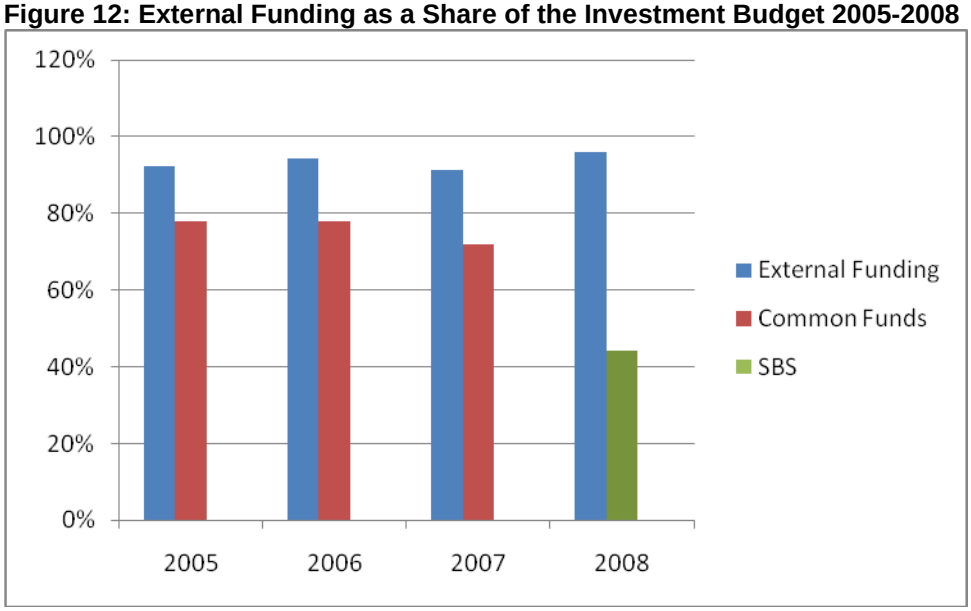
201. The sector budget allocations have therefore seen considerable increases from one year to the next. But despite these advances in the planning and budgeting process, execution remains low and there are still worrying issues related to the very low actual execution of the external component of the budget that is negatively impacting on overall performance of the sector.

202. The FCP (the Provincial Common Fund, which was merged with PROSAUDE II in 2008) in the past corrected some of the imbalances in attribution of funding, in particular the regional

imbalances, although donors still had separate projects on the side to work on specific priority areas of the sector plan (a situation which to some extent continues to date). There is insufficient data on this at present but there is concern among donors that under PROSAUDE II there may not be enough focus on equity issues from a provincial and district perspective. There are equity indicators in the PAF but these are not disaggregated for the provinces. In addition, it should be noted that although PROSAUDE I has the distinct advantage of providing 'flexible' funding, neither the 2008 nor the 2009 budget has involved increasing funding to the provinces.

203. The GoM funds available for investment in the sector are very low compared with the DP funds and this poses relevant issues concerning the sustainability of some of the actions being promoted. It is hoped that the merger of all commons funds (except for HIV/AIDS which is managed by the National AIDS Council (NAC) and by donors) will facilitate and promote better planning, spending and reporting.

Figure 12: External Funding as a Share of the Investment Budget 2005-2008

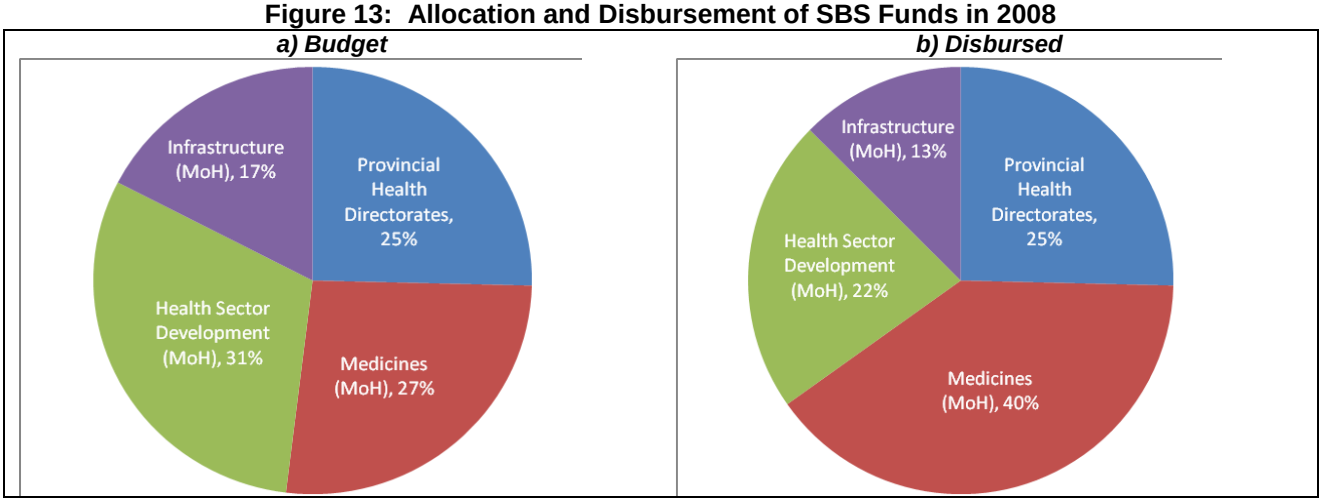


204. Figure 12 above shows the evolution of investment expenditures over a period of 4 years[6]. The total common funds are compared with the total investment in the sector. As mentioned earlier, all external funds earmarked to the sector are classified as investment, even though they typically finance operational inputs as well. Furthermore, the vast majority of these funds are allocated to the investment budget of the Ministry of Health, even though substantial resources are channelled to lower levels. This misclassification results in a misleading picture. First, it portrays an erroneous huge increase in investment funds. In fact, it is difficult to quantify the true figures of recurrent and investment expenditures. Second, the investment budget allocations are only made to broad categories (infrastructure, medicines, health sector development, provincial departments). With the exception of provinces, they are not aligned to any administrative departments responsible for execution of the budget (which is the case for the recurrent budget). This makes it very difficult to link the budget to operational plans implemented by those departments. When combined with the fragmentation of other external funding it is even more difficult to get a sense of how these break down into specific sub-sector priority budget lines. The introduction of SBS inscribed as internal funding had the potential to start to address some of the distortionary effects on budget allocations. SBS funds could have been allocated to domestic budget allocations in the recurrent budget to fund operational expenditures – for example, increasing expenditures on goods

[6] Information on 2009 could not be included here at the time that this report was produced as an exchange rate mistake as well as the recording of the PEPFAR funds on budget still needed to be corrected by the Ministry of Finance.

and services. However the government has continued to allocate SBS funds to the investment budget, maintaining its traceability.

Figure 13: Allocation and Disbursement of SBS Funds in 2008



Source: Ministry of Finance (2008)

205. So what can be said of the influence of SBS on sector expenditure? Figure 13 shows the allocation of SBS in 2008. In the first place, despite the decentralisation policy, only a quarter was allocated and disbursed to provincial levels. The remainder was administered by the Ministry of Health. This is far lower than the proportion of the recurrent budget transferred to provinces in the same year (52%). Only 13% of SBS was spent on infrastructure, despite SBS appearing in the investment budget. Meanwhile medicines – an operational input – made up 40% of SBS-funded expenditures. Thus whilst it is true that the majority of SBS funding was supporting service delivery, the vast majority of this has been centrally managed. Beyond its influence on total sector expenditure, and allocations to these broad categories, it is therefore very difficult to ascertain how Common Funds SBS has influenced expenditure patterns within the sector.

Lessons learned

206. This section first identifies key areas where the SWAp process and common funds in support of PROSAUDE I have had positive effects and then makes a tentative assessment as to whether PROSAUDE II is likely to improve the situation.

207. Areas of positive influence from the SWAp and Common Funds in support PROSAUDE I on planning, budgeting, reporting and monitoring in the health sector include:

- Support for the development of a single policy and implementation framework for the sector (the PESS) and costing of this plan (in 2007);
- Alignment of all major partners with the PESS and alignment of the PESS with the PARPA increasing the coherence between national and sectoral priorities;
- Establishment of a comprehensive structure for discussion and information-sharing with donors and other partners, including the Joint Annual Review process, that has contributed to strengthening capacity for monitoring and evaluation;
- Increasing participation of stakeholders through the establishment of consultation and review mechanisms;
- Development of a single monitoring framework with agreed indicators (the PAF) and assessment based on dialogue between all partners;
- Greater availability of documentation on planning and implementation processes in the sector.

- The financial support associated with common funds significantly increasing the scale of sector resources, through the provision of relatively flexible, on-budget sector resources. This increased funding for service delivery.

208. PROSAUDE II SBS is likely to improve the situation further by:

- Further increasing the flexibility of funding by removing most conditionalities and earmarking which characterized support during the previous period;
- Ensuring that partners commit funds in year n-1 for year n and reconfirming the amounts during budget preparation, improving predictability of funding;
- Helping facilitate links between the planning and budgeting process in the health sector to the national PES and budgeting processes;
- Strengthening the monitoring process as data are collected against the agreed indicators and the PAF review increasingly becomes the key instrument for assessing progress.

209. However, these gains may be undermined by the level of vertical and off-budget funding. Furthermore SBS in practice has yet to represent a significant shift from the common funds which preceded it. There are a number of areas in which Common Funds and/or SBS have had a negative influence or which they have failed to address:

- The dialogue among partners has dominated by discussion on modalities and procedures, first for Common Funds and now for SBS. This is at the expense of clear and comprehensive strategizing and monitoring of priority actions which need to be undertaken to improve the quality and coverage of service delivery at centralized and particularly decentralized levels (see also 4.3 below).
- There has been a failure to prioritize actions within the PESS to make it the guiding document for priority setting in the sector. This makes prioritisation in the GoM annual PES and budget more difficult. Furthermore, provincial and central plans are poorly aligned.
- Although some Common Funds and SBS has been channelled to provincial level, this has failed to support greater decentralisation of funding.
- The process of discussion and debate during the annual review processes is not effective at focusing on what needs to change in terms of sector policies and implementation to address the findings of the reviews;
- Dialogue and conditions associated with the SWAp have not proved effective at ensuring that recommendations from annual reviews are prioritised and followed up regularly. There is little distinction between what is essential and what is desirable;
- Working groups under the SWAp are not wholly effective tools for the MoH and the Government in decision making around policy and practice;
- The continued traceability of funds – both internal and external – has negative effects on the structure of the budget, and distorts budget allocations. Also, because of the very low participation of GoM in the investment budget of the sector (which continues to be predominantly funded by donors), the ownership and sustainability of expenditures is undermined.

210. Related to this final point, it is important to note that providing donors with the option to have SBS categorised as internal or external budget allocations was a potentially good practice – allowing SBS to cater for differing accountability requirements. However, it has been let down in implementation in two ways: first, by the fact that most donors, even many who provide non-traceable SBS in other countries opted for the internal option; and second, that internal SBS continued to be channelled as traceable SBS funding in the investment budget during implementation.

4.2 Influence on Sector Expenditure Control, Accounting, Procurement and Auditing

SQ4.2 What has been the influence of SBS on Expenditure, Accounting, Procurement and Auditing at the Sector Level, and what are the constraints faced and lessons learned in practice?

211. This section of the report examines the effect of SBS in practice on expenditure, accounting, procurement and auditing. As mentioned before – and because in practice the new and recently signed MoU is still to be fully reflected within the 2010 planning and budget cycle - in practice little has changed from the situation under the PROSAUDE I, on which this section focuses.

212. Donors have identified financial management as a key area of attention. There are a number of on-going efforts which are being supported by donors, the MoH and other stakeholders to strengthen this area, including an Expenditure Tracking and Service Delivery Survey (ETSDS), carried out in 2003; the establishment of a Financial Management Committee and its Technical Working Group as part of the SWAp; the contracting of a private consulting firm to help the Department of Administration and Finance (DAF) of the MoH improve its systems and train staff. As a result, 11 financial specialists were contracted by the MoH, 44 staff were trained in accounting and financial management at the central MoH, and 1200 in the provinces and districts; financial advisers have started to operate at Provincial Departments of Health (DPS); the appointment of a senior ambulatory accountant to help Provincial Departments of Health; (and, in 2006, there was a significant increase in donor off-budget funds that were put on budget.

213. As was seen earlier in this document, a PFM baseline analysis has been conducted which is a condition in the PROSAUDE II MoU, and for which the MoU foresees specific detailed follow-up studies if considered necessary. A first report of the draft health PFM has just been completed and highlights a number of critical areas of strengths and weaknesses which were reported on in Table 2 of this report. The assessment also makes it clear that the health PFM performance is – in a number of key areas – substantially below that of government as a whole. However, annual assessments of PFM provided for in the MOU may represent overkill, given the time and effort needed to carry out such assessments effectively.

214. Overall, the national systems for expenditure recording, reporting, auditing and procurement are only partially used and the capacities at sector level are weak in part due to the constant need to manage parallel systems (vertical funds).

Budget Execution

215. For the Government, SBS is important in a number of ways. The flexibility of the PROSAUDE funds is very helpful for dealing with emergencies or when there are disbursement problems. It is also a very comfortable situation for the sector in terms of human resource management, and is being used to avoid the time-consuming process of complying with the legal requirement in force that the Administrative Court should give a *visto prévio* to any planned expenditure (i.e. this is a formal procedure to allow the Court to acknowledge that it is aware of the acquisition). In this way PROSAUDE funds are used to pay for staff and salaries of contracted individuals who are not on the GoM payroll – and as the visto for authorization of TA is a time-consuming process the MoH hires the staff and pays with PROSAUDE funds while it awaits approval. Once approval is obtained the individual concerned is moved to the GoM payroll.

216. Budget execution has improved substantially in the past few years. This is due to the introduction of e-SISTAFE and of the functionality within the system for direct budget execution. Despite all discussions concerning the good and negative aspects of the national system, the sector decided to advance with a parallel system (known by its commercial name Oracle) for the

financial administration of the health sector at central and decentralized levels. Oracle is still being configured and will soon be put in place. According to the MoH this is a necessary development because e-SISTAFE does not allow for costs to be managed by portfolio managers. However, the introduction of Oracle is also related to the fact the PROSAUDE II functions like a huge project which funds provinces and departments within the MoH through normal budgetary procedures which are not linked to the administrative structure of the budget.

217. In 2008 SBS funding was far more reliable than other external vertical project funding – disbursement levels were 84% compared to 42% for the overall external investment budget in the Ministry of Health. Assuming 2008 is a representative year, this means that SBS has contributed to greater reliability of the investment budget than would have been the case if conventional project support had been used. However, SBS funded areas of the budget are still less predictable than domestic funding. As noted in Section 2, expenditures were at 96% for the investment budget and 100% for the recurrent budget in 2008.

Accounting

218. Sector expenditure and accounting is maintained via e-SISTAFE for on-budget/ on-CUT funds but parallel software is now being introduced – the aforementioned Oracle financials – for all funding to the sector. The sector has its own accounting practices and manuals in use but they are now requiring serious updating work with the introduction of appropriate internal controls.

219. There are issues in relation to this: as e-SISTAFE will not open a door for data exportation into Oracle, double accounting will take place and the margin for mistakes, duplication and other errors is very likely to be high. Additionally, there are risks around the definition of the Oracle chart of accounts: the sector is still working on the introduction of the programmatic classifier and the system should also reflect this. It is also not clear what all donors' reporting requirements are. In effect this constitutes a situation where the sector itself – through its senior management – is introducing a derogation to government systems. This is supported, however, by a number of donors who are paying for the software. An identical situation was seen in 2007/08 in the education sector where until now the parallel system is not operational but once it becomes so is likely to have the same risks.

Procurement

220. The development of databases, periodic reports and other quantitative information on matters relating to procurement and inventory management is not as advanced or formalised as the development of comparable information in the area of financial management. Key information is unavailable in some areas critical to the measurement of performance in health sector procurement and inventory management. The absence of such important data will need to be addressed.

221. The Procurement Regulation in use is the GoM regulation which was introduced in 2005/2006 (Decree 54/2005). The legal framework is clear but procedurally quite complex. On medicines and other specific sector procurements other DP rules are being applied as is specified in the July 2008 MoU for PROSAUDE II.

222. Decree 54/2005 relating to Procurement is being followed but with some limitations. Problems mentioned during interviews conducted for this study include issues related to the procedures and in particular the delays that such procedures cause. For example, the recruitment of consultants and staff takes so long that candidates take on other positions before being formally approved through the process that is now in place. One of the reasons presented by the sector in this regard is linked to the role of *visto prévio* by the Administrative Court. There have also been

significant delays in the procurement of goods. Problems of staff capacity as well as an absence of procurement plans, among other factors, exacerbate this situation.

223. One of the main reasons that the World Bank (WB) is not to be part of PROSAUDE II arises from the current procurement arrangements. WB requires fiduciary oversight in the form of a credible procurement plan and adequate procurement capacity. The World Bank assessment of the sector established that these requirements are not currently being met. A number of DP are providing TA which is working with the sector to develop such capacities.

224. The procurement system for drugs is separate from all the other sector procurement and it is expected to be managed separately by the Centre for Medication and Medical Articles (the *Centro de Medicamentos e Artigos Medicinais* – CMAM).

Auditing

225. The sector has been subject to several types of audits and reviews. There are internal audits from the Ministry of Finance carried out by the General Inspectorate of the Ministry of Finance (the *Inspecção Geral de Finanças* – IGF), reviews and audits from the Administrative Court (as part of the reviews of the GoM Annual Accounts) and also the private external audits of the CF. Under the new MoU the private external auditors which were previously used for PROSAUDE I are expected to be replaced by the Administrative Court. This is still to take place.

226. Another area of weaknesses related to inspection and audits is the low sector capacity to follow up and implement recommendations. For this reason the DPs have hired an external company to monitor the implementation of the recommendations of external financial audits.

Lessons learned

227. Areas of positive influence which can be drawn from the SWAp and PROSAUDE I on expenditure, accounting, procurement and auditing at the sector level include:

- Introduction of e-SISTAFE, which has improved budget execution by the government across the sectors, including in the health sector, and the use of this system by Common Funds and SBS have helped extend these improvements;
- Establishment of common financial management procedures which are aligned with country systems;
- Sector dialogue has contributed to the decentralization of funds to provinces (although this still mainly applies to recurrent expenditure) which is contributing to a gradual – but slow – increase in confidence in capacity at these levels.

228. SBS in support of PROSAUDE II is likely to contribute further by:

- Establishment of common financial management procedures by those donors who have subscribed to the MoU for PROSAUDE II which are even better aligned with country systems. This is not the case for donors who provide vertical funding;
- Use of government systems for procurement (with the exception of the procurement of essential medicines which continues to be separate);
- Use of government audit systems (again with the exception of the procurement of essential medicines);
- Having conducted a baseline assessment of PFM in the sector has helped diagnose key financial management issues;
- Increased reliability in execution of the investment budget, as SBS is significantly more reliable than conventional vertical project funding;
- The temporary exception of medicines from government systems may be a pragmatic solution to ensure a reliable flow of key operational inputs to the sector, if carefully managed.

229. At the same time the analysis in this report and in related studies on the health sector in Mozambique points to a number of important issues with respect to expenditure control, accounting, procurement and auditing which common funds and SBS have either had a negative effect on or have failed to address:

- Both Common Funds and SBS have contributed to excessive centralization of budget execution with little real power for the provinces, as most funds remain at central level.
- There has been a failure to adequately link the budgetary and managerial/administrative processes in the sector. The key issue is the link between MTEF and the annual budget and within the annual budget the introduction of the programmatic classifier;
- There remain administrative and procedural issues which contribute to continued problems of predictability and delays in the transfer of funds by donors, undermining the execution of the investment budget which is dominated by external funding, including SBS. Although SBS has been more reliable than other project funding, it is less reliable than the government budget, and traceability means that it does not use the government cashflow system.
- The (temporary) exception for essential medicines from government procurement and audit systems will not lead to the strengthening of those systems
- Donor requirements (related to five out of the total of 15 signatories of the MoU) that their unspent balances are earmarked to the sector mean that the traceability of their support needs to be maintained in the investment budget.

230. Whilst the story here is on balance positive, there is one important caveat. Although weak financial management systems do represent a significant risk to the effectiveness of sector interventions, a disproportionate amount of time and effort is spent on PFM issues in the dialogue, relative to issues concerning service delivery, for example. Annual assessments of PFM will only exacerbate this bias.

231. Overall, the effectiveness of SBS has been undermined by a number of more external factors. These include weaknesses in the government procurement process, excessive bureaucracy and delays, in part related to the new procurement law; and the need to update of accounting practices and procedural manuals with the introduction of appropriate internal controls to reflect the current practices.

4.3 SBS and its Influence on the Capacity of Sector Institutions and Systems for Service Delivery

SQ3.3: What has been the influence of SBS on Sector Institutions, their Capacity and Systems for Service Delivery, and what are the constraints faced and lessons learned in practice?

Human Resources

232. Mozambique continues to face a critical shortage of human resources as indicated by the fact that the number of health professionals per inhabitant is among the lowest in the world. And continuing frequent liquidity crises affect the functioning of the system. The weakness of the decentralization process also has an important impact at this level. Capacity at decentralized levels is very weak and there are insufficient incentives for health staff to be located in the rural and remote areas of the country where service provision is the poorest.

233. Some of the progress outlined above in terms of dialogue, monitoring arrangements and reporting can be expected to strengthen control, authority and ownership by the government.

However, the critical shortage of human resources at all levels of the system impacts on capacity and service delivery to a significant extent. At the same time the coordination mechanisms with external partners – although more streamlined – continue to represent a substantial workload for scare human resources and further deplete the capacity of the system. Vertical funds contribute to this burden and are an important concern in this respect.

234. It is also clear that a detailed analysis of human resource capacity has been missing during most of the period running up to PROSAUDE II. Instead, efforts have been made to address capacity through parallel vertical initiatives by a number of DPs. However, capacity has taken somewhat of a backseat during the period up to the signing of the MoU in July 2008 when the focus was on getting the mechanisms for SBS in place. There is no common position yet from DPs on how to address this issue. At the time of this study the Human Resource Development Plan was still under discussion and the funding sources for this plan were still unclear.

Capacity and systems for service delivery

235. While a number of donors have provided support to capacity building, this is an area that where there is not yet sufficient consensus. The recently launched human resource development plan provides a strategy and price tag for addressing this but has yet to achieve consensus on the part of the donors.

236. There has been a lack of systematic attention to capacity and systems for service delivery. This, in part, may be related to the fact that the priority issues for partners - e.g. good governance, transparency, justice – do not necessarily address or measure the impact on end users. It was revealing in this respect that most DPs interviewed during the study were unclear as to how developments and progress to date might have specifically impacted on systems for service delivery and to what extent these were likely to bring about the gains that were discussed in Chapter 2.

Monitoring Service Delivery

237. Monitoring and evaluation systems on the levels and quality of service delivery are available through the Joint Annual Review Reports, which provide information against the 38 agreed PAF indicators. The annual government PES report also includes information on levels and quality of service. Now that PROSAUDE II is in place, the PAF provides a good starting point for focusing more consistently on issues of service delivery.

Lessons learned

238. Areas of practice where there has been influence of the SWAp and PROSAUDE on sector institutions, their capacity and systems for service delivery include:

- The development of a performance assessment framework which is linked to the overall performance of the government and which includes key indicators of service delivery for the main areas of focus of the health sector;
- The collection – in the context of the PAF – of data that are comparable over the years which would allow the key stakeholders to engage in critical discussion and reflections;
- The establishment of procedures for annually reviewing progress, and the introduction of fora for dialogue on issues of delivery through the working groups under the SWAp;
- The production of reports in the context of the Joint Annual Reviews in the sector which will provide inputs into the technical discussions around service deliver and have the potential of ensuring that service delivery becomes a more central concern for all stakeholders;
- The progressive inclusion of key stakeholders in the dialogue around the sector, which should allow civil society (in particular) to take a more central role in promoting discussion around coverage and delivery of services.

239. Nonetheless, the main lesson from this study is that there has been insufficient attention to service delivery, capacity and human resources in the design of SBS. There have been efforts in this area, through various projects, initiatives and programmes funded by various donors over the period that this case study is examining. There has also been systematic reporting in the annual review meetings on key indicators of service delivery.

240. The SWAp, Common Funds and now SBS have not contributed effectively to service delivery as follows:

- The issue of capacity and service delivery as a whole has not figured high on an agenda which has been much more dominated by discussions around making systems work so that funds from donors can be made available through it (i.e. focused on inputs rather than on outputs). This is reflected, for example, in the fact that the most 'powerful' working group under the SWAp at present is the one on financial management.
- As a consequence, there had been insufficient attention to human resources in the dialogue in particular as well as to the systems and institutions for service delivery, although this has been addressed to some extent through the development of the Human Resource Plan
- Technical Assistance and Capacity Development activities are poorly coordinated and fragmented, and were not addressed in the design of SBS.
- The continued traceability of SBS funding has contributed to fragmented and unclear channels for financing service delivery.

