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CURRENT ISSUES IN SECTOR-WIDE APPROACHES FOR HEALTH DEVELOPMENT

Mozambique Case Study

Adrienne Brown
Overseas Development Institute

WORLD HEALTH ORGANIZATION

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Global Programme on Evidence for Health Policy

ABOUT THE INTER-AGENCY GROUP ON SECTOR-WIDE APPROACHES AND DEVELOPMENT COOPERATION

The Inter-Agency Group on Sector-wide Approaches and Development Cooperation (IAG) is a small informal group of experienced senior technical people from international development agencies. WHO provides its secretariat.

The group's interest is in advancing policy and practice of development assistance for health development. Toward this end, members of the group meet to review and discuss specific issues and topics in development aid, commission new analytic work, review results and disseminate information both through the communication networks of their own organisations and through WHO's publications series.

In 1999, the Inter-Agency Group commissioned five country case studies and a synthesis report to review experience with sector-wide approaches to date. Additional case studies are planned to document the evolution of sector-wide approaches in the context of other development initiatives and instruments, particularly poverty reduction strategies.

For additional information, please contact:

Dr K Janovsky, Secretary
Inter-Agency Group on Sector-wide Approaches and Development Cooperation
World Health Organization
CH 1211 Geneva 27
Switzerland
tel 41 22 791 2568
fax 41 22 791 4881
e-mail janovskyk@who.int

CONTENTS

ACRONYMS iv

EXECUTIVE SUMMARY v

1 **BACKGROUND AND METHODOLOGY** 1

2 **CONTEXT** 3

2.1 General context 3
2.2 Health context 6

3 **PROGRAMME SUMMARY** 9

3.1 Background 9
3.2 Proposed development process 10
3.3 Managing the process 10
3.4 Programme financing 11

4 **KEY ISSUES** 13

4.1 Implementation tasks 13
4.2 Lessons from the past 17
4.3 Government commitment to a SWAp 20
4.4 Barriers to SWAp development 20

5 **PROGRESS AND PROSPECTS** 27

5.1 What has and has not changed 27
5.2 Prospects 28

ACKNOWLEDGEMENTS 29

ANNEXES

Annex 1 Common Financial Management and Disbursement in Mozambique Sector Programmes 31
Annex 2 Terms of Reference 33
Annex 3 List of people met 35
Annex 4 Bibliography 37

ACRONYMNS

CCS	Health Sector Co-ordination Committee
CDF	Comprehensive Development Framework
DFID	UK Department for International Development
EPI	Extended Programme for Immunisation
GDP	Gross Domestic Product
GoM	Government of Mozambique
HIPC	Heavily Indebted Poor Countries
HRD	Human Resource Development
HRSP	Health Sector Recovery Programme
IFI	International Financial Institutions
IPP	Integrated Provincial Planning
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
MFP	Ministry of Finance and Planning
MINED	Ministry of Education
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non Governmental Organisation
PROAGRI	Programe Nacional de Agricultura
SADC	Southern African Development Coordination
SDC	Swiss Development Corporation
SWAP	Sector-wide Approach
TA	Technical Assistance
TAG	Technical Advisory Group
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
SIP	Sector Investment Programme
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Mozambique is unusual among the case studies countries reviewed for the Inter-Agency Group and WHO[1] in that it has a long history of donor co-ordination and funding mechanisms, many of which resemble those adopted under a sector-wide approach. These are in part a tribute to Mozambique's significant achievements in reconstruction and development since the political turmoil of the 1980s and early 1990s. Since then there has been rapid economic growth, political stability, and an increase in government funding to the health sector, which have helped to restore infrastructure, supported by important aid initiatives.

A number of problems remain, however, and it is these that both government and donors wish to tackle through a sector-wide approach. Access to health provision is very restricted, but further expansion of the infrastructure will not be sufficient to address these problems. A more rational allocation of resources is required, utilising expenditure outside the government sector, and prioritising services to reach the poorest. An ambitious programme of national decentralisation and deconcentration, when fully implemented, will present significant challenges to state health delivery. There will be also be many opportunities for working with non-governmental providers.

Although there is growing consensus between government and the donor community about the issues that need to be addressed, the experiences of the past have not all been positive and have overshadowed negotiations around sector strategy development. A small group of donors had, in the early 1990s, grown close to government as they supported a number of important health planning and financing initiatives, including a pooled fund arrangement for drugs and technical assistance, an integrated planning tool, and budgetary support for the provinces. At the same time there had been a considerable investment in capacity building in the Ministry of Health in the hope that the joint initiatives would lead to long term gains in health development. In fact the close proximity of donors to the Ministry and the relative influence of some donors over others gave cause for concern to members of both government and the donor community as a whole.

The capacity of MoH to implement a sector-wide approach is now a key issue, most importantly in its ability to make appropriate health policy which addresses the key technical considerations of the programme. Donors and government are in a process of discussion about how MoH's needs may best be met, but given some scepticism in the donor community and a wariness within the Ministry, this is a long and sensitive process. The development of the SWAp has the potential to build capacity, but also runs the risk of further disabling the Ministry unless managed carefully.

[1] Case study countries include Mozambique, Uganda, Tanzania, Cambodia and Vietnam. See inside front cover for full references.

1 BACKGROUND AND METHODOLOGY

This case study is one of five carried out for the World Health Organization and the Inter-Agency Group on Sector-Wide Approaches and Development Co-operation, conclusions from which have been drawn together in a synthesis entitled *Sector-wide Approaches for Health Development: A Review of Experience*[2]. For full references of other country case studies in the series, see inside front cover. The work was carried out by the Centre for Aid and Public Expenditure at the Overseas Development Institute.

This report is based on findings from interviews and review of the limited literature available in English. Field work was carried out for one week in mid October 1999, and entailed interviews with senior government officials, donors, representatives of other agencies, and NGOs. A list of people met is attached in Annex 3. A week was a very short time to become familiar with complex and sensitive issues, and conclusions should therefore be taken in the spirit of the Terms of Reference: *"Given the breadth of the concerns set out below, the aim will be to make well informed judgements, rather than collect large amounts of quantitative data"* (see Annex 2). It should also be noted that the report refers primarily to the situation at the time of the field work, and therefore events and opinions may have developed subsequently beyond those described here.

NOTE: This case study was written before the severe floods which badly damaged Mozambique's health infrastructure and placed new demands on both MoH and the donor community. It has not been possible (or appropriate) to explore with GoM how this might affect SWAp development and implementation.

[2] Foster, M., Brown, A., and Conway, T., Sector-wide Approaches for Health Development: A Review of Experience WHO/GPE/2000.1, April 2000.

2 CONTEXT

2.1 General context

Since the end of the civil war in October 1992, Mozambique has enjoyed rapid economic growth, achieving an average annual increase in GDP of above 6%. During the early post war period, growth was led by the expansion in agricultural production, largely a result of the resettlement of rural areas. More recently, there has been a significant expansion of the service sectors (particularly tourism and transport) and a recovery of the manufacturing sector, though admittedly from a narrow base.

The government has sought to create a favourable environment for private sector investment, arguing that investment is the key to achieving its poverty alleviation goals. To this end, the government has adopted stringent measures to ensure economic stability, thereby reducing inflation from 70% in 1994 to less than 7% in 1999. Many of the bureaucratic barriers to trade and investment have been removed. Virtually all the public sector enterprises in the banking, manufacturing and agricultural sectors have been privatised over the past decade, leaving only the major utilities in public ownership. Generous tax concessions have been used to attract private investment in major projects in tourism and manufacturing. The government is also committed to an open economy and the development of linkages with its neighbours in Southern African Development Coordination (SADC) through investment, trade and the provision of services.

Agriculture is seen as the key sector for Mozambique's future economic development and for the reduction of poverty - 80% of the population live in rural areas and depend on agricultural production for their livelihood. In order to stimulate growth, considerable investment has been made in the restoration of the rural road network and the expansion of services in rural areas. Under the 2000-04 Government Programme, priority will continue to be given to measures aimed at improving the productivity of small-scale family farmers and access to markets in rural areas.

2.1.1 Poverty Profile

Despite the impressive rates of economic growth achieved in recent years, Mozambique still presents some of the worst social indicators in the world. According to the preliminary results of the 1997 census, about 60% of the adult population is illiterate, and 60% have no access to safe drinking water.

A national household survey, carried out in 1996-97, revealed that approximately 70% of the population live in poverty, with marked disparities between rural (71%) and urban (62%) areas and between regions, the incidence of poverty being highest in the Province of Sofala (88%) and lowest in Maputo City (48%). According to the survey, 82% of poor people live in rural areas.

Although per capita GDP has grown substantially from US$87 in 1992 to US$143 in 1998, the extent to which these increases at the national level have benefited the low-income households is debatable. While the poor have benefited from improved access to social goods such as health, education and clean water, there is little evidence to suggest that their real incomes have increased significantly. There is growing awareness that economic liberalisation and broad-based growth may not be enough to tackle the widespread poverty of rural Mozambique and that an increase in

household income, through sustainable livelihood opportunities, is likely to take many years to achieve.