241. PROSAUDE II should help improve the situation to some extent through strengthened monitoring of the performance of the sector and by offering data that are comparable over the years which would allow the key stakeholders to engage in critical discussion and reflections. The PAF framework is an important instrument in this context. However, it remains to be seen to what extent this monitoring process will then focus on issues of capacity and service delivery as opposed to discussions of the design and management of aid modalities.

4.4 The Influence of SBS on Domestic Ownership, Incentives and Accountability in the Sector

SQ3.4: What has been the Influence of SBS on Domestic Ownership, Incentives and Accountability in the Sector, and what are the constraints faced and lessons learned in practice?

Domestic ownership

242. Domestic ownership has grown, and there is a strong involvement of the sector and the government in the SBS process. Domestic ownership has been helped by the integration of systems with national planning processes. There is also clearly more involvement of other key government bodies (MoF and MPD) and closer working together between these ministries to ensure a consistent message towards donors.

243. Across the various stakeholder groups mention was made of the need for government to continue to take a stronger leadership role in processes. However, to some extent this has already started happening, for example, with GoM taking the lead in deciding to involve donors less in internal MoH discussions. Similarly the MoH in 2008 decided to take GFATM out of joint arrangements for PROSAUDE II, as this was impeding progress around the SWAp. In general, the MoH has taken a stronger position in the recent period to decide on its course of action and on its main lines of policy. This was clearly shown in the manner in which the PESS was designed and finalized, and also in the development of the HR strategy. These developments are arguably good from the perspective of stronger government ownership but they have left donors unclear about

their precise room for manoeuvre and donors have a difficult time deciding how to react. This was clearly reflected in the interviews which were conducted for this study which also revealed some loss of confidence by donors as a result of this process.

244. Capacity in the sector impacts on the extent to which the sector is able to take full ownership of processes. Capacity affects the ability of the sector to engage and fully take on responsibility (for example donors frequently outnumber MoH staff in technical discussions in the working groups under the SWAp). In spite of some streamlining, processes are still heavy and time consuming – with peaks at particular times of the year. Capacity among civil society organizations to take on a strong monitoring role of the SWAp is also still weak.

245. Discipline of the donors has been important (compared to other contexts). There have been important efforts at taking joint positions amongst a large and growing group of donors. However, alignment is not complete, in part because of poor linkages between HQ and agencies in the field. In practice some processes have taken much longer because of lack of understanding at field level of the precise HQ position with respect to SBS. Links to the heads of agency at country level are not necessarily strong, which means that many of the issues that arise at the level of SBS are not being fed into discussions at more senior agency level where they may be brought up with government in other for a, including in those related to GBS.

Incentives and Accountability

246. The new MoU will be fully on-budget and the provision of financial support through the normal GoM planning and budgeting processes will contribute to building and strengthening national accountability systems: from the Health Sector to the Ministries of Planning and Finance, from Government to Parliament and the Administrative Court, from Government to its citizens. The shift by some donors from project support to SBS will strengthen the Parliamentary oversight of the budget by increasing the proportion of resources over which Parliament has a discretionary power. Nonetheless, it is also clear that while some donors are formally participating in the SWAp they are not necessarily abiding by the decisions and principles which this implies, in particular as far as harmonization and making aid more predictable are concerned. Some of the issues which arise out of this were discussed in Chapter 3.

247. The ACA, with its links to the GBS process and to the national planning and budgeting process, has a potential domestic accountability function. The PAF is an important tool in the annual review process as a standardized instrument for reporting and monitoring performance, which again is linked to the overall planning and budgeting process through the five indicators that are part of the overall PAF framework. The PAF at sectoral level includes indicators relating to donor harmonization and predictability of aid and – if closely monitored and adequately discussed – this should in principle contribute to progress in these two important areas. Nonetheless there is a risk of government partners perceiving an unequal relationship, with donors not making sufficient progress in the areas which they are responsible for while putting pressure on the MoH to make further changes in their way of operating. A 2008 internal workshop of donors on communication with the MoH highlighted the fact that there are issues in this area that will need to be addressed. To a degree the same development agencies which are contributing to increased ownership and accountability are still reducing the incentives by continuing with un-transparent project aid, because most of them are not subject to any scrutiny (let alone at parliamentary level).

248. Accountability for service delivery takes place through the annual ACA. The ACA is both a forum for donors and a mechanism for domestic accountability, and is used in this way by the MoH for its own management decisions. As a select number of the PAF indicators are part of the overall monitoring framework for the government and donors, this also strengthens the process of overall accountability.

249. However, these tools for accountability are focused at the national level. There was little evidence of attention being given to accountability for service delivery at the local level and the incentives faced by frontline service providers.

Lessons learned

250. Areas where there has been positive influence of the SWAp and PROSAUDE I on domestic ownership, incentives and accountability in the sector include:

- Alignment of donor and government accountability systems, both at sectoral level, and at governmental levels;
- Inclusion of indicators which hold DPs accountable for progress in harmonization and alignment and predictability of aid;
- Discipline by donors in sticking to a common agenda;
- Involving and holding accountable other ministries in the various steps of the process.

251. PROSAUDE II is likely to improve this situation further because the arrangement includes a growing number of donors and because the PAF allows for more careful monitoring of where progress is being made and what areas need strengthening.

252. A number of issues, however, have not been addressed by the SWAp, Common Funds and SBS:

- Capacity continues to be a major issue as this affects the ability of the sector to provide timely reports and inputs which are essential to strong accountability by the Government, and which are also critical to enabling donors to feel involved in the processes;
- Civil society is still not strong in demanding accountability. It needs to be engaged more actively, in particular in holding all partners accountable for progress on service delivery;
- Common Funds and SBS have contributed to continued centralisation of responsibility. They have not been decentralised adequately to lower levels of government, undermining ownership at these levels;
- Related to this, the focus of accountability has been on national processes. Accountability for service delivery at the local level, and the incentives faced by service providers have not been addressed.

253. Furthermore, the accountability of donors for their commitments is weak. There is need for stronger leadership by the government in holding donors to account.

5. The Effectiveness of SBS and the Conditions for Success

5.1 The Main Outputs of SBS

SQ5.1: What are the main contributions that SBS has made to the improvement of sector policy, processes, public financial management, sector institutions, service delivery systems and accountability?

254. It is too early to say what contribution SBS specifically has made to sector policy, processes, public financial management, sector institutions, service delivery systems and accountability. However, the Common Funds and associated SWAp procedures that preceded SBS made the following overall positive contributions as follows:

- The dialogue and coordination structures associated with the SWAp facilitated the development of a single policy and implementation framework for the sector (the PESS), costing of this plan, and development of a single monitoring framework (the PAF) with agreed indicators which is assessed on the basis of dialogue between partners;

- These SWAp structures also encouraged greater inclusiveness of partners in policy dialogue through a structured process for discussion and information sharing which includes the Joint Annual Review process, although differences in levels of engagement and capacity to interact persist (e.g. civil society);

- Clearer policies and the SWAp processes facilitated improved alignment by partners with government and sector planning and budgeting processes through processes which link planning, budgeting and annual reviews of the key sector stakeholders with the overall government processes;

- Harmonisation among donors around policy, financial management, procurement and monitoring and evaluation allied with greater use of government systems facilitated the strengthening of those systems. Agreement on indicators will hold donors accountable on progress in areas of harmonisation, alignment and predictability of development aid;

- There was progressive improvement in budget execution in the sector through the introduction of e-SISTAFE – this was accelerated as common funds used e-SISTAFE;

- Common Funds contributed to an increasing volume and share of external funding to the health sector appearing on budget.

- Common Funds also increased discretionary funding available to the MOH to implement the PESS, thereby contributing to strengthening government ownership. Funding flexibility is likely to improve as conditionalities and earmarking by donors continue to decrease;

- In combination, this meant that Common Funds resulted in increased funding of operational inputs, such as medicines, and infrastructure for service delivery.

- Common Funds facilitated some additional decentralization of funding to the provinces which is increasing capacity and confidence at provincial and district level and also enhancing involvement from stakeholders at these levels.

- There is gradually growing confidence in government systems;

- There has been gradual improvement of accountability at the national level as a result of the joint annual review and performance assessment framework;

- The combination of SWAp coordination structures and the use of common funds has resulted in a gradual reduction in transaction costs for the MoH.

255. However, at the time of introduction of SBS in support of PROSAUDE II in 2008, there were a number of areas where less progress had been made which are also highlighted in this study. These are related to the fact that:

- A number of other plans continue to co-exist together with the PESS, which results in a fragmented policy environment.

- Insufficient progress has been made on making key policy decisions, and establishing clear priorities for the sector to guide decision making at central and decentralized levels.

- The comprehensiveness of resource allocation was undermined by an increasing amount of vertical funding, much of which was off budget and not aligned to the PESS. Donors continue to fund parallel projects and programmes for reasons highlighted earlier in this report.

- Despite policies for decentralisation MoH remained a strongly centralized structure; decentralization of planning and implementation remains weak particularly for the external component of the investment budget. This has been reinforced by the fact that the vast majority of Common Fund resources have been managed centrally.

- Although on budget, common funds have distorted the structure of resource allocation by channelling significant volumes of operational inputs via the investment budget.

- Predictability of funding affected GoM planning and implementation capacity. Confidence among partners is still weak in some respects and this affects progress and further commitment.

- A disproportionate time in the dialogue was spent on issues to do with the management of common funds, which limited the time spent on key policy and service delivery issues.

- Human resources, including their management and capacity, are a major bottleneck to quality and decentralization of services. It has proved very difficult to retain higher calibre staff, both at central and at local level. The HRDP provides a framework for addressing this but will need support from DP and remains underfunded.

- Related to this, there was little attention paid in the dialogue to the downstream systems for service provision, the incentives faced by service providers, and accountability for service provision.

256. In its current form SBS in support to PROSAUDE II is likely to help consolidate and further the positive impact of the SWAp and common funds. However, more importantly, it has failed to address many of these weaknesses in practice. There are two main dimensions to this problem:

- The allocation of SBS funds continues to be highly centralised, with only a quarter of funding allocated to provinces. Furthermore, SBS remains separately identifiable in the investment budget, and this continues to distort resource allocation. Whilst the intention of the MoU was for SBS to fund both the recurrent and the development budgets, the practicalities were not worked out beforehand. Further progress is undermined by the fact

that vertical project funding continues to increase. Although the inclusion of more donor projects on budget is positive, efforts to get big 'vertical funders' (GAFTM, WB) to be part of PROSAUDE II have failed for now.

- The SWAp dialogue has remained preoccupied with the design and management of SBS. Vertical funds have also taken up time. Furthermore a disproportionate amount of time in the dialogue is spent on PFM. This means that other core service delivery issues continue to be inadequately addressed.

257. Moreover, there are some worrying indicators of weakness in the SBS arrangement, including in terms of confidence between the various partners (dialogue is less open than it used to be), and in terms of commitment to the principles. There are signs that even those donors who have been staunch supporters of sector budget support are no longer as committed. The departure of the GAFTM from the arrangement has weakened PROSAUDE II and risks undermining the principle of comprehensiveness and integration. Policy dialogue between government and donors has become more difficult, in part due to the new management style of the current government and of the current MoH. And in recent years, the brain drain from the sector appears to have accelerated. The MoH has lost a significant number of qualified personnel, leading to considerable drain of institutional memory and to a weakening in the policy dialogue with sector stakeholders.

258. These are issues which are weakening PROSAUDE II and which may threaten the future of SBS. Paradoxically – and along the lines of highlighted in the Mozambique Agriculture study which is a parallel case study – these issues come at a time when progress is being made in other areas. The arrangements that are in place today provide the GoM with greater flexibility and discretion in financing through the introduction of SBS, promote further alignment with country systems, and represent significant progress on the part of DPs in simplifying arrangements for the provision of support (e.g. by practically eliminating donor-specific exceptions to the MoU) and increasing the degree of predictability of their funding.

5.2 The Sector Outcomes Influenced by SBS

SQ4.2: Have the improvements in sector systems and processes to which SBS has contributed, had a positive influence on sector service delivery outcomes, and are they likely to do so in future?

259. There has been progress on selected health indicators in recent years, indicating a generally positive trend in some areas of health delivery. Between 2001 and 2005 the number of service units in the health system increased by 22% and the number of institutional births grew by 28%. Over the same period the number of mother and child health consultations increased by 28%. Vaccine administration also grew.

260. There has been a significant improvement in indicators such as Infant Mortality Rate (IMR) which declined from 147 in 1997 to 100 in 2005, the Under Five Morality Rate (UFMR) which is down to 145 per 100 live births from 219 over the same period, and in the Maternal Mortality Rate (MMR). Both IMR and UFMR have declined most rapidly in rural areas. Recent data from the Multiple Indicator Cluster Survey (MICS, conducted in 2008) shows that the UFMR in urban areas has reduced on average by 1,4 percentage points per year (from 150 per thousand to 135 per thousand), while in rural areas it has gone down by almost seven percentage points per year (from 237 to 162 per thousand). The 2008 MDG report for Mozambique notes that the country will potentially reach the MDGs for child mortality and for maternal mortality (Government of Mozambique, 2008).

261. It is reasonable to assume that the increased sector funding as a result of common funding, which peaked at 45% of sector funding in 2007, has contributed towards these improvements.

262. Despite this progress Mozambique has not performed as well in child mortality reduction as countries with a similar Gross National Income per Capita. Although the MMR has decreased it remains high and less than half of births are attended by skilled health staff – this percentage is even lower in the northern and central provinces and in the rural areas. Malaria and malnutrition are main causes of death among children. The disease burden has grown, on other fronts, to a significant extent related to the high and still growing national adult prevalence of HIV which was at 16% in 2007 (with significant regional variations within the country)[7]. The AIDS pandemic is threatening many gains, including the achievements in child mortality reduction as pediatric AIDS treatment and prevention of mother to child transmission (PMTCT) coverage, although improving, are still largely insufficient. Mozambique ranks 18th on the WHO list of high burden Tuberculosis countries.

263. In terms of service delivery the health sector has made considerable progress in the past years. Service output, coverage and service consumption have expanded. Nonetheless, inequities in health persist and geographical inequities in access to service and in quality of care provided are still substantial. For example, a comparative analysis of the 1997 and 2003 health demographic survey results shows that in some provinces indicators have worsened: for instance, the IMR went up in 3 provinces, Niassa (from 134 to 140), Cabo Delgado (from 123 to 178) and Manica (from 91 to 128). Regional differences also emerge clearly from the results of the MICS survey, with Zambézia having a UFMR which is at 205 almost double that of Maputo City (103).

Mozambique faces a health workforce crisis with only 1.26 health workers per 1000 population which is among the bottom 5 ratios in the world. Efforts over the past years to correct regional differences in staffing have produced some effect but not enough. There is reason to believe that the early gains in increasing utilization, efficiency and quality of services are now leveling off. Challenges to health service delivery are in many respects still considerable and include the fact that:

- Only two thirds of the population is reached by health services.
- Inhabitant/doctor ratios are very high.
- Most of the qualified senior practitioners are found in urban areas.
- Leakage of staff to private sector and Non Governmental Organizations (NGOs) is considerable and substantial numbers of staff are lost to AIDS each year.
- Management capacity is still worryingly weak and concerns exist about channeling high levels of funding to a sector which has limited capacity. Efficiency and effectiveness are poor.
- Funds are being re-oriented to curative care and large urban hospitals and there is a slowdown in the reduction of inequities between provinces in terms of access to goods and services.

264. Overall, large numbers of Mozambicans continue to have major difficulties in access to health services. The quality of care is also a matter of concern. Overall the health status of the Mozambican population is and remains lower than average for African Countries and far below international standards.

265. A number of factors would appear to favour progress in the future with the introduction of SBS. These include the gradual improvement in predictability of funding, efforts to address key

[7] According to the 2008 UNGASS report, the highest prevalence rates were recorded in Gaza Province (27%), Maputo City (23%), Maputo Province (23%) and Sofala (23%). The lowest rates are in the northern region (Cabo Delgado, Nampula and Niassa with 10%, 8%, and 8%, respectively). Even these statistics hide significant variations within provinces and between districts.

bottlenecks in PFM, and an improved framework for monitoring and evaluation. However, insufficient progress on addressing challenges to human resources for service delivery, the nature of the implementation of SBS thus far, and continued increases in vertical funding, together mean that it there will be challenges to ensuring that the major constraints to effective service delivery will be addressed. Most notably, there needs to be a serious and full scale effort and commitment to addressing the capacity constraints in the sector. This needs a refocusing of the sector dialogue and the implementation of SBS on service delivery, and a move away from vertical funding. The latter appears unlikely in the short term.

6. Conclusions and Recommendations

Primary Study Question:	**How far has SBS met the objectives of partner countries and donors and what are the good practice lessons that can be used to improve effectiveness in future?**

266. The SWAp process and common funding arrangements since 1998, when the first CF was established, have had a positive impact in sector policies and processes. An unprecedented number of donors have joined in the common funding arrangements and 15 donors have committed to SBS. There has also been significant improvement in the proportion of discretionary funding provided, dialogue has been streamlined, donor coordination has improved, and all of this has impacted in various aspects of sector policy, management and monitoring and evaluation. The table below summarises and highlights the key positive effects an also brings to the forefront some of the negative practices which provide lessons for other contexts.

Table 6: Summary of Practices with Positive and Negative Effects on Sector Outputs

Domain	Practice with positive effects	Practice with negative effects
Sector policy, planning, budgeting, monitoring and evaluation	- Support for the development of a single costed policy and implementation framework for the sector; - Alignment of all major partners to this policy, including those providing CFs/SBS. - Establishment of inclusive and comprehensive dialogue structures, in particular the Joint Annual Review process. - Development of a single monitoring framework with agreed indicators (the PAF) and assessment based on dialogue between all partners. - Availability of documentation on planning and implementation. - The large scale of CF and then SBS funding increasing the scale of sector resources, through the provision of increasingly flexible, on-budget funding for delivery. - Commitment of SBS funds a year prior to their provision, improving their predict-ability. - Facilitation of links between the planning and budgeting process in the health sector and the national PES and budgeting processes.	- The dialogue among partners has been dominated by discussion on modalities and procedures first for Common Funds and now for SBS. - There has been a failure to prioritize the actions within the sector policy, making it difficult to guide the annual budget. Provincial and central plans are poorly aligned. - The vast majority of Common Funds and SBS funds have been allocated and managed centrally, undermining decentralisation. - Annual review processes are not effective at focusing on addressing key issues. - Recommendations from annual reviews are not prioritised and followed up regularly. - Working groups under the SWAp are not wholly effective tools for the MoH and the Government in decision-making around policy and practice. - The traceability of both SBS and Common Funds and their allocation to the investment budget (whether internal and external in the case of SBS) has negative effects on the structure of the budget, and distorts budget allocations.
Procurement, expenditure, accounting and audit processes	- The use of government systems combined with the introduction of e-SISTAFE which has improved budget execution in the health sector. - The establishment of common financial management procedures which are aligned with country systems. - Sector dialogue has contributed to the decentralization recurrent expenditure to provinces. - Use of government systems for audit and	- The vast majority of Common Funds and SBS funds have been allocated to central government, contributing to excessive centralization of the investment budget . - There has been a failure adequately to link the budgetary and managerial/ administrative processes in the sector. - Requirements that unspent SBS balances are rolled over mean that traceability of their support and allocation to the investment budget is necessary.

Domain	Practice with positive effects	Practice with negative effects
	procurement for the majority of SBS funding. - Conducting a baseline assessment of PFM in the sector. - The provision of relatively reliable funding which has Increased reliability of investment budget execution overall. - A temporary exception of medicines from government procurement and audit systems is a pragmatic short-term solution.	- SBS funded expenditure do not use government cashflow system, and SBS funds have been less reliable than the government budget. - The (temporary) exception of essential medicines from government procurement and audit systems will not lead to the strengthening of those systems. - A disproportionately large amount of time is spent on PFM in the dialogue, at the expense of other issues.
Capacity of sector institutions and systems for service delivery	- The PAF includes key indicators of service delivery for the main areas of focus of the health sector. The collection of data that is comparable over the years should enhance dialogue. - Procedures for annually reviewing progress, and the introduction of fora for dialogue on issues of delivery through the working groups under the SWAp. - The production of reports in the context of the Joint Annual Reviews in the sector which will provide inputs into the technical discussions around service. - The progressive inclusion of civil society and other actors in dialogue, should promote discussion around coverage and delivery of services.	- Overall there has been insufficient attention to service delivery in the design and implementation of SBS. - The dialogue is dominated by issues relating to the design and management of aid modalities and public financial management. - There has been insufficient attention to HR, systems and institutions for service delivery in the dialogue. - The traceability of SBS funding has contributed to fragmented and unclear channels for financing service delivery. - TA and Capacity development activities are poorly coordinated and fragmented, and were not addressed in the design of SBS.
Domestic ownership, incentives and accountability	- Alignment of donor and government accountability systems, both at sectoral level, and at governmental levels, - Inclusion of indicators which hold DPs accountable on progress in harmonization and alignment and predictability of aid. - Discipline by donors in sticking to a common agenda. - Involvement and holding accountable of other ministries in the various steps of the process.	- Capacity affects the ability of the sector to provide timely reports and inputs which are essential to strong accountability. - Civil society is still not strong in demanding accountability. It needs to be engaged more actively. - Common Funds and SBS have contributed to continued centralisation of responsibility. - The focus of accountability (and incentives) has been on national processes and not on service delivery at the local level.

267. Whilst the achievements in donor harmonisation first through CFs and now through SBS are significant, they have come at a significant cost. The design and implementation of common funding instruments take a huge amount of government and donor time, which means that too little attention has gone to discussing the substance of delivering against health polices and delivering good quality services, and to assessing progress of health sector outcomes against inputs. Furthermore, despite the fact that they are discretionary and use government systems, common funds and SBS have not been particularly effective at supporting service delivery.

268. SBS in support of PROSAUDE II does not yet represent a departure from previous practices:

- Despite being unearmarked, SBS has been budgeted for in a similar way to previous common funds, and funding of recurrent nature is still in the investment budget.
- Because the systems for financing downstream service delivery have not been given adequate attention there is an absence of clarity as to what the government framework for

financing decentralised service delivery should look like. Consequently SBS has nothing to align to but the unclear, fragmented system that exists.
- There is insufficient funding for human resources development, and insufficient attention to service delivery systems.
- The particularities of the government budget make it impossible for the system to monitor programmatic costs and to get to the bottom of issues such as unit costs of service delivery.
- Complementary technical assistance and capacity development was not factored into the SBS design, and remains fragmented in the sector.

269. Nevertheless, it is clear that partners to the new PROSAUDE II SBS arrangement are cautiously optimistic, and there is also a significant awareness of the considerable challenges which still lie ahead. Partners are positive about some of the intermediary outcomes and generally committed to the process.

270. A key lesson from the Mozambique case should be that these are issues which need to be addressed in the design phase of any SBS process. An important opportunity to ensure that strong systems and procedures are also in place for monitoring of service delivery has been lost and it will take time to re-focus.

271. In moving forward a number of key issues will clearly need attention. The first set of issues relate to the mechanisms for funding service delivery:

- The success of SBS will depend to a significant extent on getting the financing channels for service delivery right so that the system can use its resources in the most effective and efficient way. In this area there are substantial challenges that need to be addressed which were highlighted in the previous paragraph. Work is needed to analyze how funds will be accessed by and channelled to decentralized levels to improve service delivery, and how SBS can support this. It is also essential that the sector (and other sectors) move towards budgeting system which makes it possible to assess costs per programme.

- SBS could better support systems for financing delivery if SBS inscribed as internal funding were allocated to the recurrent budget, and specifically to existing budget lines service delivery. In this way, the SBS would no longer be traceable. Furthermore, given the fact that the recurrent budget is increasingly reliable, those donors that can provide non-traceable SBS should elect for the funding to be inscribed as internal funds.

- Success of SBS will also depend on further progress by DPs in bringing aid to the sector into PROSAUDE II. This involves letting go of vertical projects and initiatives (a number of partners are moving in this direction) and increasing funding to PROSAUDE as confidence grows. It will also involve developing further confidence in monitoring systems which will allow partners to have some of the information/security which they are still getting from having vertically funded projects. There continues to be a tension between the official commitment to more open and aligned means of funding by DPs and the reality of being held accountable for results.

- The increase in vertical funding is a real reason for concern and should be a point of reflection and action in moving forward – both at country level, but also globally at the headquarters of those agencies which are as of yet unable to join PROSAUDE II. As PFM improves, as monitoring systems become stronger and provide a clearer overview of results and outcomes and as confidence increases, it may be that conditions will allow for these partners to join. In addition, this study also points to the need for changes in the manner in which global funds such as the GFATM are managed, to reduce the burden on systems and to make it possible for these vertical funds to be channelled through

government systems once these are deemed sufficiently reliable and strong. Reluctant vertical funders – such as the GFATM – may be more willing to join if they can play a key role in strengthening the systems that are currently preventing them from participating in PROSAUDE II.

- Donors, however, are focusing much more on the success in addressing PFM issues in the health sector as this is what they are ultimately held accountable for. In other words, a less than favourable audit in 2010 would represent a significant setback to the progress that has been made so far, whereas a lack of progress on key indicators is perceived by most as being of a potentially less damaging nature. This underscores the need for the 'incentives' on the donor side to be reviewed so that SBS does not become skewed as a result of an excessive focus on mechanisms.

272. The second group of problems relates to non financial inputs associated with the provision of SBS. These relate to the focus of dialogue and conditionality, and complementary technical assistance and capacity building:

- The focus of the overall dialogue and review processes needs to be reoriented towards addressing the key challenges to effective and efficient health service delivery and this needs to be much more central to the dialogue around the SWAp. This means putting sector institutions and systems for service delivery much more prominently on the agenda.

- Capacity constraints emerge throughout this study as a key concern. Efforts will need to be made to secure funding for the human resource development and retention plan.

- There needs to be more attention to the provision of technical assistance and capacity building alongside SBS funding to strengthen systems for delivery downstream, as well as to central management and monitoring of service delivery.

- There needs to be attention paid to building stronger systems for accountability for service delivery at lower levels, and not just via SWAp arrangements

273. In order to achieve progress on these different aspects, the MoH and the GoM will need to take a stronger and growing leadership role in the process, working side by side with partners to ensure adequate priority setting and to address the capacity constraints affecting the sector. Further progress will need to be made in developing the partnership between the different parties as a degree of mistrust and lack of collaboration are hampering confidence in the systems and processes. This could be helped in two ways:

- While it may appear to be a minor point, progress could be made in this area by finding ways to streamline information flows between partners so that the fora for discussion and reflection can function more effectively. Partly this is a reflection of weak capacity in the MoH, but it is also a question of instilling discipline and structure into the way in which different entities communicate, and ensuring that communication gives partners enough time to react meaningfully to ongoing actions and processes.

- The focus, quality and coordination of donor interaction with the government is critical to getting and sustaining commitment on both sides. Ensuring neutrality on the part of the focal point is important in this respect. As was suggested during the study by the current focal donor there may be an added value to considering further 'professionalizing' and enhancing the sustainability on the donor side by creating a professional coordination unit for the sector. This would reduce the burden on the focal donor, help in ensuring that the right mix of skills is available, and reduce some of the tension and loss of memory which arises from the turnover of staff. More fundamentally, donors need to find ways of

balancing the dialogue between their legitimate fiduciary concerns and the need to focus on core service delivery issues which affect the broader development effectiveness of sector interventions.

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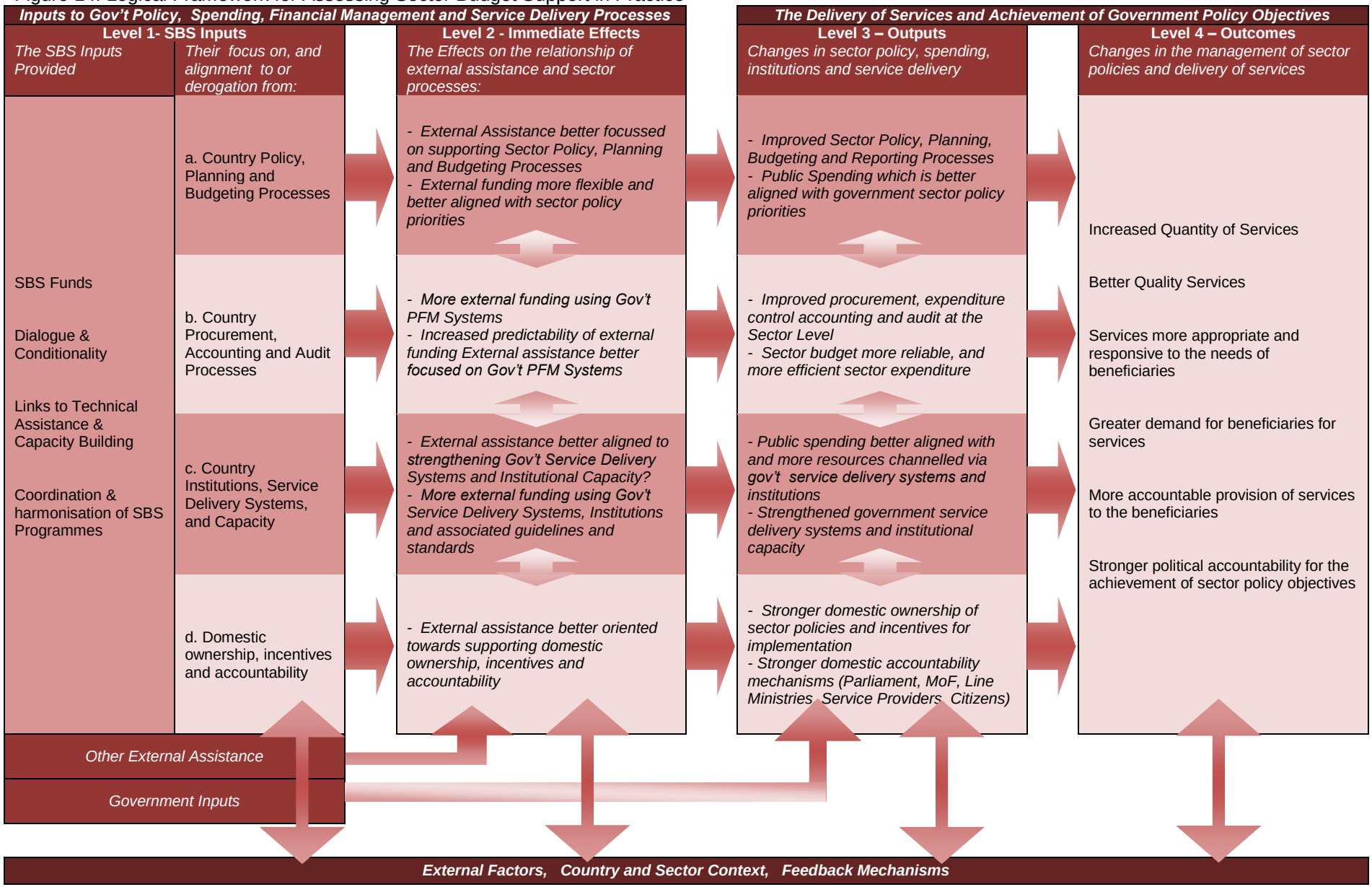
Annex 1 – Summary of Findings Against the Assessment Framework

Figure 14: Logical Framework for Assessing Sector Budget Support in Practice



a) Context in which SBS has been Provided

	Country context	Sector context	Aid management context
Moz Health 2008- SBS late comer though pre-SBS Common Basket Funding in place since 2001 and co-terminous with SWAp develop-ment	Policy: Second PRSP (called PARPA II) in place. Growth: Success story of post-war economic recovery; good macro economic and fiscal performance since late 1990s (growth rate 8% 1997-2007), PSI from IMF ongoing; Poverty reduction: Significant progress on income poverty, down from 69% (1996/7) to 54% (2002/3). Rural poverty decreased most though remains high (55%). Progress in social indicators but "long way to go". Large regional disparities, historico-political roots, persisting to this day and even increasing (e.g. higher disparity between richest and poorest provinces; poverty increasing in poorest province). Institutional context (unitary country) Decentralisation: Long-standing lack of commitment as might shift political (ruling party/opposition) balance. New government (2004) introduced the political and financial \ fiscal decentralisation. As well, administrative de-concentration has given more responsibility to provinces and especially districts. Districts are the new budgetary units. Weak civil service capacity identified as one of the three most severe obstacles to policy implementation (very low capacity level at Independence - 1975; civil war; very slow progress with public sector reform). PFM: Long history of reform; new system introduced in 2002, progress according to PEFA 2004 and 2006 (though decline in budget credibility); But weak policy-budget link, and still improving internal and external control.	Policy/plan/M&E Health services are 95% publicly provided. Post-war strategies focused on service delivery rehabilitation and manpower development; Early sector-wide support (e.g. WB SIP 1996); First sector strategic plan (PESS I) (2001-5), important but lacking details; PESS II (developed with less donor input; higher GOM ownership) also lacks prioritisation. Human Resources (HR) issues extremely severe. Separate HR Plan developed (2008), not yet funded. Decentralisation implies that central Ministry of Health (MOH) is no longer involved in provincial health budgeting, which causes concern due to regional service coverage and cost recovery disparities, and imbalances in vertical (aid) funding. This also underlines the issues around the vertical funds. Spending level Health sector budget on an increasing trend, though partly due to better capture of project funding "on budget" (2007); Large increase also tied for HIV&AIDS. Overall, sector funding highly aid dependent. E.g. sector budget was 17.8% of State Budget in 2009 (up from 6.5% in 1993 and 14% in 2002). Over 70% sector funding = 26 donors. Small increase in recurrent budget. Large and structural disparities in health funding per capita across provinces and districts. Sector results Expanded coverage (e.g. increased consultation rates) resulted in significant improvements (1995-2003) e.g. in infant and under-5 mortality rates (from 149 to 124 and from 219 to 178; most rapidly in rural areas) and maternal mortality rates; albeit from very low basis; Disease burden has raised; High and rising HIV&AIDS prevalence (from 14% in 2004 to 16% in 2006 - of the adult population). Significant challenge to maintain earlier gains, including due to acute shortage and brain drain of qualified staff.	General aid trends Aid growing since 1986 (country moving away from command economic model). In 2006 ODA = 17% GNI (52 US$/capita); BS = 21.3% ODA. Very high % GNI in early 1990s, down since, but still roughly 50% of government budget. 1980s/early 1990s: projects, BOP, food aid; Late 1990s: Emerging SWAps and sub-sectoral Common Basket Funds; Early 2000s: focus on education and health, social sector SWAps, GBS and forms of SBS. GBS up from 3% ODA in 2000 to 21% in 2006 and 31% in 2008; Major policy dialogue platform, complex dialogue structure (19 donors), Performance Assessment Framework (PAF) and donor PAF (mutual accountability), focus on systems across government. Sector support 25%-30% (Common Basket Funding). Project support remains over 30%. Aid to the sector 26 donors; Code of Conduct adopted with SWAp (2000), regularly revised to reduce transaction costs on MOH and better link up sector processes to GBS. Joint annual reviews, sector monitoring through sector PAF and PESS indicators. Joint government/donor working groups on technical issues though unclear policy role. Pre-SBS SWAp Common Basket Funds = important channels for aid until 2008 (shift to SBS) (broadest fund had 15 donors, now SBS); Recent years have seen a surge in global vertical funding (off budget/Common Basket Funds); Projects have remained very numerous; Basket/SBS donors often also have projects.

	Recent trends: Increasing corruption/ political patronage; Donor fears over more personalised policy process, lesser commitment to economic liberalisation emerging with new government/President.	PFM capacities in sector weaker than average for government.	TA pooling has been discussed but never applied. It is on the agenda again.

b) Nature of the SBS Provided

	Types:	**Timescale:**	**Donors:**
Moz Health	Mozambique SBS	2008-	Canada, EC, Denmark, Spain, Belgium, Finland, UNFPA, France, Netherlands, Ireland, Italy, Norway, UK, Switzerland, UNICEF, Catalunya

	Funds and Financial Management	**Dialogue and Conditions**	**T/A and Capacity Building**	**Links to other Aid**
Moz Health	Funding Level: High ($86m in 2009) in absolute terms**.** Represents a switch from Common Basket Funding. Some significant vertical and parallel donor project funding remains outside, however. Earmarking: The funding is earmarked to the health sector and allocated to the investment budget. There are no explicit additionality requirements. Traceability: Overall funding to PROSAUDE II, the health strategy is traceable in the budget. Funds are either inscribed as internal or external funding. Use of Other Gov't FM Systems: With the exception of parallel procurement procedures for the procurement of medicines, government financial management procedures are used in full. Audits of procurements of medicines are carried out by an independent firm.	Dialogue Structures: Dialogue takes place in the context of pre-established SWAp structures. Conditionality Framework: Disbursements are bases on an overall satisfactory performance of the health sector against agreed indicators, which are assessed at joint annual reviews. However there is no common understanding of what satisfactory performance means, and they are yet to be reviews. The EC have their own specific conditions. Focus: Whilst the dialogue is intended to be sector-wide and policy focused, in practice, a lot of dialogue time is spent on process issues relating to the management of SBS funding. Derogations: The indicator framework against which progress will be assessed is new and additional to pre-existing SWAp reporting, however it will be assessed in the context of the established processes. EC conditions	Part of SBS Instruments: SBS was designed without specific TA or Capacity building elements. Links to other initiatives: There is little explicit link of SBS to capacity building activities which are largely funded through vertical funding, or ad hoc donor support.	Links to Project Funding in the sector: Some vertical funding, including GFATM is provided in the context of the SWAp, and linked in with the dialogue. Links to GBS: There is a strong link to GBS as some key donors (DFID among them) are providing GBS. Also, the dialogue structures for sectoral reviews and for the GBS decision making are timed to fit together.

	Funds and Financial Management	Dialogue and Conditions	T/A and Capacity Building	Links to other Aid
	Derogations: Main derogations relate to the parallel mechanisms for procuring medicines and allowing traceability and roll over of some donor funds.	represent a further derogation from this.		
	Other important design features			
	N/A			
	Effects of SBS on the Quality of Partnership			
	Quality of Dialogue: Over time the SWAp dialogue has improved, and an initiative to hold discussions through a donor focal point is appreciated by the MoH, although there are concerns over the frequency of rotation of the focal point. The dialogue has become more inclusive, with improved involvement of CSOs. There are however tensions. The GoM is disappointed by the unreliability of donor funding, whilst some DPs feel that government does not always follow up on its commitments. A general concern is that the dialogue spends too much time on process issues and technicalities of managing external assistance, and not enough time on substantive policy and system issues. This has not changed with the shift to SBS. Transactions Costs: Government and civil society actors felt that transactions costs had reduced over time, and the number of meetings between GoM and donors was cited to have gone down. The story on transaction costs was not entirely positive. It was perceived that the various working groups in the SWAp structure did not work well and were less efficient than they should be. Donors continue to have a large number of parallel projects which add to transactions costs. Again, the move to SBS has had little impact on the situation, although transaction costs are lower than would be the case if SBS donors used parallel financing mechanisms. External Factors: The government overall, and the Ministry of Health, recently appears to take more time for internal reflection, without involving the donors.			

c) The Effects of SBS in Practice

i) Policy, Planning, Budgeting, Monitoring, Evaluation and Expenditure

	Inputs	Effects	Outputs
	SBS funding is on budget, is aligned with government policies and is reported on using government systems. Focus (TA/CD, dialogue, conditions) on sector policy, planning, budgeting, monitoring and evaluation processes?	External funding more flexible and better aligned with sector policies overall; assistance better focused on supporting sector policy, planning and budgeting processes.	SBS contribution to: ▪ Public spending is better aligned with government sector policies. ▪ Improved Sector policy, planning, budgeting and reporting Processes

	Inputs *Derogations: why, justified, temporary?*	**Effects** *Effects of derogations*	**Outputs** *How do derogations affect outputs?*
Moz Health	**Contextual factors:** MoH less open to discussing policy issues and arriving to policy decisions internally. Huge increases in vertical funding; overall improvements to aggregate budgeting.		
	<u>Policy, Planning and Budgeting:</u> Channels for joint policy dialogue have been established. Working groups are the main vehicle for technical policy work, and donors are involved. However, little systematic attention in the dialogue has been made to policy decisions over the years, with a disproportionate time being spent on donor funding modalities. Donors now providing SBS have supported the government to prepare the two iterations of the PESS in the past, as well as a costing exercise for PESS II. Donor SBS commitments fit into the national budgeting processes, with the JRES taking place at the beginning of the budget cycle allowing SBS commitments to feed into budget projections. SBS has kept most donors providing joint funding in the shift from Common Basket Funding, although the Global Fund, which participated in one of the Common Basket Funds, is not participating in SBS. Both externally and domestically labelled SBS remain separately identifiable and earmarked to the investment budget.	Whilst policy dialogue structures are well in place, there is insufficient time allocated to the substance of policy as too much time is spent discussing funding modalities. TA and Capacity Building is focused more on policy, planning and budgeting, following the SWAp and now SBS.	In the context of the SWAp, a clear framework for policy dialogue was developed, and this has continued with the shift to SBS. The Ministry of Health has become more confident in developing its own policy proposals. It was perceived that the various working groups in the SWAp structure did not work well and were inefficient, given the number of policy decisions which were being taken independently of the working group structure, and that the role of the working groups in decision making was unclear. However, PESS II, which is supposed to guide resource allocation, however it is broad and not sufficiently prioritised. It is not a significant improvement on PESS I. Costing of the PESSII was an important step forward, however it revealed a large shortfall in funding. This problem is exacerbated by fragmentation of planning documents The SWAp has contributed to gradual improvements in the annual planning and budgeting processes – from fragmented project funding, to a more cohesive set of support, which SBS has maintained. The annual operational plan, the PES is now prepared at the same time as the national budget, and coherence should improve. The new timing for donor SBS commitments will allow greater predictability in budgeting. Overall systematic weaknesses in budgeting remains. They are input based budgets, which makes them difficult to link to plans; there are incremental increases in recurrent funding and weak links between recurrent and development, which itself is made up of significant operational funding. The investment budget, to which SBS funds contribute, remains centralised at the health ministry. This makes planning and budgeting at the provincial level, which receives investment funding difficult. Parallel project funding creates incentives for provinces to engage directly with donors.
	<u>Monitoring and Reporting processes:</u> The joint annual review (ACA) is the main focus point for discussing sector performance.	The SWAp facilitated the development of structures to monitor	M&E processes have been streamlined in the context of the SWAp from fragmented project-based monitoring, to common sector processes, and this has been maintained in the context

	Inputs	Effects	Outputs
	There has been move to a Performance Assessment Framework, with reporting against a common set of indicators and based on a dialogue between sector and DPS. These include key targets relating to input, outputs, impact and process indicators. However, this has not been linked to the process of agreeing actions at the reviews. Historically, there have been issues with the poor response and follow up to these recommendations. A problem is that these have not been linked to the conditionality framework, and that there is insufficient prioritization of the recommendations This has been highlighted in several annual reviews and will still need to be addressed	sector performance, The health PAF represents a step forward. The continuation of parallel projects and vertical programs continues to present a problem for sector monitoring.	of SBS. The annual review is an important forum to discuss sector performance. The Performance Assessment Framework represents progress in development of an instrument to monitor progress and is integrated with the process of agreeing on actions at the Annual Review.
	<u>Resource Allocation:</u> SBS funding does not represent an increase, but a switch from Common Basket Funding. It remains substantial, $xxx in 2008. It is separately identifiable in the investment budget, even though it is explicitly not earmarked to any specific expenditure. This is expect to change in 2010 budget. Dialogue on resource allocation??	An increase in volume of flexible external funding has been provided as a result of SBS, but this is earmarked to the investment budget and the increasing scale of vertical funding has undermined this.	Overall Sector Resource Allocation has tripled between 2005 and 2009, but this has been as a result of increase in vertical funding and not SBS, which represents a switch from Common Basket Funding. SBS represented less than a third of external funding in the health sector budget in 2008. This has resulted in substantial increases in the investment budget, with little commensurate increase in recurrent funding. The investment budget is made up of a large share of operational funding. Once it appears in the investment budget it is not aligned to the administrative departments of the MoH (which appear in the recurrent budget), which makes it very difficult to link the budget to plans. Thus it is unclear whether overall resource allocation is well oriented to sector policies or not, despite the flexibility that is there. Whilst the investment budget is centrally managed, the recurrent budget is highlight decentralised to provinces. Neither the 2008 or 2009 budget has resulted in increasing funding to the provinces, and there are concerns that equity concerns will not be addressed. Large disparities in budget allocations to provinces are testimony to this problem.

ii) Procurement, Accounting and Audit

	Inputs	Effects	Outputs
	SBS funding uses government expenditure control,	External funding uses	SBS contribution to:

	Inputs accounting and audit processes. Focus (TA/CD, dialogue, conditions) on strengthening government expenditure control, accounting and audit processes at the sector level? *Derogations: why, justified, temporary?*	**Effects** government FM systems more and is more predictable; assistance better focussed on gov't FM systems. *Effects of derogations*	**Outputs** ▪ Improved sector procurement, expenditure control, accounting and audit at the sector level; ▪ Sector budget more reliable and sector expenditure more efficient. *How do derogations affect outputs?*
Moz Health	**Contextual factors:** High levels of vertical funding in the sector; improvements in PFM, including the introduction of e-SISTAFE.		
	Donors have identified financial management as a key area of attention, and it has been a major focus of the dialogue. An annual assessment of progress on sector PFM, against a baseline established in early 2009, is a condition for SBS. The dialogue on procurement has also been prominent but weaknesses remain, and there is so far less progress in addressing these. SBS uses common financial management procedures which are largely aligned with government systems, and include the use of government procurement and audit systems, although an exception has been made for medicines to ensure that the move to new modalities, and the glitches that still exist in the use of the government procedures, do not affect the timely procurement and delivery of drugs. However, also, a number of SBS donors are supporting the acquisition and establishment of a software package for financial management which is parallel to the system which has been introduced government wide by (e-SISTAFE Vs Oracle Financials). The MoH alleges that this is necessary because the treasury system does not allow for management by portfolio. This is a symptom of the majority of external funding; SBS operates as large projects in the investment budget, but actually fund recurrent activities. These projects do not link to the administrative structure of the recurrent budget and need to be broken down to make them manageable. This would not be necessary if SBS and other donor funding funded the recurrent budget.	Although SBS uses government systems, the share of external funding using government systems has gone down as a result of the increase in vertical funding. The nature of external funding in the investment budget has led to the creation of parallel FM systems.	Over time budget execution has improved with the use of e-SISTAFE, the treasury's financial management system. However external funding, including SBS has influenced the nature of the investment budget in such a way that it is deemed necessary to develop parallel PFM systems. This could have been avoided if SBS was not separately identifiable in the budget, and were used to fund recurrent activities. Procurement remains weak, and subject to delays. Government procurement systems are bypassed for medicines under SBS, as is the case with other vertical programmes. This is a temporary measure and the MoU for PROSAUDE II clearly states that this will need to be addressed in the years to come. Nonetheless there is a risk of continuing to undermine system strengthening in the future, even though this is cited as a temporary measure. The use by SBS of the government audit systems, which has yet to take place, may support their strengthening in future.

iii) Capacity of Sector Institutions and Systems for Service Delivery

	Inputs	**Effects**	**Outputs**
	SBS use of Govt mainstream funding mechanisms and service delivery institutions (structures, guidelines, standards) Focus (TA/CD, dialogue, conditions) on devt and strengthening of mainstream service delivery institutions? Derogations: why, justified, temporary?	SBS contribution to focus aid (funds and other inputs) on govt service delivery systems & capacity Effects of derogations	SBS contribution to: ▪ Increased **total** funds flows through mainstream govt channels for service delivery, & used within regular institutional service delivery framework ▪ Stronger service delivery systems and institutions How do derogations affect outputs
Mozambique Health	**Contextual factors:** 95% health care is publicly provided; Ongoing decentralisation and consultative deconcentration; Severe restrictions on sector staff management policies, arising from macrofiscal considerations related to reducing GOM wage bill; Continued provision of aid through projects (including by health SBS donors), large increase in (off-budget) vertical funds, staff turnover and lack of specialist skills in donor agencies; Large and structural inequality in service coverage and in flows of resources, hence access to services, across provinces; Early (post-war) gains in services and outcomes are levelling off.		
	SBS considerably strengthens the use of GOM funding mechanisms for service delivery, building on prior Common Basket Funding experience. There are concerns over inequality of funding across provinces and possible impact on service delivery now that provincial health budgets will be decided through the regular budget allocation processes rather than Common Basket Funding processes. Systemic HR and capacity issues seriously affect the sector. This has been recognised since the post-war period [specific HR development plan in 1992; focus on institutional and organisational development in 1st sector-wide strategic plan PESS I (2001); focus on service delivery capacity and service quality in PESS II (2007-12)], but inadequately addressed. Albeit costed, PESS II was prepared without a detailed analysis of HR capacity needs, and it lacks prioritisation. GOM recently submitted a separate HR development plan (2008) aimed to address root causes of weak capacity (linked to salary differentials and staff training). SBS donors have yet to develop a common position with regard to support to the plan. It is not clear to what extent the plan would succeed to overcome the macrofiscal constraints preventing structural changes to staffing and HR management policies. Through projects and programs, donors (including SBS	The effects of SBS funds are unclear as they may be undermined by the other aid flows of funds. SBS donors argue that projects help them understand the reality on the ground, acknowledging that under the current arrangements for SBS there are challenges to ensuring that quality and access of service delivery remains central. The use of GOM systems by projects and vertical funds is limited, and the management of parallel systems continues to put a burden on the sector, although overall transaction costs are said to have reduced. Continued parallel projects and associated bilateral dialogues also take up GOM time and energy. Staff turn-over in donor agencies and lack of specialist expertise of	Notwithstanding the increasing resources for service delivery, rising inequality in funding across provinces would worsen inequality in service coverage. There are no specific equity indicators in the PAF which would allow tracking this. Common Basket Funding has allowed overcoming staffing limitations through hiring contract staff (through the "investment budget") and apparently this would continue to be possible with SBS. But this clearly is not a sustainable solution in terms of service delivery. There has been insufficient attention to capacity and systems for service delivery, which may be due to the fact that priority issues for DPs (good governance, transparency) don't necessarily address the impact on end users. The weakness of the decentralisation process plays out here too, though pre-SBS inputs did not address this as fully as might have been possible (no focus on district level).