2.1.2 Trends in ODA

Mozambique has benefited from substantial inflows of ODA, throughout the 1990s, averaging US$600 million per year. During this period there has been a significant change in the structure of aid flows and management. Emergency and food aid dropped off sharply from 1992, being replaced by aid to resettlement and reconstruction. Prior to the elections in 1994, the UN played a key role in the co-ordination of donor support to the reconstruction programmes, much of which was channelled through international NGOs working on area-based programmes. Since the elections, the proportion of aid flows channelled through NGOs has gradually fallen and support to projects in government increased. Subsequently, the difficulties encountered in co-ordinating and managing a diverse portfolio of projects has encouraged the development of sector programmes in five key sectors: health; education; agriculture; roads; and water.

Mozambique acceded to HIPC in June 1999. Under the terms of this agreement, Mozambique's external debt will be reduced from US$5.6 billion in net present value terms in 1996 to US$1.1 billion. The IMF calculates that scheduled debt service will fall from US$113 million pre-HIPC to US$100 million post HIPC, though actual debt service is expected to be US$70 million less than the scheduled debt service. While accession to HIPC is an important step in the reduction of Mozambique's debt burden, there is some controversy regarding the actual level of relief provided. It has been argued that HIPC has only cancelled debt that would never have been paid. Nevertheless, the government anticipates that the HIPC will permit an increase of 10% in expenditure on education and health.

2.1.3 National Development Plans

Development policy is presented in a five year Government Programme, approved by Parliament at the beginning of each legislature, which presents the broad outline of government development policy, though generally lacks reference to specific targets or financial commitments. For the period 1995-99, the main objectives outlined in the Government Programme were the maintenance of peace and national unity, the creation of employment and the expansion of health and education services.

More detailed sectoral strategies, together with performance targets and broad guidelines on implementation arrangements, are approved by resolution of the Council of Ministers. These sector strategies have guided elaboration of the integrated sector programmes (SWAps) in five key sectors: health, education, agriculture, water, and roads. The sector programmes remain indicative planning instruments which are not subject to a formal approval process. The main formal planning instrument is an annual plan, prepared by the sectors and Ministry of Planning and Finance and submitted to parliament for approval together with the budget. In theory, the annual plan and budget should operationalise the priorities traced in the sector programmes.

More recently, during late 1998 and 1999, a Poverty Reduction Action Plan was prepared by the government in order to ensure that all government agencies address poverty alleviation issues. This Action Plan has been used to guide sectors in the

presentation of their proposals for the medium term expenditure framework and the elaboration of operational plans for the sectoral programmes.

2.1.4 Budget Framework and Reforms

In 1997 the Government of Mozambique began a wide-ranging programme of budget reform, encompassing the areas of financial programming, aid management, budget execution, accounting, debt management and auditing. The principal objectives of this reform are to increase transparency in the management of public resources, to improve the efficiency and efficacy of public expenditure in pursuit of the development objectives defined by the government, and to ensure long-term fiscal sustainability.

Major achievements of the reform process to date include closer linkages between the annual planning and budgeting processes, through the introduction of programming and monitoring indicators in the main sectors and development of a medium term fiscal programming instrument, which provides a framework for the inter-sectoral allocation of resources.

These measures, supported by extensive training programmes in all sectors, have brought about significant improvements in transparency of the budget process. Nevertheless, much remains to be done. A large proportion of aid flows and earmarked receipts is still not reported by the beneficiary institutions and the budgetary status of many of the autonomous bodies has yet to be defined. Other areas which are still relatively weak are accounting, treasury management and inspection. These are likely to be the priorities of the reform process in the coming years.

2.1.5 Public Sector Reform

The 1995-99 Government Programme set out an ambitious decentralisation strategy, which envisaged the creation of new rural and urban local authorities with responsibility for the provision of services in a wide range of sectors, including primary health care. Following parliamentary review, however, a more gradual approach to decentralisation was adopted: the new municipal authorities were, initially, restricted to 33 towns and cities and their functions limited to the provision of basic urban services. Responsibility for other services will be transferred from central government to municipal authorities on the basis of a time table to be defined by the respective line Ministry and the requisite resources will be transferred from the sector budget. In these circumstances, no significant devolution of responsibilities is anticipated in the near future.

In parallel to the municipal development programme, the government has sought to delegate responsibilities from line Ministries to lower levels of the administrative hierarchy, particularly the provincial level. The most important of these measures has been the delegation of authority for the hiring, firing and promotion of all civil servants with medium level qualifications - more than 70% of all civil servants and 90% of provincial level personnel, including virtually all teachers and health workers - to provincial governors. This has been accompanied by a significant deconcentration of resources to the provincial governments, particularly in the education and health sectors, where budget limits have increased by 149% and 121% in real terms from 1995 to 1999. Nevertheless, decisions concerning the allocation of resources at provincial level continue to be relatively centralised.