	Inputs	Effects	Outputs
	donors) have supported strengthening management capacity. But this has focused on central and provincial levels, taking insufficient account of decentralisation and the role of districts. MOH has recently decided to end TA who were occupying line positions. TA pooling has been discussed but not pursued thus far though this is making a "come-back". SWAp/SBS performance monitoring focuses on service delivery through the inclusion of related indicators in the *health PAF*[8] *(a derogation to government systems which in the sector is said to be reasonably well owned).* But M&E systems are weak, making it difficult to get adequate reporting including on service delivery.	certain donors, as well as the move towards reducing specialist staff in agencies, to some extent limits the capacity of donors to interact and provide the kind of support which is needed to move SBS forward effectively.	The weakness of sector M&E systems makes it difficult to assess service delivery performance and is a challenge for the SBS.

iv) Domestic Ownership, Incentives, and Accountability

	Inputs	Effects	Outputs
	How do SBS inputs support ▪ Stronger ownership of policies (all levels) and incentives to implement them (any particular effort)? ▪ Stronger domestic accountability[9]/avoid parallel requirements & biasing accountability to donors (aid dialogue)?	SBS contribution to aid influence on: ▪ Strengthening ownership and incentives ▪ Strengthening domestic accountability/ avoidance of parallel requirements & of diversion of attention	SBS influence on ownership, incentives & domestic accountability (stronger sense of responsibility & demand for performance etc.)
	Derogations to domestic accountability systems: why, justified, temporary	Effects of SBS derogations on aid influence on ownership, incentives and accountability	
Mozambique health	**Contextual factors:** 95% health care is publicly provided; Ongoing decentralisation and consultative deconcentration; Severe restrictions on sector staff management policies, arising from macrofiscal considerations related to reducing GOM wage bill; Continued provision of aid through projects (including by health SBS donors), large increase in (off-budget) vertical funds, staff turnover and lack of specialist skills in donor agencies; Large and structural inequality in service coverage and in flows of resources, hence access to services, across provinces; Early (post-war) gains in services and outcomes are levelling off; Overall increase in GOM assertiveness in policymaking		
	Discretionary funding available to MOH through pre-SBS Common Basket Funding to implement the PESS contributed to strengthening MOH ownership. This is likely to be further strengthened with fully un-earmarked SBS. But there are still several	The health SWAp has systematised GOM/ donor interaction over policy; contributed to better aligning aid to priorities identified through the dialogue; contributed to better align aid fund management with GOM management systems. This has facilitated	The move to SBS has been time- and energy-consuming, which has tended to divert attention of all stakeholders away from policy processes and content. There seems to be mixed feelings as to whether GOM taking more of a lead in policy/planning was a good thing or not. SBS

[8] These indicators focus on extension service, farmers' access to market information and to markets, and land registration and management.
[9] Understood as accountability to parliament, of sector spending agencies to Min Finance, of service providers to sector ministry/LG, of service providers to citizens, of LGs to sector ministries (within respective mandates)

	Inputs	Effects	Outputs
	plans in the sector. Funds and other pre-SBS inputs helped build sector management capacity – though imperfectly (e.g. donors outnumber GOM staff in sector working groups). The SWAp mechanisms have been increasingly integrated with GOM processes, and this is further strengthened with the provision of SBS (e.g. detailed calendar fitting with GOM budget calendar). With the SBS PAF the assumption is greater (joint) attention to results and this is integrated with GOM accountability processes (PAF reporting integrated in annual report to Parliament). The process of moving from Common Basket Funding to SBS has coincided with the period of preparation of the PESS II, to which donors have been far less associated than for PESS I. Donors have expressed some reservation regarding the extent to which the PESS II effectively allows for priority setting although it is presumably more strongly owned by the MoH than PESS I. Similarly, donors appear to be taken aback by the initiative of MOH with regard to the HR development plan (2008). The PAF in the health sector is not donor-driven and is an integral part of the planning and monitoring cycle. However, inconsistent follow-up of issues identified in the Joint Reviews has been a problem; in part due to the sheer number of recommendations and the lack prioritisation..	greater policy ownership and supported domestic accountability lines and processes (including greater involvement of MOF and MPD) However, the extent to which donors were participating in all decisions may have been seen as intrusion, which may explain the greater distance which the new Minister seems to have established with donors (cutting down "substitution TA", privileging internal policymaking/planning processes). Moreover, the SWAp failed to produce a consensus (among donors and between donors and GOM) on how to address the HR crisis in the sector,. Common Basket Funding and now SBS "system alignment" have (had) positive planning and FM capacity effects but project funding and now vertical funding undermine the effect of Common Basket Funding/SBS on incentives (e.g. provinces continue to approach donor projects separately and donors also perpetuate this by maintaining separate interventions in addition to their support to SBS).	donors' reactions to PESS II and the HR development plan suggest a form of disconnect between SBS inputs and supporting GOM ownership. On the other hand, the move toward fewer/lesser derogations and in particular, the foregoing of any earmarking for SBS funds, should further reinforce policy ownership and strengthen incentives to implement plans and budgets that have not been constrained by donor earmarking requirements. But this, in turn, is undermined by the increasing proportion of funds channelled through parallel projects and programmes due to vertical funding in particular. Weak capacities and superficial participation (especially from/at decentralised levels) may also hinder fuller ownership. Pre-SBS Common Basket Funding and now SBS funding help mitigate the HR crisis through financing contractual staff hiring, but this doesn't address the underlying staff incentive issues, which is an issues which the HR plan – recently launched by the MoH but yet to be responded to – does comprehensively seek to address. Weak M&E systems also affect the capability of GOM (and its partners) to address incentive issues.

d) The Outputs and Outcomes of SBS

	Main SBS Outputs Influencing Outcomes	**Outcomes Influenced by SBS**
	Changes in sector policy, spending, institutions, service delivery systems and accountability influencing sector outcomes	Changes in the implementation of sector policies and delivery of services influenced by SBS
Mozambique Health	It is too early to say what contribution SBS specifically has made to these areas. SBS also represents a switch in modality, and has not resulted in increased sector funding. However the Common Basket Funds and associated SWAp procedures that preceded SBS improved consultation in policy processes; improved the discretion the MoH had over its resources to implement the PESS thereby contributing to strengthening government ownership and accountability. Within the sector, the understanding of key PFM issues that need to be addressed has increased and there is growing confidence in those systems. SBS is likely to maintain and further these improvements due to its better alignment and use of government systems. . However, there are a number of areas where less progress has been made: vertical funding continues to increase relative to SBS and SWAp funding before it, whilst project funding also continues; continued traceability of SBS funding; there remains fragmentation in sector planning; policy priorities are insufficiently clear; human resources have received insufficient attention to date; centralised nature of SBS especially for the investment budget (which SBS funds); and predictability of funding affects GoM planning and implementation capacity.	Progress on a select number of key health indicators suggest that service delivery in some areas has improved. There is, however only limited evidence so far that service provision at the field level, or the implementation of sector policies, have had a positive influence on sector outcomes. It is too early to assess the effect of the switch to SBS on these outcomes. However a number of factors would appear to favour some progress in future, including the improving predictability of funding, efforts to address key bottlenecks in PFM, and an improved framework for monitoring and evaluation. However this would need to be accompanied by improved prioritisation of sector resources, and addressing the capacity constraints to delivery in the sector, including human resources, which has yet to happen.

Annex 2 – Country and Sector Data

a) Core Country Data

Mozambique	1990	1995	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	SSA (2007)
Exports of goods and services (% of GDP)	8	16	12	13	18	25	28	29	32	33	41	39	**34**
GDP growth (annual %)	1	3	11	8	1	12	9	6	8	8	9	7	**6**
GNI per capita, Atlas method (current US$)	170	130	220	240	230	230	230	230	260	290	310	330	**951**
GNI per capita, PPP (current international $)	270	300	390	420	420	460	520	550	580	630	670	730	**1,869**
Gross capital formation (% of GDP)	22	27	18	20	31	20	30	22	19	19	19	19	**22**
Inflation, GDP deflator (annual %)	34	51	5	4	12	15	8	5	7	9	7	6	**6**
GDP (current US$m)	2,463	2,247	4,240	4,448	4,249	4,075	4,201	4,666	5,698	6,579	6,961	7,790	**847,438**
Official development assistance and official aid (%GDP)	40	47	25	18	21	24	53	22	22	20	23	23	**4**
Official development assistance and official aid (current US$m)	998	1,062	1,040	819	906	963	2,218	1,049	1,243	1,290	1,605	1,777	**35,362**
Revenue, excluding grants (% of GDP)	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Total debt service (% of exports of goods, services and income)	26	35	18	17	12	8	6	6	4	4	2	1	**5**
Fertility rate, total (births per woman)	6	6	-	-	6	-	6	-	-	5	5	5	**5**
Population growth (annual %)	1	3	3	2	3	3	3	2	2	2	2	2	**2**
Population, total (m)	14	16	17	18	18	19	19	20	20	21	21	21	**800**
Income share held by lowest 20%	-	-	-	-	-	-	-	5	-	-	-	-	**-**
Poverty headcount ratio at national poverty line (% of population)	-	-	-	-	-	-	-	54	-	-	-	-	**-**
Agriculture, value added (% of GDP)	37	35	31	29	24	23	28	28	27	27	28	28	**15**
Primary completion rate, total (% of relevant age group)	26	26	13	14	16	19	22	-	30	42	42	46	**-**
Ratio of girls to boys in primary and secondary education (%)	-	-	-	74	75	77	78	-	82	83	85	85	**-**
Births attended by skilled health staff (% of total)	-	-	-	-	-	-	-	48	-	-	-	-	**45**
Contraceptive prevalence (% of women ages 15-49)	-	-	-	-	-	-	-	16	-	-	-	-	**23**
Immunization, measles (% of children ages 12-23 months)	59	71	64	66	71	74	77	77	77	77	77	77	**73**
Life expectancy at birth, total (years)	44	45	-	-	45	-	44	-	-	43	42	42	**51**
Malnutrition prevalence, weight for age (% of children under 5)	-	-	-	-	-	-	-	21	-	-	-	-	**27**
Mortality rate, under-5 (per 1,000)	201	190	-	-	184	-	-	-	-	174	171	168	**146**
Prevalence of HIV, total (% of population ages 15-49)	1	4	8	9	10	10	11	12	12	12	12	12	**5**
Roads, paved (% of total roads)	17	19	19	19	19	19	-	-	-	-	-	-	**-**
Improved sanitation facilities, urban (% of urban population with acces	-	49	-	-	51	-	-	-	-	-	53	-	**-**
Improved water source (% of population with access)	36	39	-	-	41	-	-	-	-	-	42	-	**-**

Source: World Bank Website – Africa Quick Query (2009)

b) Sector Expenditure Data

Overall Expenditure in the Sector

Description (Sector \ Institutions)	CGE			CGE			CGE			State Budget (OE)			Proposal of OE		
	2005			2006			2007			2008			2009		
	Current Expenditure	Investment Expenditure	Total Expenditure	Current Expenditure	Investment Expenditure	Total Expenditure	Current Expenditure	Investment Expenditure	Total Expenditure	Current Expenditure	Investment Expenditure	Total Expenditure	Current Expenditure	Investment Expenditure	Total Expenditure
HEALTH	1,891,051	2,792,340	4,683,391	2,451,962	3,387,037	5,838,999	2,839,781	4,375,300	7,215,081	3,417,596	6,789,802	10,207,398	3,446,566	13,704,847	17,151,413
Health System	**1,891,051**	**2,438,345**	**4,329,396**	**2,451,962**	**2,899,134**	**5,351,096**	**2,839,781**	**3,992,899**	**6,832,680**	**3,417,596**	**6,152,076**	**9,569,672**	**3,446,566**	**13,113,951**	**16,560,518**
Ministry of Health	567,899	2,355,745	2,923,644	865,932	2,747,693	3,613,625	913,710	3,807,953	4,721,663	1,090,105	5,162,378	6,252,483	1,126,325	11,874,421	13,000,747
Provincial Directorate of Health	1,033,347	67,125	1,100,472	1,236,398	126,560	1,362,958	1,475,742	171,311	1,647,053	1,252,216	961,969	2,214,185	1,246,769	1,222,189	2,468,958
Provincial Hospitals	0	0	0	0	0	0	0	0	0	211,988	5,150	217,138	218,315	0	218,315
General Hospitals	0	0	0	0	0	0	0	0	0	126,516	0	126,516	63,914	0	63,914
General Hospitals	*0*	0	0	*0*	0	0	*0*	0	0	*0*	0	0	*50,243*	0	50,243
Central Hospital of Maputo	193,436	4,425	197,861	236,556	7,617	244,173	309,726	9,450	319,176	487,914	15,000	502,914	524,239	17,342	541,581
Other Central Hospitals	96,369	11,050	107,419	113,076	17,264	130,340	140,603	4,185	144,788	227,889	7,579	235,468	169,623	0	169,623
Psychiatric Hospital	0	0	0	0	0	0	0	0	0	20,968	0	20,968	22,590	0	22,590
General Hospitals	0	0	0	0	0	0	0	0	0	0	0	0	24,547	0	24,547
HIV/SIDA	**0**	**353,995**	**353,995**	**0**	**487,903**	**487,903**	**0**	**382,401**	**382,401**	**0**	**637,726**	**637,726**	**0**	**590,895**	**590,895**
National Council to Combate HIV/AIDS	0	353,995	353,995	0	487,903	487,903	0	382,401	382,401	0	637,726	637,726	0	590,895	590,895

Million of MT

Source: CGE 2005, 2006, 2007, LOE 2008 e 2009

Current Expenditure in the Sector

Current Expenditure in the Health Sector in 2005 (Million of MTn)																		
Classification by Insitutions	Personnel Expenditures			Good and Services			Current Transfers			Other Current Expenditures and *Encargos Gerais*			Capital expenditure			Total	Realiz.	%
	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%			
Health Ministry	93,464	93,464	100	675,679	469,967	70	2,599	2,599	100	117,680	370	0	11,500	1,499	13	900,922	567,899	63
Provincial Directorate of Health	651,529	651,529	100	410,241	329,344	80	5,439	4,867	89	69,829	36,281	52	19,390	11,326	58	1,156,428	1,033,347	89
Central Hospitals	174,088	174,088	100	130,378	113,669	87	549	333	61	16,375	0	0	3,292	1,715	52	324,683	289,805	89
Other Institutions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**919,081**	**919,081**	**100**	**1,216,298**	**912,980**	**75**	**8,587**	**7,799**	**91**	**203,884**	**36,651**	**18**	**34,182**	**14,540**	**43**	**2,382,033**	**1,891,051**	**79**

Current Expenditure in the Health Sector in 2006 (Million of MTn)																		
Classificação Orgânica	Personnel Expenditures			Good and Services			Current Transfers			Other Current Expenditures and *Encargos Gerais*			Capital expenditure			Total	Realiz.	%
	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%			
Health Ministry	98,377	96,100	98	692,519	692,399	100	352	239	68	57,964	55,170	95	22,132	22,024	100	871,344	865,932	99
Provincial Directorate of Health	809,609	795,791	98	380,503	379,713	100	13,770	3,133	23	48,119	46,508	97	13,517	11,254	83	1,265,518	1,236,398	98
Central Hospitals	222,743	202,193	91	129,346	129,344	100	1,406	880	63	5,570	1,566	28	15,701	15,652	100	374,765	349,635	93
Other Institutions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**1,130,729**	**1,094,083**	**97**	**1,202,368**	**1,201,456**	**100**	**15,527**	**4,252**	**27**	**111,653**	**103,245**	**92**	**51,350**	**48,930**	**95**	**2,511,626**	**2,451,965**	**98**

Current Expenditure in the Health Sector in 2007 (Million of MTn)																		
Classificação Orgânica	Personnel Expenditures			Good and Services			Current Transfers			Other Current Expenditures and *Encargos Gerais*			Capital expenditure			Total	Realiz.	%
	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%	Budget	Realiz.	%			
Health Ministry	100,654	100,654	100	760,498	759,886	100	11,829	11,770	100	3,916	3,443	88	36,885	36,885	100	913,781	912,638	100
Provincial Directorate of Health	950,237	950,237	100	447,295	447,109	100	29,309	28,793	98	31,242	31,233	100	19,471	19,208	99	1,477,555	1,476,580	100
Central Hospitals	251,450	251,449	100	178,513	178,513	100	2,038	2,038	100	739	739	100	16,340	16,340	100	449,081	449,080	100
Other Institutions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**1,302,341**	**1,302,340**	**100**	**1,386,306**	**1,385,508**	**100**	**43,175**	**42,601**	**99**	**35,897**	**35,415**	**99**	**72,696**	**72,433**	**100**	**2,840,416**	**2,838,297**	**100**

Source: CGE 2005, 2006, 2007

Investment Expenditure in the Sector

Description	CGE 2005	CGE 2006	CGE 2007	State Budget (OE) 2008
TOTAL - Investment Expenditures	**2,792,340**	**3,387,037**	**4,375,300**	**6,789,802**
Internal Component	*215,158*	*189,467*	*379,018*	*260,328*
External Component	*2,577,182*	*3,197,570*	*3,996,282*	*6,529,474*
Total Common Fund	**2,176**	**2,643**	**3,151**	**3,013**
PROSAUDE Common Fund	1,209	1,126	1,007	2,146
SAUPROV Common Fund	147	461	663	
Common Fund of Drugs	717	846	1,246	290
HIV/SIDA Common Fund	103	210	235	577

Source: CGE 2005, 2006, 2007 and OE 2008

* For 2008, the values for common fund are from Budget Execution Report III and correpond the actual budget until September

Annex 3 – Country and Sector Aid Data

a) Country Aid Data

Donor	2005	2006	2007	2008	2009
ADB	91,313,433	125,765,509	79,519,403	163.988.576	208.002.985
AUSTRIA	2,590,966	5,934,173	2,375,429	6.978.020	6.759.696
BELGIUM	11,277,916	14,893,246	16,160,729	17.031.773	16.622.133
CANADA	23,479,687	37,432,153	37,322,184	61.060.525	59.409.314
DENMARK	45,469,339	44,266,356	65,886,172	96.347.339	90.322.030
EC	185,960,913	170,560,033	195,765,157	224.146.220	183.580.363
FINLAND	25,937,587	28,173,683	27,915,227	39.442.857	43.000.000
FLANDERS	19,999,097	3,950,994	20,703,660	5.047.624	10.203.176
FRANCE	18,200	20,112,314	19,094,099	22.734.007	22.391.107
GERMANY	22,697,933	39,475,463	51,426,309	59.462.340	82.962.294
IRELAND	26,474,160	26,679,693	60,560,081	45.203.169	75.857.143
ITALY	26,379,424	34,277,546	42,603,841	27.286.187	14.210.053
JAPAN	406,204	13,742,935	20,660,719	24.799.048	23.496.366
MCC	0	4,506,226	1,600,796	8.577.864	49.421.287
NETHERLANDS	56,725,643	64,009,724	84,242,576	84.742.317	104.670.410
NORWAY	59,594,350	59,708,053	65,454,300	47.931.439	42.024.176
PORTUGAL	25,916,560	24,695,199	22,982,389	8.153.300	7.070.037
SPAIN	22,008,321	26,931,634	35,050,423	33.588.239	33.050.964
SWEDEN	78,971,158	95,688,006	97,957,105	114.514.198	115.882.438
SWITZERLAND	11,799,931	9,792,556	19,304,573	20.802.568	6.587.302
UK	78,395,833	101,303,051	111,947,469	117.173.020	119.460.784
USAID	58,348,343	73,467,636	106,064,761	168.371.522	180.532.397
WORLDBANK	240,820,000	222,685,000	239,682,821	219.180.000	293.550.000
GRAND TOTAL	**1,132,766,487**	**1,248,051,181**	**1,424,280,221**	**1.616.562.152**	**1.789.066.454**
UN Agencies	**2005**	**2006**	**2007**	**2008**	**2009**
FAO	3,058,653	5,393,266	4,981,861	8.739.131	8.372.083
GLOBALFUND	16,384,567	23,387,475	42,336,774	50.176.449	45.599.209
UNAIDS	73,540	209,252	203,688	317.126	607
UNDP	4,607,443	6,612,487	16,689,032	12.091.528	6.876.000
UNESCO	0	182,178	993,800	2.577.659	2.874.810
UNFPA	0	0	24,164,962	9.954.409	13.059.649
UNHABITAT	442,992	161,581	0	0	0
UNHCR	0	0	450,750	1.597.058	1.412.000
UNICEF	7,466,660	8,110,257	28,281,870	25.445.710	27.229.000
UNIDO	0	863,000	1,268,000	2.245.000	6.736.000
WFP	27,248,000	28,784,000	32,462,640	32.310.104	40.500.000
WHO	0	0	0	1.496.985	3.101.650
GRAND TOTAL	**59,281,855**	**73,703,496**	**151,833,377**	**146.951.159**	**156.367.401**

* Please note that the total UN agencies may include bilateral funding from bilateral Donorsalready included on the side of the Donor in ODAmoz

Source: ODAMOZ (http://www.odamoz.org.mz/ptreports/annual_totals.asp)

b) Aid to the Sector

Level of Aid and Mix of Aid Modalities in the Health Sector

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Common Funds	$17m (18%)	$20m (21%)	$37m (33%)	$63m (43%)	$106m (45%)	$99m (41%)	$125m (45%)	$0m (0%)	$0m (0%)
SBS	$0m (0%)	$0m (0%)	$0m (0%)	$0m (0%)	$0m (0%)	$0m (0%)	$0m (0%)	$74m (35%)	$86m (n/a%)
Vertical/Project Funding	$75m (82%)	$75m (79%)	$75m (67%)	$85m (57%)	$130m (55%)	$141m (59%)	$150m (55%)	$138m (65%)	n/a

Source: Table (data 2001 – 2007) imported from IHP 2008c[10]

Number of Aid Instruments in the Health Sector

Type of Aid	Total
Budget Support	3
SWAP	12
Project	59
Technical Assistance (TA)	21
Studies	6

[10] Source quoted in the original document: MoH, Directorate for Planning and Cooperation

Annex 4 – Inventory of Sector Budget Support

a) Details of Inputs by Type of SBS

This table provides a detailed description of SBS inputs provided in the country.

SBS Input	MoU – PROSAUDE I	MoU – PROSSAUDE II
(i) SBS Programmes and their Objective		
Programmes Included (state donor)	▪ Common Fund for Support to the Health Sector - PROSAUDE I (November 2003); ▪ Addendum to the PROSAUDE of the Provincial Common Fund (May 2004) ▪ Addendum to the PROSAUDE of the Common Fund for Drugs and Medical Supplies – FCMSM (signed July, 2004) ▪ Second Addendum to the addendum to the PROSAUDE of the FCMSM (March, 2007)	▪ PROSAUDE II ▪ Single financing mechanism, inscribed within the State Budget.
What Were the Objectives of SBS Operations and how has this evolved over time?	▪	▪ Implementation of the health sector PESS
(ii) Level of Funding and Arrangements for Predictability		
Trends in the size of SBS agreements over time. (relate to table in part c of the inventory)	▪	▪
Mechanism and timing communication of amounts for the next financial year and the medium term and their reliability in practice. (relate to table in part c of the inventory)	▪	▪ The CPs will ensure the predictability of funds provision, by providing MISAU with an indication of their medium-term financial commitment, preferably on a rolling basis over at least three consecutive years, based on the budget needs of the PESS and consistent with the Medium Term Expenditure Framework (MTEF). The commitments will be confirmed on an annual basis, in accordance with the procedures set out in Article 5.A of the respective MoU; ▪ Disbursement plan for year n+1 will be agreed upon between MISAU and the CPs prior to the end of year n. As much as possible, this plan will take into account MISAU's treasury plan, based on the Health Sector PES.

SBS Input	MoU – PROSAUDE I	MoU – PROSSAUDE II
No. and timing of tranches within the financial year and their predictability in practice.	▪ The disbursements by the Co- operation Partners will be made in two annual (fixed or variable) tranches. ▪ Every quarter, the CGF shall request the transfer of the funds from the FOREX PROSAUDE account, through the Central Treasury Account in Meticais, to the Directorate of Administration and Management (DAG) / MISAU's PROSAUDE Account in Meticais. The DNT / MPF shall have a time limit of 15 days to carry out the transfers. The initial transfer shall be made with no submission of proof of expenses and shall correspond to the expenses planned in the Operational Plan for the current year.	▪ The disbursements by the Co- operation Partners will be made in one or two annual (fixed or variable) tranches. ▪ Over the fiscal year, disbursements will be made in a timely fashion as agreed in the calendar so as to respect MISAU´s financial needs.
(iii) Earmarking, Additionality and Disbursement Channels		
Route of channelling funds to treasury and thereafter to sector institutions (describe diagram in section b of inventory)	▪ PROSAUDE combines funds provided by the Signatory Partners, deposited into a FOREX PROSAUDE account at the Bank of Mozambique. These funds will be transferred by the Ministry of Planning and Finance (MPF) upon request by MISAU. MISAU will then be responsible for managing the funds, ▪ PROSAUDE funds will be channeled to any and all cost centres in the health sector that receive and manage funds from the State Budget ▪ The Common Fund for Drugs and Medical Supplies will, from 2004, be managed by the Centre for Drugs and Medical Supplies (CMAM) on behalf of MISAU; ▪ As from 2004, the Provincial Common Fund (FCP) will be managed by MISAU. The funds will be deposited at a Commercial Bank, in the name of MISAU/Directorate for Administration and Management (DAG), and will be transferred to the accounts of the Provincial Directorates of Plan and Finance (DPPF) in accordance with management norms to be agreed between the Signatory Partners of the FCP, MISAU and MPF. In the	▪ Disbursements shall be deposited into a specific Forex account in USD and/or EURO, indicated by the GoM, entitled to of the Ministry of Finance - the national Directorate of Treasury, hosted by the Bank of Mozambique. ▪ From this Forex account funds will be transferred via transitory account in Meticais to the General CUT. In the General CUT the PROSAUDE II funds will be coded as either internal or external funds, depending on the specification of the donor. The transitory account will remain in place only for so long as it is required. ▪ From the General CUT, it will follow national financial procedures. ▪ **In general**: flow of funds from the Forex account through the transitory account to the General CUT and at the other hand the flow of funds from the Credit Suisse account for the procurement of medicines and medical supplies

SBS Input	MoU – PROSAUDE I	MoU – PROSSAUDE II
	medium term (3-5 years), and as and when considered suitable by MISAU's management and the Signatory Partners, the FCP will be transferred to the PROSAUDE FOREX account and channeled through the Treasury's Account at the BM, to the DPPFs.	
Requirements for additionality of funds to sector budgets / programmes within the sector, if any.	▪ None	▪ None
Arrangements for earmarking of funds to specific programmes in the budget and during budget execution	▪ Nature of the CF (targeting specific priorities) allowed for earmarking in the budget.	Funds can be marked internal or external, but specific earmarking is not possible under PROSAUDE II
(iv) Conditionality and Dialogue		
Nature of Underlying MoU/Agreement (this may be agreement specific or joint)	▪ The MoU refers to the management norms for PROSAUDE ▪ The respect for human rights, democratic principles, the rule of law and good governance, which govern the domestic and international policies of the Signatories, form the basis of the cooperation and constitute essential conditions of this Arrangement.	▪ The Second MoU signed in July, 2008 sets out the terms and procedures for channelling external financial support to the Health Sector in support of implementation of the PESS within the overall framework of a partnership between MISAU and the enlarged group of Co – operation Partners. ▪ This partnership is based on the principles of a harmonized Sector-Wide Approach (SWAp) in support of building an effective health system that benefits the Mozambican population and contributes to sustainable development. The partnership presupposes mutual commitment, reliability, respect, confidence and accountability.
The nature of Performance indicators monitored, and the source of performance indicators	▪	▪ The performance of the health sector for the whole year of 2008 will be assessed using the Performance Assessment Framework for the Health Sector (Health PAF) and its targets for 2008; ▪ The monitoring and the review process have as their objective to be fully in harmony with and integrated into the GoM's planning, budgeting, and reporting cycle and follow an agreed timetable

SBS Input	MoU – PROSAUDE I	MoU – PROSSAUDE II
Accountability requirements for SBS programmes	▪ None	None
Existence of any performance assessment framework or equivalent, and description of its structure and content.	▪	▪ An annual Public Financial Management (PFM) assessment, that will include the quality of planning and budget execution, will assess progress in this area. This external independent assessment will be financed by one of the CPs, while not ruling out alternative financing. The PFM assessment will be concluded annually before the Annual Joint Evaluation (ACA) of the sector, thus allowing its results to feed into the Joint Review. At the end of the annual Mid-Year Review of year n the signatories will agree on the type of PFM assessment that will be undertaken before the ACA in year n+2.
Process for reviewing adherence to conditions	▪ Undertaken by CF partners with MoH	▪ Monitoring against PAF indicators
Linking of conditions to the triggering of release of funds	▪ The initial disbursements made by the Signatory Partners into the PROSAUDE FOREX account for the Health Sector shall was depending on the effectiveness of the conditions defined in Section 20 of this MoU and on each Signatory Partner receiving a formal request from MISAU a least one month before the date of the disbursement. The subsequent disbursements made by the Signatory Partners into the FOREX account shall be carried out as follows: **a. Disbursement for the first semester**: ▪ Existence and approval of the Health Sector's Annual Operational Plan for the year in question and consistent with the objectives of the PES concluded by the 30th of November. The Annual Treasury Plan reflecting quarterly periods should be annexed thereto; ▪ The recommendations of the joint evaluation of the Health Sector performance and reflected in the Annual Operational Plan; ▪ In compliance with the Agreed Annual Disbursement plan,	▪

SBS Input	MoU – PROSAUDE I	MoU – PROSSAUDE II
	the receipt of a formal letter of request for disbursement from the Technical Group of the Financial Management Committee (GT-CGF) approved by the CGF to each Signatory Partner at least one month before the date for the deposit; ▪ Approved Final Audit Report from the year before (starting from the first semester of the third year in operation of PROSAUDE). **b. Disbursement for the second semester**: ▪ Annual activity and financial report for the previous year; ▪ PROSAUDE's Preliminary Annual Audit Report (including auditor's issued opinion) (starting from the second semester of the second year in operation of PROSAUDE); ▪ In compliance with the Agreed Annual Disbursement Plan, the receipt of a formal letter of request from the GT-CGF approved by the CGF to each Signatory Partner at least one month before the date for the deposit.	
Mechanisms/Fora for dialogue with respect to SBS	▪ Joint Annual Reviews (ACA), working groups, coordination through focal donor	▪ Joint Annual Reviews (ACA), working groups, coordination through focal donor. Timing linked to government planning cycle
(v) Links to TA and Capacity Building (See Annex 3b)		
Is the provision of technical assistance and capacity building an explicit part of the programme? If yes, describe.	▪ The TA and capacity building is an explicit part of the programme because one of the way that PESS aims to achieve its objectives is: Through institutional capacity building, particularly in the areas of policy analysis, planning, management and system administration. ▪ ▪ The funds provided by the Signatory Partners through PROSAUDE shall be exclusively used to finance Mozambique's health sector expenses which are accepted as eligible	▪ The TA and capacity building is an explicit part of the programme ▪ PROSAUDE II funds will be used to cover all eligible expenditures, defined as being: (i) Consistent with the PESS; (ii) Consistent with the Annual Economic and Social Plan of the Health Sector (Health Sector PES), that has been formally presented and discussed with the CPs before sending it to

SBS Input	MoU – PROSAUDE I	MoU – PROSSAUDE II
	expenses ▪ PROSAUDE's expenditures (hereinafter referred to as *eligible expenses*) to be financed in the scope of the PROSAUDE in any given year are defined and agreed as being all the expenses arising from the carrying out of activities and investments that are: **i.** Registered in the State Budget; **ii.** Consistent with and priorities in the context of the PES and the PESS **iii.** Included in the Annual Operational Plan of the Health Sector.	MPD; and (iii) Reflected in the budget approved (or legally revised) by the Parliament (Assembleia da República). ▪ Under no circumstances should the CPs earmark their contributions within PROSAUDE II for specific activities. PROSAUDE II funds can be used for all budgeted expenditures within the sector, and need not be limited to the financing of expenditures classified as investment.
Is the provision of TA/Capacity building in other programmes/provided by other donors explicitly linked to the provision of SBS?	▪ No	▪ No
Are there TA/Capacity Building conditions built into the SBS programme? If yes, describe.	▪ No	▪ No
(vi) Coordination with other SBS programmes and other aid modalities *e.g. common calendar, joint missions, common set of indicators, pooling of funds, delegated cooperation or silent partnership, Joint diagnostic and performance reviews*	Yes	▪ Yes
What provisions are there for coordinating the provision of SBS and its associated dialogue and conditionality amongst DPs providing SBS?	▪ Donor meetings	▪ Donor meetings
What provisions are there for coordinating the provision of SBS inputs with General Budget Support?	▪ None	▪ Through Heads of Cooperation ▪ Timing so that SBS discussion fits into GBS dialogue ▪ Working group members shared over SBS and GBS mechanism
What provisions are there for coordinating the provision of SBS with project and other forms of aid to the sector?	▪ Through sector dialogue if projects are on-budge	▪ Through sector dialogue if projects are on-budget
(vii) SBS as a transition mechanism		
Have donors providing project/basket funding shifted their support to SBS? What was the justification for doing so?	▪ Yes the PROSAUDE I and FCP. It is important to note that the funds provided by the Signatory Partners through PROSAUDE will be deposited, managed and used in accordance with the norms and regulations of the State Budget; ▪ This mechanism increase transparency and improving control and management of	▪ Yes, the PROSAUDE II that include all funds. ▪ PROSAUDE will be managed using the rules, norms and regulations of the State Budget; ▪ This mechanism increase transparency and improving control and management of funds. ▪ Facilitates the monitoring

SBS Input	MoU – PROSAUDE I	MoU – PROSSAUDE II
	funds.	and evaluation of the use of funds
Have donors shifted from the provision of SBS to general budget support? What was the justification for doing so?	▪ No	▪ Yes, some donors have partially shifted (e.g. DFID)
(viii) Influence of HQ requirements on the design of SBS instruments		
Degree to which the design of SBS has been influenced by donor HQ requirements	▪	▪

b) Financial Contributions against Budget over Time (US$m)

Description	CGE 2005	CGE 2006	CGE 2007	State Budget (OE) 2008
TOTAL - Investment Expenditures	**2,792,340**	**3,387,037**	**4,375,300**	**6,789,802**
Internal Component	*215,158*	*189,467*	*379,018*	*260,328*
External Component	*2,577,182*	*3,197,570*	*3,996,282*	*6,529,474*
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SAUPROV Common Fund	147	461	663	
Common Fund of Drugs	717	846	1,246	290
HIV/SIDA Common Fund	103	210	235	577

Source: CGE 2005, 2006, 2007 and OE 2008

* For 2008, the values for common fund are from Budget Execution Report III and correpond the actual budget until September

Annex 5 – Key SBS Documents

a) Performance Assessment Framework for the Health Sector

The Health Sector Performance Assessment Framework

Regarding
PROSAUDE II

Maputo, July 2008

Article 1: Introduction

In order to annually assess the performance of the health sector, there is a need for a unique framework jointly agreed by MISAU and CPs.

The Health Sector PAF is an agreed matrix of input, output, outcome, impact and process indicators and their respective targets to measure performance of the sector in delivering quality services through effective and efficient management and utilization of human and financial resources at national, provincial and district levels.

The purpose of a health sector performance assessment framework (Health Sector PAF) is to enable all health sector partners (not only those contributing to PROSAUDE) to develop a joint assessment with MISAU of results achieved each year. It is intended to look at performance against targets in high priority areas. It is important that the PROSAUDE II MoU is complementary to Direct Budget Support (DBS), and therefore the Health Sector PAF indicators and targets should complement and supplement both those of the DBS PAF and the PARPA.

Article 2: The indicators

The indicators have been chosen from across the width of the sector, including issues such as financial management, budget execution, human resources management, etc., process issues such as the timely completion of policies and strategies, and progress made in taking forward institutional reform. In addition to targets for year n+1, the Health Sector PAF will also include indicative targets for the succeeding three years (year n+2, n+3, and n+4), based on realistic medium term commitments against each indicator, and targets already set in the PESS, PARPA and MTEF.

While drafting the Health Sector PES for the coming year (year n+1), MISAU will each year review and confirm indicators and targets in the Health Sector PAF. Indicators should however as far as possible remain the same over the medium term to allow the identification of trends, and targets should only be changed if appropriately justified, such as by a significant change in context. This will be done through a process of dialogue between directorates within MISAU and between Ministries, in particular with MPD and MF.

Article 3: Process

The Health Sector PAF will orient the dialogue between MISAU and CPs on health services performance. MISAU will therefore make the assessment of performance against the Health Sector PAF matrix an integral part of its annual Health Sector Implementation Report (Balanço do PES Saúde).

At the first CCS meeting of each year, the main focus will be on MISAU's and CPs' performance in the previous year (year n-1), where the performance against Health Sector PAF targets will be a core topic for discussion.

In the context of the annual assessment of performance in year n-1, CPs and MISAU will also review indicators and targets for the Health Sector PAF for the next year (year n+1). This will prepare for the Health Sector PAF proposal for year n+1 that MISAU will define by means of intra- and inter- ministerial dialogue in respect to and during the same period as the definition of the Health Sector PES for year n+1. The Health Sector PAF, including targets for year n+1, will then be agreed at the same time that the health Sector PES is agreed between MISAU and CPs, at the second biannual CCS at the end of July. The Health Sector PAF, complete with targets, will then be annexed to the Health Sector PES that MISAU submits to MPD.

Article 4: Performance based financial commitments

The assessment of the results in year n-1 against PAF targets will determine CPs' indicative financial commitments for year n+1. The assessment process will culminate in a joint agreement amongst signatories on the adequacy of the overall performance. This will be sufficient for some donors to provide their full indicative commitments, but others may wish to provide (a proportion of) their funds against the achievement of a specific set of indicators and targets. Specificities particular to individual CPs' mechanisms of performance based financing are given in Annex 1. This may include the use of a split response mechanism.

Objective	Indicator
Reduce child and youth mortality	*Rate of child and youth mortality*
1. Strengthening of the PAV activities, notably the component of the mobile groups in order to at least maintain the % of children aged below one with high DPTHepB3 coverage	Coverage rate with DPTHepB3 amongst children aged below 1
2. Strengthening of the PAV activities, notably the component of the mobile groups to increase the % of children fully vaccinated	% of children aged below 1 fully vaccinated
3. Strengthening of the actions required to expand the AIDI strategy (Integrated Focus on Children's Diseases) at the primary level	% of USs from the primary level in which the AIDI strategy is being implemented
4. Carry out the required actions to reduce mortality due to acute malnutrition amongst children aged between 0 and 5	Institutional mortality rate due to acute malnutrition
5. Improvement and expansion of nutritional surveillance, for the timely spotting of risk situations.	Nº of sentinel posts for nutritional surveillance established and in operation
6. Reduce maternal mortality	Maternal mortality ratio
7. Expansion of the coverage of institutional birth deliveries	Rate of coverage of institutional birth deliveries
8. Sensitization of the community/NGOs to build waiting premises for pregnant women in all referral health facilities (USs) in district headquarters	% of referral USs located in district headquarters in which there are waiting premises for pregnant women
9. Increase in the nº of Health Facilities that	Nº of Health Facilities per 500 000 inhabitants that provide

Objective	Indicator
provide Basic Emergency Obstetrics Care	Basic Emergency Obstetrics Care (COEB)
10. Nº of Health Facilities per 500 000 inhabitants that provide Basic Emergency Obstetrics Care (COEB)	Nº of new users of modern Family Planning methods
11. Expansion of the presumptive intermittent treatment (TIP) in pregnant women that run the risk of getting malaria	% of pregnant women that receive at least one dose of TIP amongst the users of prenatal consultations
Reduce the acute malaria incidence rate amongst children below the age of 5 years	*Acute malaria incidence rate amongst children below the age of 5*
12. Strengthening the individual and collective protection actions for the whole population, through accessible and low cost interventions	% of houses sprayed with insecticide during the last 12 months in relation to the target nr. of houses
Reduce the rate of acute malaria incidence amongst children below the age of 5 years	*% of pregnant women and children below the age of 5 years that sleep protected by REMTILD (Mosquito Net Treated with Long-Lasting Insecticide)*
13. Strengthen the actions for individual and collective protection for the whole population, through interventions that are accessible and low cost	% of pregnant women and children below the age of 5 years that have received at least one REMTILD
Reduce the tuberculosis prevalence rate	*Tuberculosis prevalence rate*
14. Accelerated expansion of the DOTS strategy	Detection rate of cases with BK+
15. Accelerated expansion of the DOTS strategy	Cure rate with the DOTS treatment
16. Implementation of the interventions to address the co-infection of TB/HIV, to increase the number of patients with TB and HIV with access to ARVT	% of patients with TB that received counselling and were HIV tested
Reduce the risk of mother to child HIV vertical transmission	% children below the age of 2 years infected with HIV
17. Increase the Nº of Health Facilities that provide prevention services of MTCT	Nº of Health Facilities undertaking PMTCT
18. Increase in the Nº HIV+ women that receive ARV in order to reduce the risk of mother to child transmission	% and (Nº) of HIV+ pregnant women that received ARV drugs in the last 12 months to reduce the risk of mother to child transmission
Increase the nº of patients receiving antiretroviral treatment	*% of adults eligible to treatment receiving combined ARVT according to the country's protocols*
19. Increase the capacity of the Health Facilities to diagnose and treat AIDS	Nº of Health Facilities administering ARVT
20. Increase the nº of children under antiretroviral treatment in the country	Nº of children that benefit from paediatric ARVT.
21. Increase of the nº of adults eligible for treatment that received combined ARVT according to the country's protocols	Nº of adults with advanced HIV infection receiving combined ARVT (anti-retroviral treatment) according to the country's protocols (disaggregated by sex)
Contribute to reduce the HIV prevalence rate amongst the youth aged between 15 - 24 years	Average HIV prevalence rate amongst female pregnant youth aged between 15-24 years
22. Expansion of the SAAJs networks into the most peripheral Health Facilities	Nº of Health Facilities with SAAJ (Friendly Services for Adolescents and Youngsters)
23. Establishment of ATS in the SAAJs	Nº of SAAJ users, cumulative and just first consultations
Increase the access to healthcare and reduce the iniquity in its consumption	*% of the population with easy access to one health facility (< 30 minutes on foot)*
24. Improvement and expansion of the health network closer to the communities	Nº of interventions in the Health Facilities, including houses built over the five-year period (example: constructions, rehabilitations, promotions)
Increase the access to healthcare and reduce the iniquity in its consumption	*Ratio of external consultations per inhabitant between the rural and urban districts*
25. Increase in the healthcare provided to the	External consultations per inhabitant

Objective	Indicator
population, notably to the most deprived population strata	
26. Improved allocation of resources through the review of the criteria for their allocation	Iniquity rate
27. Timely provision in sufficient quantity of essential medicines to all Health Facilities in the country	% of requisitions satisfied in relation to the items requested and contained in the national medicines book
Improve the availability of resources that contribute to enhance the quality of the health services offered to the population at all levels	*% of Health Facilities that have water and electricity supply services*
28. Carry out the necessary actions to ensure that the health facilities are equipped with basic infrastructures (esp. water and electricity)	Nº of Health Facilities with water and electricity supply services
Strengthen and improve the health sector planning processes and instruments	*% of teams (collective boards in districts trained and with capacity building in planning)*
29. Training and allocation of adequate staff and in sufficient quantity in all health facilities of the NHS, in order to set up balanced health teams at all levels	Inhabitants by medical doctor and paramedic
30. Training and allocation of adequate staff and in sufficient quantity to all health facilities of the NHS, in order to establish balanced health teams at all levels	Inhabitants per health technical staff
31. Develop, institutionalize standardised planning instruments and build the capacity of the health staff at the central, provincial and district level	Nº of district level teams that received capacity building in the area of planning, based on the new planning directive developed at the central level
Strengthen and improve the financial management in all its components and at all levels in the health sector	*Expenditure executed as a % of the approved budget for the health sector*
32. Improvement of the budget management processes	Rate of the budget execution of the funds under MISAU´s management
Strengthen and improve the financial management in all its components and at all levels in the health sector	*% of audits conducted with UNQUALIFIED OPINION*
33. Improvement in the budget management processes	% of the recommendations from the audits in the year n-2 implemented annually at the provincial level
34. Improvement in the budget management processes	% of the recommendations from the audits in the year n-2 implemented annually at the central level
Improve the predictability of the external funds for the health sector and promote the harmonization between MISAU and the cooperating partners	*% of bilateral and multilateral partners with multiannual financial commitments (at least 3 years)*
35. Improve the adherence of the sector partners to the planning cycle and methodology of the Government of Mozambique	% of partners of PROSAUDE II that made disbursements as provided for in the Memorandum of Understanding
36. Improve the adherence of the sector partners to the planning cycle and methodology of the Government of Mozambique	% of bilateral and multilateral partners that support the Health Sector and provide timely the necessary information to MISAU to enable the inclusion of their funds/projects in the State Budget.
37. Reduction of the workload on MISAU due to the bilateral and multilateral partner missions at the central, provincial and district level	% of NGOs that signed the new Code of Conduct (that are members of NAIMA and/or contracted by MISAU) that provide timely to MISAU the necessary information for the inclusion of their funds/projects into the State Budget
38. Reduction of the workload on MISAU due to the bilateral and multilateral partner missions at the central, provincial and district level	Total nº of missions per year from the HQs of the partners that provide support to the Health Sector (bilateral and multilateral partners)

b) Memorandum of Understanding for Common Funds (2003)

Health Sector Strategic Plan
(PESS)

Memorandum of Understanding

Between

THE GOVERNMENT OF THE REPUBLIC OF MOZAMBIQUE
Ministry of Planning and Finance
Ministry of Health

AND

Irish Embassy; DFID; The Government of the Kingdom of Norway; European Commission; Swiss Agency for Development and Co-operation (SDC); Ministry for Foreign Affairs of Finland; Danish Embassy; The Netherlands Embassy; Canadian International Development Agency

In respect of

Common Fund for Support
to the Health Sector
(PROSAUDE)

MAPUTO, November 12, 2003.

For the purposes of this Memorandum of Understanding (MoU), Signatory Partners are defined as

those who, among other cooperation partners, signed this Arrangement and channeled their financial support through the Common Fund for Support to the Health Sector (PROSAUDE) in accordance with the mechanisms and procedures presented herein.

The Government of the REPUBLIC OF MOZAMBIQUE, here represented by the Ministry of Planning and Finance and the Ministry of Health (hereinafter referred to as the Government), and the Signatory Partners who have signed this document, are herein together referred to as the Signatories,

WHEREAS the Government requested that the Signatory Partners provide financial and technical assistance to the Health Sector by supporting the Sector's budget with a view to strengthening the expenditure programme of the Government of the Republic of Mozambique in the Health Sector in the scope of the Health Sector Strategic Plan (PESS);

THAT the Signatory Partners agreed to provide the said financial and technical assistance in the form set forth in the bilateral arrangements between the Government of the Republic of Mozambique and each of the Signatory Partners;

THAT the Signatories agreed that, to facilitate the effective financial support to the State Budget for the Health Sector, the allocation and use of the funds in question shall, *inter alia*, be channeled through PROSAUDE, guided by the terms of this MoU;

THAT, without prejudice to any of the provisions hereunder, the said arrangements shall remain valid and in effect, since the objective of the present MoU is to better define and clarify the roles and responsibilities of the Signatories in carrying out the joint activities contained in the PESS;

THAT the Signatories wish to agree on procedures for the adjudication of funds and disbursements, audits and reports, monitoring and evaluation, financial management and exchange of information among themselves in relation to the execution of the PESS and the achievement of the objectives of the funding granted on these terms;

THAT the implementation of the PESS shall be the responsibility of the Government of the Republic of Mozambique through the Ministry of Health (MISAU);

Furthermore, WHEREAS this is not an international treaty, it will be nevertheless be governed by bilateral arrangements and in the event of a dispute, the English version of this MoU shall prevail;

NOW, THEREFORE, the Signatories agree on the following points:

1. Introduction

This MoU is a part of the documents prepared in the SWAp context, namely:

- The Action Plan for the Reduction of Absolute Poverty (PARPA) which defines the health sector as a priority area in the efforts to guarantee the sustainable economic and social development of the Country;
- The PESS 2001-2005, approved in April 2001;
- The Kaya Kwanga Commitment (Code of Conduct) signed in April 2001 and revised and signed in July 2003, which provides a framework for co-operation issues between the Signatory Partners and the Government of the Republic of Mozambique.

Respect for human rights, democratic principles, the rule of law and good governance, which govern the domestic and international policies of the Signatories, form the basis of the cooperation and constitute essential conditions of this Arrangement.

The MoU refers to the management norms for PROSAUDE and has the following Annexes:

1. PROSAUDE's financial flow mechanisms
2. Forecast for the six monthly financial flow and Disbursement Plan (Contributions)
3. MISAU's planning, budgeting and monitoring cycle
4. PROSAUDE Transfer Mechanisms– Disbursement requirements
5. Report submission, audits, deposits and transfer cycle

6. PROSAUDE's quarterly and annual management report models *(to be finalized by end of March 2004)*
7. PROSAUDE's auditing terms of reference *(to be finalised by end of December 2003)*
8. PROSAUDE's procurement procedures manual *(Final Draft in circulation)*
9. PROSAUDE's Financial Management Procedures Manual *(to be finalized by end of March 2004)*
10. Addendum to the MoU for Provincial Common Fund *(to be finalized by end of November 2003)*
11. Financial Flow Mechanism for the Provincial Common Fund
12. Addendum to the MoU for the Common Fund for Drugs and Medical Supplies *(to be finalized by end of November 2003)*
13. Financial Flow Mechanism for the Common Fund for Drugs and Medical Supplies.

2. THE PESS

The PESS is a Government of the Republic of Mozambique programme that has financial support from various cooperation partners for MISAU's reform and activities. The principles that guide the PESS are:

- Efficiency and equity
- Flexibility and diversification
- Partnerships and community participation
- Transparency and accountability
- Integration and coordination.

The PESS aims at achieving its objectives by:

a) Consolidating the provision of quality health services for the poor;
b) Advocacy for health;
c) Reinforcing the pharmaceutical sector;
d) Implementing flexible financing strategies;
e) Through institutional capacity building, particularly in the areas of policy analysis, planning, management and system administration.

3. Funds integrated in the PROSAUDE

a) PROSAUDE combines funds provided by the Signatory Partners, deposited into a FOREX PROSAUDE account at the Bank of Mozambique (BM). These funds will be transferred by the Ministry of Planning and Finance (MPF) upon request by MISAU (see section 11). MISAU will then be responsible for managing the funds, including their allocation in accordance with policy and strategy priorities and ensuring that generally accepted accounting system procedures in conformity with the SISTAFE law are followed.

b) PROSAUDE funds will be channeled to any and all cost centres in the health sector that receive and manage funds from the State Budget and which are to be implemented in accordance with the agreed Annual Operational Plan and Budget. A list of applicable cost centres shall be approved together with the Annual Operational Plan and Budget.

c) The Common Fund for Drugs and Medical Supplies will, from 2004, be managed by the Centre for Drugs and Medical Supplies (CMAM) on behalf of MISAU (see sub-paragraph "f" of no. 3 and Annex 12);

d) As from 2004, the Provincial Common Fund (FCP) will be managed by MISAU. The funds will be deposited at a Commercial Bank, in the name of MISAU/Directorate for Administration and Management (DAG), and will be transferred to the accounts of the Provincial Directorates of Plan and Finance (DPPF) in accordance with management norms to be agreed between the Signatory Partners of the FCP, MISAU and MPF. In the medium term (3-5 years), and as and when considered suitable by MISAU's management and the Signatory Partners, the FCP will be transferred to the PROSAUDE FOREX account and channeled through the Treasury's Account at the BM, to the DPPFs. The norms and procedures for the gradual transfer of the management of FCP from the Swiss Agency for Development and Co-operation (SDC) to MISAU are

described in Annex 10. The Signatory Partners that support the FCP will sign an addendum to this MoU.

e) Prior to the merging of PROSAUDE and the FCP as described in paragraph (d) above, and in order to channel more funds to the FCP if so required by the MISAU Annual Operational Plan and Budget, PROSAUDE funds may be transferred from the Central Treasury to the Provincial Treasury and from there to the Provincial Common Fund accounts at DPPF level, consistent with the Approved Annual Disbursement Plan.

d) The gradual integration of the FCP as well as the Common Fund for Drugs and Medical Supplies aims at achieving a suitable level of management capacity and has as its ultimate aim the creation of a single funding system. The process of integrating the FCMSM into the FCG will be discussed and approved during 2004.

4. Advantages of PROSAUDE

a) The allocation of funds from PROSAUDE and the State Budget to the Health Sector shall be carried out so as to ensure the most efficient allocation of funds and strengthening and use the Government of the Republic of Mozambique's own systems for procurement, resource disbursement and management of health resources. This will require a great progressive change on the part of the Signatory Partners, to use common systems devoted to the effective and efficient use of health resources;

b) The use of standard national instruments to plan, prepare budgets, manage, carry out assessments and audits;

c) The use of similar mechanisms for fund management will reduce transaction costs – less bureaucratic work, fewer staff members and less time needed to process and carry out the accounting of cooperation partners' funds;

d) The common monitoring parameters conceived for the PESS shall be used to monitor PROSAUDE.

5. Basis for Participation in the PROSAUDE

This MoU presents the norms and regulations according to which the support from the Signatory Partners will be channeled through PROSAUDE. The basic principles for the support given by the Signatory Partners to this fund include the following:

a) The funds provided by the Signatory Partners through PROSAUDE will be deposited, managed and used in accordance with the norms and regulations of the State Budget;

b) The funds provided by the Signatory Partners through PROSAUDE shall be exclusively used to finance Mozambique's health sector expenses which are accepted as eligible expenses (as defined in Section 7 below);

c) Signatory Partners may not earmark PROSAUDE's funds for any specific objective. MISAU will allocate all available funds to health priorities through the Annual Operational Plan;

d) All health activities in the public sector in Mozambique, to be carried out by MISAU or any agency contracted by MISAU with the support of the Signatory Partners, shall be in accordance with the Economic and Social Plan (PES) and the PARPA and undertaken to achieve the objectives set out therein;

e) All Signatory Partners and other partners shall, jointly with MISAU, review the sector's priorities and performance in accordance with MISAU's planning, budgeting and monitoring cycle (see Annex 3).

6. Co-ordination and assessment meetings

a) Co-ordination between the Signatory Partners and MISAU shall be carried out through the first contact donor and the fortnightly meetings of the SWAp Working Group (GT-SWAp) at MISAU;

b) At a GT-SWAp meeting during the first month of every year, the budgeting limits approved by Parliament for the sector's State Budget shall be submitted to the Signatory Partners with a clear indication of any revision that may have been introduced.

c) The Signatory Partners, other partners and the Government shall meet twice a year during the Sector Coordinating Committee (CCS). MISAU shall be responsible for convening the meetings and the agendas shall be discussed jointly. The CCS's Secretariat shall prepare an *aide memoire* with the recommendations of the CCS for approval and signature by the participants;

- At the first semester's meeting (June) of the CCS, MISAU shall submit a status report for the previous year as well as a preliminary report of the annual audit for the previous year to the Signatory Partners. The annual report shall cover the activities implemented during the previous year and the evaluation of progress in the achievement of the objectives of the PESS. Both reports shall reflect the execution of the activities and the financial execution of the Annual Operational Plan of the previous year. At this meeting, joint evaluation report will be presented and MISAU shall also present to the Signatory Partners the priority activities to be included in the Annual Operational Plan for the following year, together with the indicative General State Budget amounts and the financial commitments expected from the Signatory Partners;

- At the CCS of the second semester (Nov/Dec), MISAU and the Signatory Partners shall discuss the Annual Operational Plan priorities for the following year in accordance with the objectives of the PESS. The Signatory Partners shall confirm their respective annual financial commitments based on the need for funds established in the Annual Operational Plan and taking into account budgetary cover. The Signatory Partners and MISAU shall agree on the activities or sub-components of the PESS that will be implemented through PROSAUDE. The Signatory Partners shall also discuss with MISAU any pending matters relating to the execution, policy or strategy that may be addressed by both the Signatory Partners and the Government. In addition, information regarding the Signatory Partners' indicative financial commitments for a three-year period (Annex 3) shall be submitted.

7. Eligible Expenditure

a) PROSAUDE's expenditures (hereinafter referred to as *eligible expenses*) to be financed in the scope of the PROSAUDE in any given year are defined and agreed as being all the expenses arising from the carrying out of activities and investments that are:

i) Registered in the State Budget;

ii) Consistent with and priorities in the context of the PES and the PESS:

iii) Included in the Annual Operational Plan of the Health Sector.

b) Exceptionally in respect of the eligibility criteria referred to above, unforeseen and unplanned expenses (e.g., expenses not included in the Annual Operational Plan) may be defined as and declared to be eligible expenses by the Financial Management Committee (CGF) and the Signatory Partners. In all these cases, the new expenses must serve to support the activities and/or investments in accordance with the objectives and priorities of the PESS.

c) All reviews of Annual Operational Plan shall be submitted in aggregate form to the Signatory Partners at the quarterly meetings of the CGF for approval. Approval shall be noted in agreed minutes of these meetings. If revisions are required to the AOP through the year, these shall be discussed and approved at specially convened meetings and the outcome of these meetings recorded in agreed minutes.

d) Notwithstanding the premises of this MoU, financing of the eligible expenses by each of the Signatory Partners shall always depend on and be governed by the terms of the bilateral arrangements between each of the Signatory Partners and the Government of the Republic of Mozambique. The Signatory Partners shall ensure, however, that their bilateral arrangements shall be consistent with this MoU.

8. PROSAUDE

The funds made available by all Signatory Partners for the funding of the eligible expenses of the PESS shall follow the mechanism for the fund flow described in Annex 1. The BM shall notify the Signatory Partners, MPF and MISAU in writing of the receipt of external funds. The BM shall apply the exchange rate corresponding to the date on which the funds are deposited in Meticais into the account of the National Treasury Directorate (DNT). The deposits made by the Signatory Partners shall be controlled by the norms described below (see also Annexes 4 and 5):

a) Norms for the Disbursements of Funds by Signatory Partners

i) The initial disbursements made by the Signatory Partners into the PROSAUDE FOREX account for the Health Sector shall depend on the effectiveness of the conditions defined in Section 20 of this MoU and on each Signatory Partner receiving a formal request from MISAU a least one month before the date of the disbursement.

ii) The subsequent disbursements made by the Signatory Partners into the FOREX account shall be carried out as follows:

1. Disbursement for the first semester:

a) Existence and approval of the Health Sector's Annual Operational Plan for the year in question and consistent with the objectives of the PES concluded by the 30th of November. The Annual Treasury Plan reflecting quarterly periods should be annexed thereto;

b) The recommendations of the joint evaluation of the Health Sector performance and reflected in the Annual Operational Plan;

c) In compliance with the Agreed Annual Disbursement plan, the receipt of a formal letter of request for disbursement from the Technical Group of the Financial Management Committee (GT-CGF) approved by the CGF to each Signatory Partner at least one month before the date for the deposit (see section 12 below).

d) Approved Final Audit Report from the year before (starting from the first semester of the third year in operation of PROSAUDE).

2. Disbursement for the second semester:

a) Annual activity and financial report for the previous year;

b) PROSAUDE's Preliminary Annual Audit Report (including auditor's issued opinion) (starting from the second semester of the second year in operation of PROSAUDE);

c) In compliance with the Agreed Annual Disbursement Plan, the receipt of a formal letter of request from the GT-CGF approved by the CGF to each Signatory Partner at least one month before the date for the deposit.

The deposits shall be made in foreign currency in the PROSAUDE FOREX account at the BM. If, due to unforeseen circumstances, there are delays or interruptions in the commitments made by the Signatory Partners the CGF must make the necessary arrangements so as to avoid the resulting negative impact.

b) Norms governing transfers from the FOREX Account to DAG / MISAU's account.

Every quarter, the CGF shall request the transfer of the funds from the FOREX PROSAUDE account, through the Central Treasury Account in Meticais, to the Directorate of Administration and Management (DAG) / MISAU's PROSAUDE Account in Meticais. The DNT / MPF shall have a time limit of 15 days to carry out the transfers. The initial transfer shall be made with no submission of proof of expenses and shall correspond to the expenses planned in the Operational Plan for the current year. (The schedule referred to in Annex 5 indicates the time limits for the submission of the quarterly package by the cost centres and by DAG / MISAU to MPF.)

The subsequent transfers shall take the following into consideration:

i) Submission of the monthly statement reports and the quarterly and annual financial execution reports and approval by the CGF in accordance with the terms of Section 11 of this MoU and Annexes 5 and 6;

ii) Submission of the quarterly treasury plan and approval by the CGF in accordance with the schedule and criteria defined in Annex 5;

iii) The non-submission of the foregoing shall determine that the replenishment by the Signatory Partners be carried out when their fulfillment takes place. Systematic delays in the submission of these items shall be considered violations of this MoU.

Even if the contribution of one or more cost centres to the quarterly consolidated management report is delayed, DAG shall still submit it (along with the accompanying documents), to MPF and the Signatory Partners.

Once the late reports have been updated and submitted, the CGF shall decide if the cost centre will or will not later receive this portion (in accordance with PROSAUDE's Financial Management Procedure Manual).

A further condition for contributions by Signatory Partners to the FOREX account of PROSAUDE in MPF shall be timely three-monthly disbursements from Treasury to MISAU, both in relation to PROSAUDE and State funds, in accordance with the mutually agreed Treasury Plan for the Health Sector.

9. Reporting on expenditures /accounts

Each central level cost centre shall submit the following reports:

a) The monthly PROSAUDE management Balance Report in accordance with State management norms.

b) Quarterly PROSAUDE management Report including:
   i) Consolidated monthly management Balance Reports for the last quarter;
   ii) Level of execution per programme;
   iii) Brief financial report with comments (Due: Thirty days after the end of the month).

c) Annual PROSAUDE management Report including:

i) Consolidated quarterly management Reports for the year;
ii) PROSAUDE programme financial analysis and performance evaluation (Due: Forty-five days after the end of the month).

These reports must comply with:

- The time limits defined in Annex 5 and
- The report formats defined in Annex 6.

Accountability at provincial level shall remain in the current form.

10. Audits

a) The annual audits of PROSAUDE's accounts (including the FOREX account, MISAU/DAG's account in Meticais and the International Procurement foreign currency account) shall be carried out by an independent internationally recognized auditing firm in accordance with accepted accounting principles.

b) The selection of the firm shall be made by MISAU and the Signatory Partners in collaboration with the Tribunal Administrativo upon tender, and in accordance with the selection procedures and Terms of Reference in Annex 7. The annual report will be submitted to the Tribunal Administrative, to the CGF and to the Signatories in accordance with Annex 5. These audits shall be financed by PROSAUDE and shall provide an opinion on the appropriateness of transaction coding; the appropriateness of internal control systems, specifically those pertaining to financial management and procurement; and whether funds are being used for their intended purpose;

c) Subject to their annual work plan, the MISAU's Inspectorate General may carry out quarterly reviews of the cost centers. These reports shall be submitted to the CGF in accordance with Annex 5.

11. Financial Management Committee (CGF)

a) The procedures for fund management and execution and the achievement of the objectives of the financing granted in these terms shall be executed through a CGF created for this purpose.

b) The CGF shall be chaired by the MISAU Permanent Secretary and shall include the following officers:

- National Director of Health (DNS);
- Director of Planning and Co-operation (DPC);
- Director of Administration and Management (DAG);
- Director of Human Resources (DRH);

Depending on the matters being addressed, the National Director may be accompanied by the Deputy Directors and/or Heads of Department. MPF representatives and the Signatory Partners shall be invited to the CGF meetings on a quarterly basis. Whenever justified, the CGF may meet extraordinarily and whenever it is deemed to be necessary, representatives from the MPF and the Signatory Partners shall be invited.

c) The CGF's terms of reference include the following tasks:

1) Verifying and approving the annual budgets and the quarterly budget plans produced by the cost centres;

2) Approving the proposal for the allocation of funds and authorizing disbursements to the cost

centres, FCP, FCMSM and MISAU foreign currency account for international procurement;

3) Quarterly and annually reviewing and approving PROSAUDE's Management Reports submitted by the GT-CGF;

4) Maintaining the link to the Signatory Partners through the first contact donor in order to ensure that the Annual Approved Disbursement Plan complies with the PROSAUDE's Annual Approved Treasury Plan, taking the necessary steps to find adequate solutions in the event of a delay in the deposits into the FOREX account;

5) Authorizing the proposed annual redistributions and unforeseen expenses;

6) Reviewing and approving the Internal and External Audit Reports and ensuring the implementation of the recommendations;

7) Assessing the performance of each cost centre, including the evaluation indicators of the PESS, taking the appropriate steps to correct the situation;

8) Monitoring staff development and capacity improvements, including the computerization of the integrated system of financial information;

9) Informing the Signatory Partners about the decisions made by distributing minutes of the meetings and through the GT-SWAp and the CCS;

10) Proposing solutions at the highest level (Minister of Health - Minister of Plan and Finance – respective Ambassadors of the Signatory Partners) in the event of delays in the disbursements or commitments not being fulfilled by the Signatory Partners.

12. The Technical Group of the Financial Management Committee (GT-CGF)

a) The CGF shall be supported by the Technical Group (GT) in the management of the funds allocated to the sector. The GT-CGF shall be coordinated by the Directors of Planning and Co-operation and of Administration and Management, and shall include the following representatives of each one of MISAU's Directorates:
   - Deputy Director of Finance (DAG)
   - Head of the Department of Finance (DAG)
   - Manager of DNS's funds (DNS)
   - Coordinator of the Technical Group for Planning (GTP – DPC)
   - Manager of DRH's funds (DRH)
   - Manager of funds for the Minister's Office
   - Logistics Representative (DAG);

b) The GT-CGF shall report on issues relating to PROSAUDE and shall ensure:

1. The submission of formal requests to the Signatory Partners for disbursement of funds;

2. The documentation required to request disbursements from DNT/MPF for within the time limits agreed in the Agreed Annual Disbursement Plan (Annex 5);

3. That the accounting records, including those of the bank accounts, are kept up to date;

4. That adequate internal control and audit systems are created and maintained for budget allocation and re-allocation and for monitoring budget execution;

5. That the Financial Procedure Manual is applied, complying with the agreed time limits (the Manual is therefore to be regularly updated);

6. That the Procurement Procedures Manual is applied creating consistency among the expenses supported by the different cost centres in the procurement of goods and services in accordance with the established norms and procedures;

7. The execution of the budget rigorously follows the established financial flow, and that the monthly and quarterly PROSAUDE management reports system meets expectations;

8. That explanatory notes are prepared in the monthly PROSAUDE management reports justifying unforeseen expenses in the quarterly treasury plan, guaranteeing that they have been previously approved by the CGF;

9. The review and approval by the CGF of the monthly, quarterly and annual PROSAUDE management reports submitted by the cost centres and the DAG;

10. The evaluation of the reports presented by the internal/external auditors and to guarantee that the auditors' recommendations are acted upon;

11. Monitoring and accompanying the development of the funds management mechanism in accordance with the performance indicators agreed in the PESS;

12. The production and distribution of minutes of the meetings to all CGF members.

13. Procurement

a) The cost centres will carry out the management of the PROSAUDE's procurement processes defined in PROSAUDE's Procurement Manual (Annex 8).

b) Every quarter, the CGF shall send a request to DNT-MPF for the transfer of funds into MISAU's foreign currency account for international procurement in accordance with PROSAUDE's Agreed Annual Disbursement Plan.

14. Consultation, Co-ordination and Supervision

a) MISAU and the Signatory Partners shall maintain constant dialogue and exchange information on issues relating to the implementation of the PESS and PROSAUDE.

b) Each Signatory Partner shall inform MISAU and the other Signatory Partners through the first contact partner, with at least three months prior notice, whenever:

1. It is intended that their arrangements for the PESS be materially changed;

2. It is intended that financing of the PESS through PROSAUDE be totally or partially suspended or ended.
   In these cases, a meeting between the MISAU and the Signatory Partners shall be convened, with at least two weeks´ prior notice.

c) The CGF shall guarantee that, on a quarterly and annual basis, the PROSAUDE management reports are presented to each one of the Signatories within the anticipated timeframe;

d) On three months prior notice, the Signatories shall decide jointly on timeframes, terms of reference and make up of the joint PROSAUDE evaluation missions or specific sector performance missions.

e) The Signatories shall provide evidence of the authority of the person or persons who, on their behalf, shall take any action or execute any required documents or permit that any action be taken or be executed by them under the terms of this MoU, and shall supply signature specimens for each one of those persons.

15. Corruption

The Signatories shall require that both staff and consultants at PROSAUDE do not take advantage of their positions for their own benefit or in detriment of others, namely, by not accepting nor demanding, as a in return for their work, any gratuities or promises of gratuities. Should such a situation arise, it must be analysed at the CGF level and submitted to the Minister of Health who shall act in accordance with the legislation in force.

MISAU shall act with full rigor in applying the legislation in force in order to prevent and / or correct any anomalous situations that may compromise the good operation of PROSAUDE.

16. Suspension of disbursements

In the event of non-compliance with the provisions of Sections 8, 9, 10, 15 or 17 of this MoU, the Signatory Partners shall have the right to suspend disbursements to PROSAUDE. Prior to any suspension of disbursements, the Signatory Partners shall timely inform MISAU of that possibility and shall specify the necessary actions that must be taken within a specific time limit in order to prevent this suspension of disbursements. In any event, before the execution of a suspension of disbursement, all the Signatory Partners shall hold a meeting with the CGF in order to seek a solution for the implementation and / or submission of the information in question.

In the event of any disputes that may arise in the application or interpretation of this MoU, the Signatories will consult with each other with a view towards reaching an amicable solution.

17. Other obligations of the Government of the Republic of Mozambique

In order to facilitate the success of the implementation of PROSAUDE, the Government of the Republic of Mozambique shall make all possible efforts to:

a) Guarantee all necessary authorizations, including work permits for consultants, import licenses and foreign exchange license authorizations that may be required in connection with the implementation of PROSAUDE;

b) The Government shall maintain, or cause to be maintained,, accounting systems, staff systems, registration systems and adequate accounts that together reflect, in accordance with the prevailing accounting systems, the operations, resources and expenses related to PROSAUDE of the government sectors or agencies responsible for the execution of PROSAUDE or any of its components;

c) The Government shall make the information referred to above available to the Signatory Partners.

d) The Government, through the MPF, shall ensure the availability of the funds deposited by Signatory Partners to the FOREX PROSAUDE in accordance with the mutually agreed Treasury Plan, as well as the availability of allocated State Budget funds to the Health Sector

18. Funds not used

Future disbursements by the Signatory Partners shall take into account the funds remaining from previous years.

At the DAG PROSAUDE Account and at cost centre levels, the balance shall be deducted from the allocation for the following year. PROSAUDE's Financial Management Procedure Manual defines the manner in which State Budget funds and Signatory Partners' funds shall be segregated.

19. Revision of the MoU

In order to ensure that the lessons learnt from first experiences, both in the management of PROSAUDE and the new SISTAFE, are taken into consideration, this MoU shall be regularly revised.

Any alteration to the present MoU or its annexes shall only be valid when agreed in writing by all Signatories. Annexes that are not approved at the time of signing this MoU shall be approved by signatures of all Signatories.

The new procedures foreseen in the SISTAFE shall be included in the Financial Management Procedure Manual and the Procurement Procedure Manual to be applied at all levels.

20. Entry into force of the MoU

The MoU enters into force upon its signature and the signature of the respective bilateral arrangements between the Government of the Republic of Mozambique and each Signatory Partner.

Further, the points specified below shall be conditions for this MoU to enter into force:

a) Constitution and functioning of the CGF and the GT-CGF at MISAU;

b) Opening of:

1. PROSAUDE's FOREX Account at BM in the name of MPF
2. PROSAUDE Account in Meticais at DAG / MISAU and the MISAU Account in US dollars for international supplies.
3. An Account in Meticais for each cost centre.

c) The registering of the PROSAUDE budget at the National Directorate of Planning and Budget (DNPO).

d) The adoption and use of the Procurement Procedure Manual in order to operationalise PROSAUDE (Annex 8).

The Government of the Republic of Mozambique shall be responsible for ensuring that the Conditions for the entry into force of this MoU are met and, once they have been met, to provide proof thereof to the Signatory Partners.

Any other partner wishing to join PROSAUDE at a later stage shall sign an addendum to the present MoU. This addendum shall then constitute an integral part of the present MoU.

The MoU does not govern the manner in which other forms of support may be given to the PESS.

Assinaturas

Maputo, 12 Novembro 2003.

Ministério da Saúde _____

Ministério do Plano e Finanças _____

DFID - Department For International Development _____

Embaixada da Irlanda _____

Governo do Reino da Noruega _____

Comissão Europeia _____

Embaixada dos Países Baixos _____

Embaixada da Dinamarca _____

Ministério dos Negócios Estrangeiros da Finlândia _____

Agência Suíça de Desenvolvimento e Cooperação _____

Agência Canadiana para o Desenvolvimento Internacional _____

c) Memorandum of Understanding for Sector Budget Support (2008)

Memorandum of Understanding

Between

REPUBLIC OF MOZAMBIQUE

Represented by the Ministries of Health, Planning and Development, and Finance

And

Canadian International Development Agency; Catalan Agency for Development Co-operation; European Commission; Flemish Ministry of Foreign Affairs; French Development Agency; Irish Aid; Ministry for Foreign Affairs of Finland; Norwegian Ministry of Foreign Affairs; Royal Danish Embassy; Spanish International Cooperation Agency; Swiss Agency for Development and Co-operation; The Dutch Ministry for Development Cooperation; United Kingdom Department for International Development; United Nations Children's Fund; United Nations Population Fund

Regarding PROSAUDE II

MAPUTO, July 2008

Index

Acronyms and Abbreviations

ANNEXES

ACRONYMS AND ABBREVIATIONS

ACA - Annual Joint Evaluation of the Performance of the Health Sector
BM - Bank of Mozambique
CCC - Joint Co-ordination Committee
CCS - Sector Co-ordination Committee
CF - Common Fund
CFMP (MTEF) - Medium Term Expenditure Framework
CMAM - Centre for Drugs and Medical Supplies
CNCS - National Health Co-ordination Council
CPs (PCs) - Co-operation Partners
CUT - Single Treasury Account
DAF - Directorate of Administration and Finance
DNT - National Treasury Directorate
DPS - Provincial Health Directorate
e-SISTAFE - Electronic State Financial Management System
FC - See CF Common Fund
FCMSM - Common Fund for Drugs and Medical Supplies
FCP - Provincial Common Fund
Forex - Convertible currency
GoM - Government of Mozambique
IGF- General Finance Inspectorate
JR - Joint Review

MDGs – Millennium Development Goals
MF - Ministry of Finance
MoU - Memorandum of Understanding
MISAU - Ministry of Health
MPD - Ministry of Planning and Development
MTEF (CFMP) - Medium Term Expenditure Framework
ODAMOz-database – Database on Official Development Aid to Mozambique
OE - State Budget
PAF (QAD) of the Health Sector - Health Sector Performance Assessment Framework
PAPs - Program Aid Partners
PARPA - Action Plan for the Reduction of Absolute Poverty
PCs (CPs) - Co-operation Partners
PEFA - Public Expenditure and Financing Accountability
PES Health - Economic and Social Plan for the Health Sector
PESS - Health Sector Strategic Plan
PETS - Public Expenditure Tracking Survey
PFM - Public Financial Management
QAD - See PAF
SISTAFE - State Financial Management System
SNS -National Health Service
SWAp - Sector Wide Approach
TA - Administrative Court
ToRs - Terms of Reference
UFSA – Functional Unit for the Supervision of Procurement
UGEA - Management and Execution Unit for Procurement

Memorandum of Understanding regarding support to the health sector through Joint Financing Procedures between the Ministry of Health, the Ministry of Planning and Development and the Ministry of Finance of Mozambique and the Health Sector Group of Co-operation Partners.

This Memorandum of Understanding (hereinafter referred to as MoU) regarding Joint Financing Procedures is signed on the 30th day of July 2008 between the Ministry of Health (hereinafter referred to as MISAU), the Ministry of Planning and Development (hereinafter referred to as MPD) and the Ministry of Finance (hereinafter referred to as MF) of the Government of Mozambique (hereinafter referred to as GoM), and the Co-operation Partners (hereinafter referred to as "CPs") to contribute to the funding for the implementation of the Ministry's Health Sector Strategic Plan (PESS). MISAU, MPD, MF and the CPs are hereinafter referred to together as the Signatories.

Preamble

i This MoU sets out the terms and procedures for channelling external financial support to the Health Sector in support of implementation of the PESS within the overall framework of a partnership between MISAU and the enlarged group of CPs.

ii This partnership is based on the principles of a harmonized Sector-Wide Approach (SWAp) in support of building an effective health system that benefits the Mozambican population and contributes to sustainable development. The partnership presupposes mutual commitment, reliability, respect, confidence and accountability.

iii This MoU, for joint support to the Health Sector (hereinafter referred to as PROSAUDE II), is a document prepared in the context of the Kaya Kwanga Commitment (Code of Conduct) signed in April 2001, revised and signed in July 2003, which frames the co-operation issues between the CPs and the GoM. This MoU is also consistent with the MoU between the GoM and Program Aid Partners (PAPs) for the provision of Direct Budget and Balance of Payments Support.

iv This MoU presents a single financing mechanism, inscribed within the State Budget (OE), by which funds will be made available through the Treasury and audited with the OE by the General Finance Inspectorate (IGF) and by the Administrative Court (TA). It is intended that funds meant for the purchase of medicines and medical supplies pass through the Single Treasury Account (CUT) as soon as is appropriate. The Signatories commit themselves to work along these lines and to achieve

this goal in the medium term (see Article 15.4).

v This document replaces the Memorandum of Understanding between the GoM and a Donor Group regarding the Common Fund for Support to the Health Sector (PROSAUDE I) signed in November 2003, including the Addendum to the PROSAUDE of the Provincial Common Fund (FCP), signed in May 2004, the Addendum to the PROSAUDE of the Common Fund for Drugs and Medical Supplies (FCMSM), signed in July 2004, and the 2nd Addendum to the Addendum to the PROSAUDE of the Common Fund for Drugs and Medical Supplies (FCMSM), signed in March 2007.

vi Annexes 1 to 8 are reference documents and are an integral part of this Memorandum of Understanding. They can be revised by the joint MISAU and CP WGs, with revisions approved jointly by MISAU and the CPs.

vii Financial contributions by each CP will be agreed upon within the context of the "Bilateral Agreements" between the GoM and the respective CP. The present MoU, as a framework for the CPs support to PROSAUDE II, will be the basis for these bilateral agreements and will be annexed to those. In the event of discrepancies between the specific provisions of the bilateral agreement and the MoU, the CP concerned will inform the signatories regarding those discrepancies. All individual donor specifications to the MoU will be reflected in Annex 1 and in the bilateral agreements. This MoU is not an international treaty. The provisions of the bilateral agreements will prevail over this MoU. CPs are committed to reduce and eliminate those exceptions over time, if possible inside the duration of this MoU.

Therefore, the Signatories have agreed as follows:

Article 1
Fundamental Commitments

The fundamental commitments forming the basis of the cooperation of the health sector partners are:

- Mozambique's commitment to meet the Millennium Development Goals (MDGs) for health;
- A commitment to ensuring the quality and effectiveness of the health services in order to respond to Mozambique's needs and to the promotion of regional and gender equity in health service provision;
- MISAU's commitment to sound financial management and procurement practices, transparency and good governance in the use of funds, and its determination to strengthen institutional and management capacity in the health sector**.**

Article 2
Scope of the MoU

2.1 The present MoU has been drawn up within the context of the Mozambican Health Sector Strategic Plan (PESS), formulated within the context of the GoM's overall economic and social development program and of the Absolute Poverty Reduction Strategy (PARPA). The PESS lays out the GoM's vision for improving the health status of the Mozambican population, especially the poor. It emphasizes the expansion of quality health care as the cornerstone of improvement of the health status of the population.

2.2. This MoU establishes the financial procedures for the channelling of external funds through common mechanisms aligned as much as possible with the GoM's public financial management system, to support implementation of the PESS in order to strengthen institutional and financial management capacity, in terms of:

(i) Annual joint monitoring and evaluation of performance of MISAU and the CPs against agreed targets for the implementation of the PESS and the annual PES;
(ii) Common procedures for commitment and disbursement on the part of the CPs;
(iii) Procedures for reporting and auditing.

2.3. The Signatories strive to achieve the highest degree of alignment with the budgetary and accounting system and with the GoM's legislation, with the objective of an alignment of processes so as to make planning and implementation more efficient, reduce the administrative burden and minimize transaction costs, while at the same time recognizing the need to strengthen MISAU's internal capacity and procedures.

2.4 With this MoU, the Signatories commit themselves to respect the principles of harmonization and alignment, as internationally agreed in the context of the Paris Declaration on Aid Effectiveness and the principle of mutual accountability, including the financial component. The GoM also commits itself to encourage all partner agencies intending to contribute to the health sector, to sign and comply with the PROSAUDE II MoU.

Article 3
Respective Responsibilities

3.1 MISAU is responsible for the implementation of the PESS. Following the GoM's annual planning and budgeting cycle, MISAU will translate the PESS into an annual Economic and Social Plan for the Health Sector (Health Sector PES) which is consistent with the matrix of indicators and annual targets agreed upon by MISAU and the CPs for monitoring the progress of PESS implementation (Health Sector Performance Assessment Framework or Health PAF, see Article 4.2 and Annex 2). The aim of the Health Sector PES is to reflect all of the sector's interventions, targets, and internal and external resources, and will be the subject of discussion between MISAU and all of the CPs prior to its finalization.

3.2 The CPs will ensure the predictability of funds provision, by providing MISAU with an indication of their medium-term financial commitment, preferably on a rolling basis over at least three consecutive years, based on the budget needs of the PESS and consistent with the Medium Term Expenditure Framework (MTEF). The commitments will be confirmed on an annual basis, in accordance with the procedures set out in Article 5.

3.3 MISAU will immediately inform all CPs of any circumstances as may interfere with or threaten the proper use of PROSAUDE II funds. In order to resolve the issue, MISAU will call a meeting to consult with the CPs on suitable action to be taken. CPs can decide to suspend, reduce or cancel disbursements if the fundamental commitments (Article 1) or basic assumptions (Article 4.1) are proven to have been violated.

Article 4
Planning, Budgeting and Resource Allocation

4.1 PROSAUDE II funds will be used to cover all eligible expenditures, defined as being:

(iv) Consistent with the PESS;
(v) Consistent with the Annual Economic and Social Plan of the Health Sector (Health Sector PES), that has been formally presented and discussed with the CPs before sending it to MPD; and
(vi) Reflected in the budget approved (or legally revised) by the Parliament (Assembleia da República).

Under no circumstances should the CPs earmark their contributions within PROSAUDE II for specific activities. PROSAUDE II funds can be used for all budgeted expenditures within the sector, and need not be limited to the financing of expenditures classified as investment.

4.2 The Health Sector PES should demonstrate how MISAU intends to reach the targets for the Health Sector Performance Assessment Framework (Health Sector PAF), and should include the methodology and criteria used for their prioritization and resource allocation, as well as the recommendations of the Balanço de PES and the Annual Joint Evaluation (ACA) of the health sector's performance of year n-1 and those of the Public Financial Management Assessment (PFM) and audits of previous years. The Health Sector PAF is an agreed matrix of input, output, outcome, impact and process indicators and their respective targets to measure performance of the sector in delivering quality services through effective and efficient management and utilization of human and financial resources at national, provincial and district levels. Targets for the health sector's performance in year n+1 will be agreed between MISAU and the CPs as part of the year n planning process, and progress against them will be assessed through the ACA process, including the Health Sector PAF, in year n+2. The Signatories will attach the agreed Health Sector PAF to this MoU annually as an updated annex (see Annex 2).

4.3 Alterations to the Health Sector PES and budget which are the legal responsibility of the Government will be made in conformity with the budget and SISTAFE laws. Any addendum requiring approval by the MF or MPD will be shared with the CPs for their information.

4.4 All of the sector's activities will be planned and reported (see Annex 3), whatever the source of financing. MISAU will guarantee that the financial records of all activities managed by MISAU are in accordance with the current national norms and legislature.

Article 5
Commitments and Disbursements

5.1 In order to facilitate integrated planning and annual budget preparation in accordance with GoM's cycle, the CPs will communicate annually the total financial commitments which they intend to make available to the sector for the following year, within a four-week period following the end of the Annual Joint Review (around April each year) in year n.

In order to guarantee minimal predictability, once commitments are given, they cannot be reduced

and will be disbursed, except in the event of violation of the fundamental commitments (Article 1) and basic assumptions (Article 4.1) of this MoU.

The preliminary Health Sector PES for year n+1, as presented by MISAU in the CCS in July of year n, will take into account the financial commitments to PROSAUDE II as given by the CPs in May of year n.

The commitments will be entered into the ODAMoz database. The CPs will also endeavour to provide by Mid November of each year the indicative commitments for the years n+2, n+3 and n+4 as required for the MTEF preparation process.

5.2 For determination of their annual financial commitments for the following year (n+1), the CPs will assess in year n the results of the GoM's performance in the health sector for year n-1, as demonstrated through the outcome of the ACA of the health sector's performance, in particular measured through the Health Sector PAF indicators and targets (see Annex 2), including the ones related to financial management and the results of available audit reports and Public Financial Management Assessments. Considering agreed targets, the progress in year n-1 (and in terms of financial audits, n-2) will affect commitment levels for year n+1.

5.3 A disbursement plan for year n+1 will be agreed upon between MISAU and the CPs prior to the end of year n. As much as possible, this plan will take into account MISAU's treasury plan, based on the Health Sector PES. The disbursements by the CPs will be made in one or two annual (fixed or variable - see Annex 1) tranches. Over the fiscal year disbursements will be made in a timely fashion as agreed in the calendar (see Annex 3), so as to respect MISAU's financial needs, independently of the sector's in-year performance or for reason of delays in the submission of reports during the year concerned.

5.4 MISAU will send a formal written request to each one of the CPs, at least 5 (five) weeks prior to the agreed date of disbursement. As soon as the disbursement has been made each CP will inform MISAU for purposes of confirmation and cross-checking of information. MISAU or MF will immediately confirm receipt of the funds, in writing, to the CP concerned.

5.5 Expenditures include actual expenditures and committed but not paid expenditures. Committed but not paid expenditures include:

(i) The non-executed portion of the value of signed contracts under execution in the procurement of goods, delivery of services and construction works, inscribed and budgeted for in the State Budget of year n;
(ii) Expenditure to be paid and, exceptionally, not paid until the closure of the exercise.

Committed but not paid expenditures will be paid in year n+1 to complete their respective activities as already commenced in year n.

Article 6
Co-ordination, Monitoring and Review

6.1 Co-ordination, monitoring and review with regard to the implementation of the PESS will take place within the context of the SWAp (see ToRs in Annex 4) and the reporting structure as defined in Article 7. Compliance with the terms of this MoU on the part of the CPs, in particular with Articles 2, 4 and 5, will be monitored on an annual basis through relevant indicators in the Health Sector PAF.

6.2 The monitoring and the review process have as their objective to be fully in harmony with and integrated into the GoM's planning, budgeting, and reporting cycle and follow an agreed timetable (Annex 3).

6.3 Any concerns with the implementation of the PESS, and the use of PROSAUDE II funds in relation to this matter, will in the first instance be addressed through joint co-ordination, monitoring and analysis mechanisms.

Article 7
Reports and Documents

7.1 On an annual basis MISAU will provide all CPs with all relevant sector documents (see Annexes 3 and 4) in respect of annual planning, budgeting and monitoring, as specified:

Planning and monitoring documents:

(i) The annual Health Sector PES, including the health sector budget;
(ii) The matrix of sector performance indicators (Health Sector PAF);
(iii) Annual progress reports of the PES of the Health Sector (Reports on "Balanço do PES-Sectorial"), based on the Health Sector PAF for year n-1;

(iv) Budget Execution Report for year n-1;
(v) Annual external and internal audit reports and Public Financial Management Assessment reports.

7.2 MISAU will furnish the CPs with copies of the documents mentioned in Article 7.1, not later than 10 (ten) working days prior to the dates set for the meetings between MISAU and CPs in which the reports will be presented and discussed (see Annexes 3 and 4). Non-compliance with this rule will result in postponement of the above-mentioned meetings, with the latter being scheduled immediately following the sending of the reports to the CPs.

7.3 The CPs will comment on the documents and reports referred to in Article 7.1 within the time limits agreed between the parties. These documents will form the basis for discussion and meetings within the context of the SWAp (see Annexes 3 and 4). Absence of comments from the CPs within the time limits agreed upon by the Signatories will be interpreted as the CPs having taken a position of "no comment" on those documents.

Article 8
Flow of Funds

8.1 Disbursements shall be deposited into a specific Forex account in USD and/or Euro, indicated by the GoM, entitled to of the Ministry of Finance- the National Directorate of Treasury, hosted by the Bank of Mozambique (BM). From this Forex account funds will be transferred via a transitory account in Meticais to the General CUT (see Annex 5a and 5b). In the General CUT the PROSAUDE II funds will be coded as either internal or external funds, depending on the specification of the donor (see Annex 1). The transitory account will remain in place only for so long as it is required.

Changes in the coding of funds has to be communicated by the CPs to MISAU, after the Annual Joint Evaluation (ACA) and before 30 de Maio of year n.

From the General CUT, it will follow national financial procedures. This flow of funds is described in Annex 5.

8.2 As a temporary measure, until such time as the funds meant for the procurement of medicines and medical supplies are integrated into the Forex account, CPs disbursements will also be deposited into a Forex account in Swiss Francs, in the name of the Bank of Mozambique, on the Credit Suisse account in Zurich (see Annex 5). Once the conditions of Article 15.4 are met, only the Forex account in Mozambique will be used. The interest earned on the designated Forex account in Credit Suisse will be credited to the same account.

8.3 The balances, i.e. the non-executed funds, may be treated differently by different CPs, in accordance with the following two options:

i. The balances in Meticais, which are already inscribed in the General CUT and coded as internal funds, will be treated the same as for the State Budget (OE);
ii. The balances in Meticais, which are already inscribed in the General CUT and coded as external funds, will be re-inscribed into the budget of the Sector in year n+1 as external resources of the sector.

See for more details Annex 1 regarding coding of donor funds and Annex 5 regarding the financial flow.

8.4 The balances at the level of the Forex account in foreign currency will be re-inscribed into the budget of the Sector in year n+1.

Article 9
Financial Management, Procurement Procedures and Monitoring

9.1 MISAU will execute all financial management in accordance with applicable national legislation, specifically regarding financial management as set out in the Sistafe Law 9/2002, of February 12, Decree 23/2004 of August 20.

For the procurement process, MISAU will apply the Contract Regulations of Public Work contracts, Supply of Goods and the Delivery of Services, approved by the Decree 54/2005 of December 13, and the Ministerial Diplomas number 145/2006, 147/2006, 149/2006, 150/2006 and 151/2006.

For the application of the Regulation and the Ministerial Diplomas mentioned above, the Management and Execution Units for Procurement (UGEAs) will use the Procedures Manual developed by the Management and Execution Unit for Procurement (UGEA) of the MF.

For specific issues, not foreseen in the above mentioned documents, MISAU will develop complementary norms on procurement that will be approved as a Ministerial Diploma. If considered necessary, complementary norms on procurement and a Ministerial Diploma will be finalised by 31/12/2008, to enter into force from 01/01/2009.. The elaboration of these norms will be the responsibility of MISAU with support from the CPs, and the approval of the Ministerial Diploma will be the responsibility of MISAU and MF.

The specific management norms and procedures for the Account for the Procurement of Drugs and Medical Supplies are described in Annex 6.

9.2 MISAU will guarantee and maintain its UGEAs with suitable capacity and resources, in light of Decree nº 54/2005 of December 13. The UGEAs of MISAU will be responsible for the management of the procurement processes for all funds made available, in accordance with the Procurement Plan, which is an integral part of the annual Health Sector PES. This procurement plan is to be discussed with the CPs before its finalization.

Article 10
Audits and Public Financial Management Assessments

10.1 It is the aim of the CPs to strengthen MISAU's capacity to budget and manage funds in keeping with national legislation. An annual Public Financial Management (PFM) assessment, that will include the quality of planning and budget execution, will assess progress in this area. This external independent assessment will be financed by one of the CPs, while not ruling out alternative financing. The PFM assessment will be concluded annually before the Annual Joint Evaluation (ACA) of the sector, thus allowing its results to feed into the Joint Review. At the end of the annual Mid-Year Review of year n the signatories will agree on the type of PFM assessment that will be undertaken before the ACA in year n+2. Apart from the annual audit, there will only be one PFM assessment undertaken annually (see Annex 7).

10.2 Based on the results of the PFM assessment and the annual audit reports, CPs might request a rapid situational assessment at any time throughout the year, carried out by private firms. Findings from the rapid situational assessments would be fed directly into a financial management strengthening plan to ensure that follow up can be monitored on an ongoing basis.

10.3 Annual financial audits of the internal and external funds in the CUT, and of a sample of MISAU's respective expenditures at different levels, will be undertaken in accordance with the prevailing legislation by the independent supreme audit institution, the Administrative Court (TA). These audits will use international standards of auditing and will assess progress in the way sector funds are being used.

MISAU will send the Acórdãos (Decisions) of the Administrative Court (TA) to the CPs as soon as they are available (see annex 8).

10.4 MISAU will provide its final accounts to the Administrative Court (TA) by 31 March of year n+1.

10.5 The flow of funds from the Forex account through the transitory account to the General CUT as well as the flow of funds from the Credit Suisse account for the procurement of medicines and medical supplies will be audited annually by a private independent audit firm.

10.6 Regular audits of the procurement process, including procurement audits of medicines and medical supplies, which will include the process of tendering, importation, stocking and distribution, will be in accordance with current national legislation and regulations, and will be undertaken by a private independent audit firm. The timing, the ToRs and the procurement audit report are to be agreed between the CPs and MISAU.

10.7 All audit reports, made by IGF on MISAU's institutions, including provincial and district level, will be made available to the CPs.

10.8 The annual plan as well as the Audit reports of the Entity of Internal Control of MISAU will be made available to the CPs.

10.9 The content of all available audit reports and respective management letters, including the plan for implementation of the recommendations, will be discussed in the meetings between MISAU and CPs (see Annex 4).

10.10 The Signatories of the present MoU understand that all findings and recommendations of

internal or external audits will constitute the basis for the necessary corrective measures and reforms. Any failure to acknowledge this fact will be subject to the provisions foreseen in Articles 11 and 13.
Article 11 **Non-Compliance, *Force Majeure***
11.1 In the event of major non-compliance with the fundamental commitments (Article 1) or basic assumptions (Article 4.1) of this MoU, the CPs may suspend, reduce or cancel further disbursements and commitments to PROSAUDE II or demand reimbursement of the disbursed funds.
11.2 If a CP intends to suspend new disbursements or reduce or cancel its commitments or demand reimbursement, it will consult with the other CPs and MISAU before deciding on such a disruption. The CPs will discuss consequences for the implementation of the PESS and a possible joint position on the measures to be taken or which is required to ensure a process involving correction rather than a break.
11.3 If it is not possible to arrive at a joint consensus on the sanctions/corrective measures required, each CP may inform MISAU and the other CPs in writing of its intentions to suspend, reduce or cancel disbursements or commitments to PROSAUDE II or demand reimbursement. The CP will strive at having at least the support of one other CP.
11.4 The CPs may suspend, cancel or reduce new disbursements, in the event of extraordinary circumstances beyond the control of MISAU or breach of underlying principles as referred to in the MoU for the provision of Direct Budget and Balance of Payments Support which may impede effective implementation of the PESS. If the CPs consider suspending new disbursements they will bilaterally notify MISAU. The suspension will be lifted as soon as these circumstances have ceased to exist and/or appropriate corrective actions have been implemented.
11.5 In the event of non-compliance with the terms of this MoU on the part of the CPs, MISAU may request that part corresponding to the non-compliant CP be withdrawn from support to PROSAUDE II on a temporary or permanent basis.
11.6 In exceptional circumstances, and if justified, the CPs may undertake independent evaluations and audits, though this is discouraged. In such cases the CPs will inform the others signatories, and where possible, will engage in a joint process, sharing results and investigating any cases by means of the mechanisms provided by this MoU.
Article 12 **Anti-corruption**
12.1 MISAU will require that its staff and consultants attached to projects or programs financed through PROSAUDE II refrain from offering to third parties, or from looking to accept or being enticed by third parties, for themselves or for any other party, with any gift, remuneration, compensation or benefit of any kind, or whatever else as could be interpreted as a fraudulent, illegal or corrupt practice.
12.2 MISAU will take immediate measures in accordance with the legislation in effect and will inform the CPs of the measures taken in any instances of corruption as referred to in this article. The CPs reserve the right of unilaterally or jointly holding back disbursements or demanding the total or partial reimbursement of the funds.
12.3 It is understood that MISAU will actively implement the national anti-corruption strategy and will ensure that there is a suitable sector-level response within the context of the national anti-corruption strategy. The Signatories shall inform each other of any instances of corruption as referred to in this Article.
Article 13 **Modification, Admission and Withdrawal of CPs**
13.1 Any amendment to the terms and provisions of this MoU will only take effect if agreed to in writing by the Signatories.
13.2 The Signatories look favourably upon the admission into this MoU of such other CPs as may wish to support the implementation of the PESS through PROSAUDE II.
13.3 Upon presentation of a written request, the Signatories may admit new CPs to this MoU. Their admission will be documented through an amendment to this MoU signed by the new CP and MISAU. MISAU will inform the other CPs, MF and MPD and furnish each of them with a copy of the amendment referred to above.
13.4 The withdrawal of a CP's support should not affect the disbursements of funds already inscribed in the State Budget for a specific year, unless justified by violation of the fundamental commitments of article 1 and/or basic assumptions (Article 4.1).
Article 14 **Dispute Resolution**
14.1 For disputes that may arise between the Signatories as to the interpretation, application and

implementation of this MoU, the Signatories will consult with each other for the purpose of seeking an amicable solution.
14.2 It is understood that the two versions of this MoU, in Portuguese and English, have equal interpretive validity. In the event of a dispute the language of the bilateral agreement will prevail.
Article 15 **Temporary Provisions**
15.1 The performance of the health sector for the whole year of 2008 will be assessed using the Performance Assessment Framework for the Health Sector (Health PAF) and its targets for 2008 as outlined in Annex 2.
15.2 All disbursed funds to the PROSAUDE and/or the FCMSM accounts made in 2008 before the signing of this MoU will follow the rules and regulations of this MoU as soon as it is signed.
15.3. Audits of funds inscribed in the PES 2008 and expenditures occurred in 2008 will follow the processes as outlined in this MoU.
15.4 The financing mechanisms for procurement of medicines and medical supplies, stipulated in Article 8.2, are transitory until such time as conditions exist for this to be done through the Single Treasury Account (CUT). To that end, it is necessary that there be: (i) CUT in multiple currencies in e-SISTAFE; (ii) a financial management system and administration capacity within BM and MISAU/ DAF to permit the advance of funds for the opening of letters of credit in the process of procurement of medicines and medical supplies.
15.5 As long as the Credit Suisse Account continues to exist, the balances of this account will remain in the same account and pass to year n+1.
15.6 During a transitory period, in order to better monitor the procurement process of medicines and medical supplies, MISAU and CPs will agree to contract an independent firm to carry out supervision and monitoring of the procurement of drugs and medical supplies. The MISAU and CPs will agree on the schedule and the ToRs of this work.
Article 16 **Entry into Effect**
16.1 This MoU enters into effect after the signing by the Signatories taking into account the temporary provisions in Article 15.

Maputo, aos 30 de Julho de 2008
Assinaturas / Signature

Prof. Dr. Paulo Ivo Garrido, Ministro
Ministério da Saúde/ Ministry of Health _____

Dr. Aiuba Cuereneia, Ministro
Ministério do Plano e Desenvolvimento/ Ministry of Planning and Development _____

Dr. Manuel Chang, Ministro
Ministério das Finanças/ Ministry of Finance _____

Mr. Luc Pincince, Head of Cooperation a.i
Canadian International Development Agency**/** Agência Canadiana para o Desenvolvimento Internacional _____

Mr. Rui Álvaro Serra da Costa Reis, Representative
Catalan Agency for Development Cooperation/ Agência Catalã de Cooperação para Desenvolvimento _____

Mr. Francisco Garcia , Chargé d'affaires
European Commission/ Comissão Europeia _____

Mr. Yves Wantens, Representative
Flemish Ministry of Foreign Affairs/ Ministério dos Negócios Estrangeiros de Flandres _____

Ms. Genevieve Verdelhan-Cayre, Director a.i.
French Development Agency/ Agência Francesa de Desenvolvimento _____

Ms. Denise Hanrahan, Chargée de Affaires a.i.
Irish Aid/ Ajuda Irlandesa _____

Ms. Lotta Karlsson, Chargée d'affaires a.i
Ministry for Foreign Affairs of Finland/ Ministério dos Negócios Estrangeiros da Finlândia _____

Mr. Thorbjørn Gaustadsæther, Ambassador
Norwegian Ministry of Foreign Affairs/ Ministério dos Negócios Estrangeiros da Noruega _____

Mr. Johny Flentø, Ambassador
Royal Danish Embassy / Embaixada Real da Dinamarca _____

Mr. Miguel González Gullón, Coordinador General
Spanish International Cooperation Agency/ Agência Espanhola de Cooperação Internacional _____

Mr. Thomas Litscher, Head of Mission and Head of Co-operation
Swiss Agency for Development and Co-operation/ Agência Suíça de Desenvolvimento e Cooperação _____

Ms. A.A. Vogelaar, Head of Cooperation a.i.
The Dutch Ministry for Development Cooperation/ Ministério Holandês para a Cooperação para o Desenvolvimento _____

Mr. Neil Squires, Head of Cooperation a.i
United Kingdom Department for International Development/ Departamento do Reino Unido para o Desenvolvimento Internacional _____

Ms. Leila Pakkala, Representative
United Nations Children's Fund/ Fundo das Nações Unidas para a Infância _____

Ms Rati Ndlovu, Deputy Representative
United Nations Population Fund/ Fundo das Nações Unidas para a População _____

Anexo 1 – ***Annex 1***
Especificações dos Doadores – ***Donor Specifications***

Conforme o artigo 8.1. do MdE, entende-se que todos os fundos serão canalizados a partir de uma conta Forex passando por uma conta transitória para a CUT e desta para o Ministério da Saúde, utilizando o e-SISTAFE. Os fundos serão codificados como fundos internos ou externos dependendo da especificação do doador, como mencionado na tabela 1 abaixo.

As per article 8.1 of the MoU, it is understood that all funds will be channelled from a Forex Account through a transitory account to the CUT and from there to the Ministry of Health, using e-SISTAFE. The funds will be coded as internal or external funds depending on the specification by the donor as stated in the table 1 below.

Tabela/ *Table 1*: Codificação dos fundos dos PCs/ *Codification of the funds of the CPs*

Especificação por PC (doador) na codificação dos fundos ***Specification per CP (donor) on coding of funds***	
PCs cujos fundos serão codificados como fundos internos/ *CPs whose funds will be* ***coded as internal funds***	PCs cujos fundos serão codificados como fundos externos/ *CPs whose funds will be* ***coded as external funds***
Comissão Europeia/ European Commission	Agência Canadiana para o Desenvolvimento Internacional/ Canadian International Development Agency
Agência Francesa de Desenvolvimento/ French Development Agency	Agência Catalã de Cooperação para Desenvolvimento/ Catalan Agency for Development Co-operation
Agência Espanhola de Cooperação Internacional/ Spanish International Cooperation Agency	Ajuda Irlandesa/ Irish Aid
Departamento do Reino Unido para o Desenvolvimento Internacional/ United Kingdom Department for International Development;	Agência Suíça de Desenvolvimento e Cooperação/ Swiss Agency for Development and Co-operation
Ministério dos Negócios Estrangeiros da Noruega/ Norwegian Ministry of Foreign Affairs	Embaixada Real da Dinamarca/ Royal Danish Embassy
	Ministério dos Negócios Estrangeiros de Flandres/ Flemish Ministry of Foreign Affairs
	Ministério dos Negócios Estrangeiros da Finlândia/ Ministry for Foreign Affairs of Finland
	Ministério Holandês para a Cooperação para o Desenvolvimento/ The Dutch Ministry for Development Cooperation
	Fundo das Nações Unidas para a Infância/ United Nations Children's Fund
	Fundo das Nações Unidas para a População/ United Nations Population Fund

O Ministério das Finanças tratará os saldos, isto é, os fundos não executados, em Meticais, que já estejam inscritos na CUT, diferentemente de acordo com a codificação dos fundos seguindo indicações dos diferentes Parceiros de Cooperação, segundo as duas opções seguintes:

1. Aqueles fundos que foram codificados como fundos internos ao entrar na CUT serão tratados tal como o Orçamento do Estado, logo que se tornarem parte deste
2. Aqueles fundos que foram codificados como fundos externos ao entrar na CUT serão reinscritos no orçamento do sector da saúde no ano n+1 como fundos adicionais externos para o sector.

Os saldos a nível de conta Forex em moeda estrangeira serão reinscritos no orçamento do Sector no ano n+1 como recursos externos do sector.

The Ministry of Finance will treat the balances, i.e. the non-executed funds, in Meticais that have already been entered in the CUT, differently according to the coding of the funds following the indication of the different Cooperating Partners, according:

3. *Those funds that were coded as internal funds on entry in CUT will be treated in the same way as the State Budget as they have become part of it;*
4. *Those funds that were coded as external funds on entry in CUT will be reinscribed in the budget of the health sector for year n+1 as additional external funds for the sector.*

Os saldos na conta Forex em moeda estrangeira serão reinscritos no orçamento do sector para o ano n+1 como fundos adicionais externos para o sector

The balances in the Forex account in a foreign current will be reinscribed in the budget of the sector for year n+1 as additional external funds for the sector.

The European Commission (EC) will use a split response mechanism, with fixed and variable portions. The financial commitment for year n+1 will be based on performance in year n-1.

Variable portions will be linked to the following targets and indicators selected from the PAF and agreed with MISAU:

Rate of coverage of institutional births	*Target as agreed in the health sector PAF met, as demonstrated in the joint health sector review (ACA) and Balanço de PES.*
Rate of budget execution of funds under MISAU management	*Target as agreed in the health sector PAF met, as demonstrated in the joint health sector review (ACA) and Balanço de PES.*

*The score will be either **'1' for target fully met** or **'0' for target not met**. The weight of each indicator is 50%. The total score for the two indicators can thus be 2, 1 or 0.*

- *"Fully met" means that the indicator performance was equal or more favourable than the target;*
- *"Not met" means that the expected result was not achieved.*

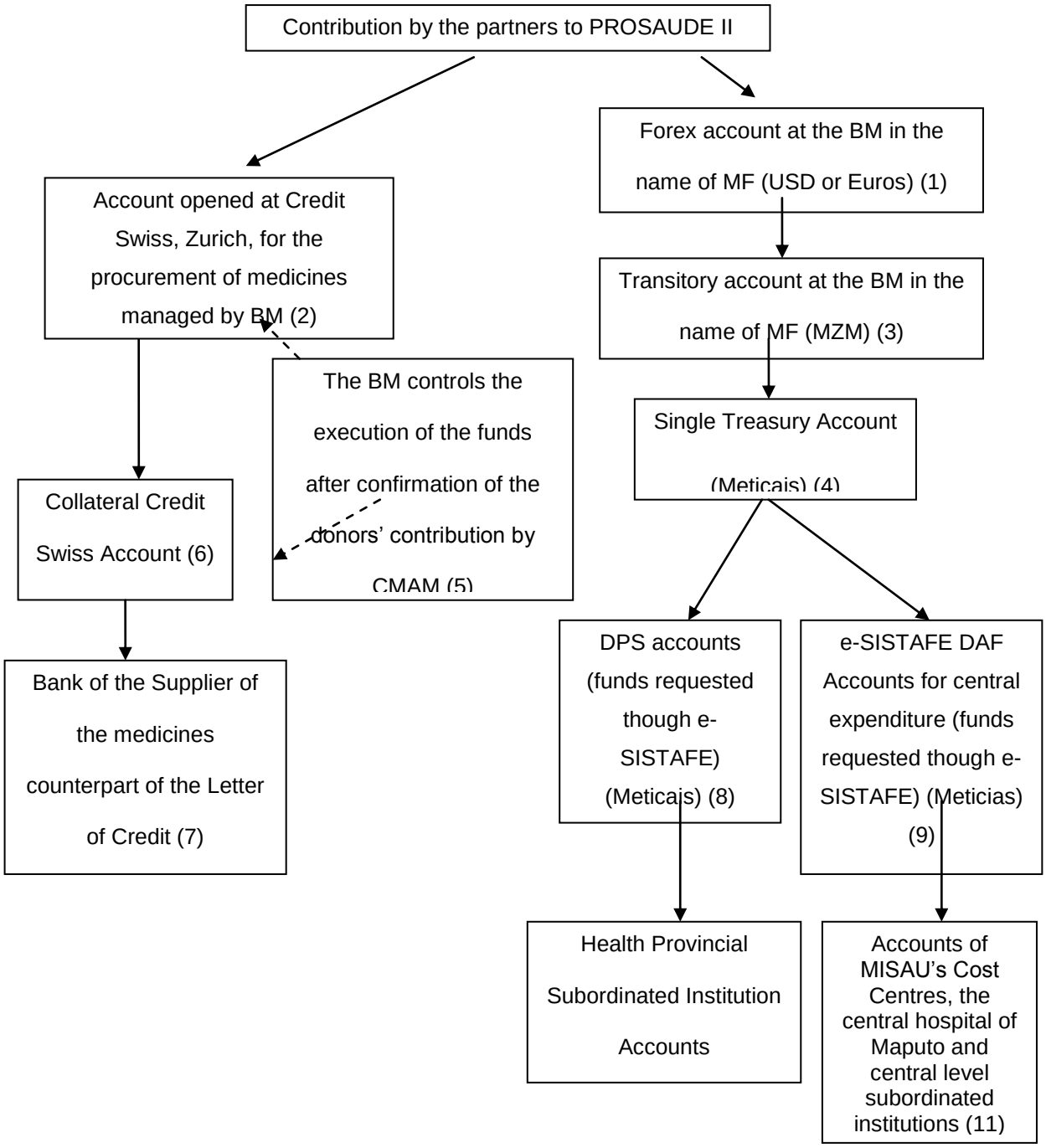
d) Annual Calendar for Planning, Budgeting and Reports

January	Closure of financial year n-1 Start of CP disbursements to PROSAUDE II accounts for year n in accordance with the agreed Disbursement Plan. Start of Joint Annual Evaluation (ACA) of the Sector for year n-1 including Health PAF indicators.
February	GoM sends to CPs Audit Reports for year n-2, prepared: - by the Administrative Court (TA) for all sector funds in the Single Treasury Account (CUT); - by the General Finance Inspectorate (IGF) for all sector funds in the Single Treasury Account (CUT).
March	Conclusion of the Joint Annual Evaluation of the sector (ACA) for year n-1 including the Health PAF Indicators. First Meeting of the Sector Coordination Committee (CCS) 1. Presentation of the Progress Report (Balanço do PES Sectorial) for year n-1; 2. Presentation of Joint Annual Evaluation of the Health Sector (ACA) of year n-1; 3. Change of focal partner team. National Coordinating Council for Health (CNCS)(without partner participation). Delivery to MPD of MTEF for years n+1, n+2 and n+3. MISAU sends, by 31 of March, to the Administrative Court the final accounts for year n-1.
April	Aide Memoire on Joint Review: Programme Assistance Partners (PAPs) and Government. Complete 12 months Progress Report (Balanço do PES), including the Budget Execution Report and the pertinent information previously included in the Summary of Statistical Information (to be revised before the end of 2008). Start of Audits: - External for all sector funds in the CUT for year n-1 and the respective expenditure, by the TA; - Internal for all sector funds and respective expenditure for year n-1 by the General Finance Inspectorate (IGF); - External for the flow of funds from the PROSAUDE II Forex account to the transitional account and from there to the General CUT as well as the flow of funds from the Credit Suisse account to the supply of drugs and medical items, by a private, independent accounting company.
May	Final Aide Memoire of the CCS of March Commitments for year n+1 of the CPs (common and vertical funds) based on the performance evaluation (Health PAF). Start of the planning process of MISAU (Sector PES for year n+1), including recommendations of the last ACA.

June	Continuation of preparation of Sector Economic and Social Plan (PES) for year n+1, including the matrices for Cost Centres, the pharmaceutical sub-sector, the allocation plan for the provinces and vertical funds.
July	Second meeting of the Sector Coordination Committee (CCS): 1. Presentation of the final external audit report for year n-1 of the PROSAUDE Forex account and the Credit Suisse account for the pharmaceutical sub-sector; 2. Evaluation of compliance with recommendations of the last ACA; 3. CP approval of final proposal for Sector Economic and Social Plan (PES and Sector Budget) for year n+1 to be submitted to MPD, including the PAF for the health sector with targets for year n+1.
August	Start of the Mid-Year Review of the PAPs and the Government including review of the indicators and targets of the General-PAF. 6-month Progress Report (Balanço do PES-Saúde Semestral) for year n. Decision on the type of Public Financial Management Assessment (PFM) to be done in year n+1.
September	Conclusion of the Mid-Year Review. Final Aide Memoire of the CCS of July.
October	Joint Coordination Committee- Extended (CCC-Alargado): 1. Presentation by the respective working groups and evaluation of their performance; 2. Approval of the ToRs for the Joint Annual Evaluation (ACA) for year n+1.
November	Start on preparation of MTEF: The CPs make their medium term commitments to facilitate the start of the elaboration of the MTEF for years n+2, n+3 and n+4. MISAU sends to the CPs the PES of year n, approved by the Parliament, including the harmonized operational matrices.
December	Joint Coordination Committee – Extended (CCC-Alargado): 1. Presentation of Final Treasury Plan; 2. Confirmation of Disbursement Plan; 3. Approval of the priorities of the working groups for year n. MISAU sends letters to CPs requesting disbursements of funds of PROSAUDE II, to be effected in year n in agreement with the agreed Disbursement Plan.

e) Financial Flow Mechanism for the PROSAUDE II

Initial Arrangements



Explanatory notes for the Initial Financial Flow Mechanism for the PROSAUDE II

1 Deposit by the Partners brought forward in American dollars (USD) or Euros (€) to PROSAUDE's Forex account. The account is in the name of and managed by the Ministry of Finance – National Treasury Directorate, with the making of transactions on it being upon instruction of the Directorate of Administration and Management (DAF) of MISAU.

2 Deposit by the Partners in the Crédit Suisse account in Swiss francs for Procurement of Drugs and Medical Supplies. The account is managed by the Bank of Mozambique, with the making of transactions on it being upon instruction from the Ministry of Health – Drugs and Medical Articles Depot.

3 Deposit in the transitory account in Meticais (MZM), of funds transferred from the Forex Account upon instruction of the DAF and coded either as internal or external funds on the basis of the specification by the donors (see annex 1).

4 Deposit in the Single Treasury Account (STA) in Meticais (MZM), of funds transferred periodically from the Transitory Account upon instruction of the DAF and upon an Overall PROSAUDE Cash Plan for direct execution by the central bodies (through the DAF) and the provincial bodies via e-SISTAFE.

5 Parallel management of the Crédit Suisse account by the BM. The management includes letters of credit, oversight of payment to suppliers, and oversight of transactions and balances. The BM oversees the flow of funds from the principal and collateral Crédit Suisse Accounts.

6 Crédit Suisse collateral account where the funds are secured in relation to the letters of credit opened for the account of the suppliers.

7 Bank used by the drugs supplier, the payments to which take place in line with the contractual conditions and upon presentation of documentary evidence to the BM.

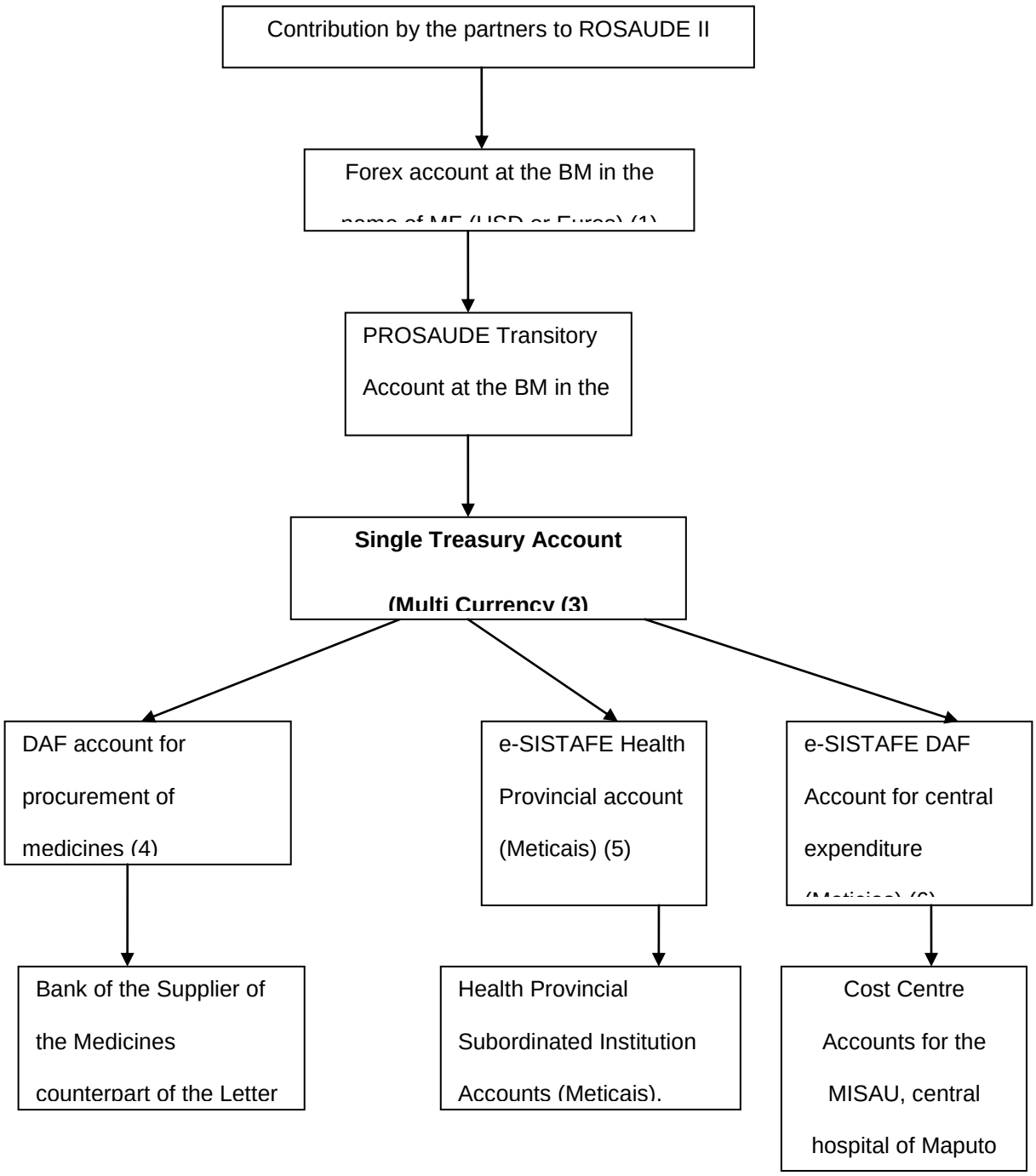
8 Direct execution by the DPSs through e-SISTAFE, respecting the budget tables which have been approved and are available in the system. E-SISTAFE is not available at district level, for which reason the funds come to the latter by transfer by the DPS, in keeping with the financial programming in the system.

9 Direct execution by the DAF through e-SISTAFE, respecting the budget tables which have been approved and are available in the system. The funds may be transferred to the bank account of the DAF (procedure referred to as an Advance Payment) or directly to the account of the beneficiary (procedure referred to as the Direct Route). E-SISTAFE is not available at central cost centre level, for which reason the funds come to the latter by transfer by the DAF, in keeping with the financial programming in the system.

10 Deposit of funds in the account of the subordinated institutions upon instruction of the DPS through e-SISTAFE, whether by Advance Payment or by Direct Route.

11 Deposit of funds in the account of the Cost Centres upon instruction of the DAF, through e-SISTAFE, whether by Advance Payment or by Direct Route.

Final Financial Flow Mechanism for the PROSAUDE II



Explanatory notes for the Final Financial Flow Mechanism for the PROSAUDE II

1 As soon as appropriate, the contributions of the CPs directed to PROSAUDE will be deposited in line with the Sectoral PES Cash Plan (MISAU) in the Forex Account at the BM in the name of MF (USD or Euros).

2 Deposit in the transitory account in Multi Currency, of funds transferred from the Forex Account upon instruction of the DAF and coded either as internal or external funds on the basis of the specification by the donors (see annex 1).

3 Deposit in the Single Treasury Account (CUT) in Multi Currency of funds transferred periodically from the Forex Account on instruction of the DAF and through an Overall PROSAUDE Cash Plan for direct execution by the central bodies (through the DAF) and by the provincial bodies via e-SISTAFE.

4 Transfer to the drugs procurement account via e-SISTAFE. This account is managed by the DAF. Management includes letters of credit, oversight of payment to suppliers, and oversight of transactions and balances.

5 Direct execution by the DPSs through e-SISTAFE, respecting the budget tables which have been approved and are available in the system. E-SISTAFE is not available at district level, for which reason the funds come to the latter by transfer by the DPS, in keeping with the financial programming in the system.

6 Direct execution by the DAF and DPSs through e-SISTAFE, respecting the budget tables which have been approved and are available in the system. The funds may be transferred to the bank account of the DAF (procedure referred to as an *Advance Payment*) or directly to the account of the beneficiary (procedure referred to as the *Direct Route*). e-SISTAFE is not available at central cost centre level, for which reason the funds come to the latter by transfer by the DAF, in keeping with the financial programming in the system.

7 Bank used by the drugs supplier, the payments for which take place in line with the contractual conditions and upon presentation of documentary evidence to the BM. The payments are made through the letter of credit mechanism.

8 Deposit of funds in the account of the subordinated institutions upon instruction of the DPS through e-SISTAFE, whether by *Advance Payment* or by *Direct Route*.

9 Deposit of funds in the account of the Cost Centres upon instruction of the DAF, through e-SISTAFE, whether by *Advance Payment* or by *Direct Route*.