The government has also embarked upon a programme aimed at revitalising the civil service and reducing the loss of civil servants to the private sector and donor organisations. Key elements of this process have been the reclassification of approximately 80% of civil servants, introduction of a new system of careers and remuneration from 1999, the decompression of salaries and the introduction of a service wide training programme. However, the initial reaction to the first step in the salary decompression was disappointment and it is unclear whether the salary reform will effectively stem the haemorrhage of skilled and qualified personnel from the public sector in the near future.

2.2 Health context

The population of Mozambique continues to live with the twin legacy of economic hardship compounded by war, despite the improvements outlined above. The lack of essential services such as sanitation and electricity, and the limited access to health care are reflected in the following indicators:

Table 1 Health indicators

Indicator	
Life expectancy at birth (years)	46.5 years (1997)
Maternal mortality ratio	1,500 per 100,000 births (1998)
Infant mortality rate	134 / 1000 per live births (1997)
HIV+ prevalence among adult population	14.5% (1998)
Total fertility	5.8 children per woman (1992-97)

Source: UNDP, 1998, except for HIV prevalence (source: National AIDS Control Programme, MoH)

Access to health services is a key problem for Mozambique. The picture of health provision was relatively hopeful post independence as the government expanded primary health care infrastructure in the rural areas, building a programme based on communities and production centres. However by 1987 a third of these units had been destroyed or closed. Although most were rebuilt by the mid 1990s, the increase in need for services had by then outstripped development. Now approximately only 39% of the population have access to health care[3], although there are significant geographic variations between and within urban and rural areas. It is not clear to what extent these variations are exacerbated or assisted by government allocation of provinces to donors so that aid may be targeted geographically. There is an equalisation mechanism in place within donor budgetary support arrangements and in the system of government allocations but the impact is limited, reflecting in part a dearth of health management information and planning capacity. Either way the availability of government provided health care was in 1996 limited to an average of one health post per 24,561 inhabitants, one health centre per 76,338, and one rural hospital per 667,961[4].

The use of private practice and traditional healers represents one solution that households employ when faced with limited government services. The pharmacy

[3] UNDP (1998).
[4] ibid.

sector is particularly heavily dominated by private provision, and these pharmacies are spread more evenly around the country than private clinical practices, indicating a widespread reliance on this form of access to drugs. Private clinical practice is focussed largely on Maputo city and province (77%)[5], and although nationally the sector is not large (approximately 30 clinics and 41 pharmacies[6]), it is growing, especially in urban areas. Many government employed doctors maintain a private practice but use state facilities, which effectively means that the state sector is subsidising the private. Information is limited about the size of the private sector, and it probably exists beyond that suggested by the estimates above.

Overall expenditure in the health sector in 1997 was estimated to be $8.84 per capita[7] which falls short of the $12 suggested by the World Bank[8] in 1993, but is close to the World Bank/WHO calculation of $9.24 proposed in 1994[9]. However of this $8.84 at least 50% of recurrent expenditure goes to hospitals for mainly curative services[10], thereby drastically reducing the amount left over for preventative care. The implication of this for extending services is discussed in section 4.1.2. Beattie and Kraushaar (1999b) identify a number of trends for health financing which also highlight the pressure on government to fund priorities, both from the point of view of having to make services more effective, and in the need to attract more donor funds:

- government commitment to the health sector has increased, with health growing as a portion of the state budget from 8.2% in 1996 to 9.6% in 1999
- however donor expenditure is declining which means that overall health funding is diminishing. This is attributed to much of the post war reconstruction having been completed, but also to increasingly strict donor standards for programme compliance
- this represents a change in the balance between government resources and international assistance from nearly 20%:80% in the mid 1990s to roughly 50%:50% in 1999, which is potentially more manageable for the government, although it is now faced with an overall shortage of funds. The aid mechanisms promised by the sector-wide approach may, however, facilitate more expenditure by donors, and return overall health funding to an upward, or at least constant, trend.

[5] Yates, R. and Zorzi, N. *Health Expenditure Review Mozambique*, Management Sciences for Health, Boston, Draft version March 1999 quoted in Beattie and Kraushaar (1999b).
[6] Beattie and Kraushaar (1999b).
[7] ibid.
[8] World Bank (1993).
[9] World Bank (1994).
[10] ibid.

3 PROGRAMME SUMMARY

3.1 Background

Mozambique does not yet have a sector-wide approach to health development. It does however have a number of building blocks towards one, and it has the intention to achieve a SWAp. The lessons from the past, including pooled funding, budgetary support, and donor co-ordination are all relevant to the process the Ministry of Health has now started of developing a 5 year sector strategy and implementation plan. Other government-wide initiatives, including the development of an MTEF, are also relevant.

Prior to the introduction of the idea of a sector-wide approach, there were several milestones in creating joint working arrangements between donors groups and GoM:

• Swiss Development Corporation (SDC) took on the role of lead donor, liasing between MoH and other funding agencies	1992
• SDC began budget support which was supported by an Integrated Provincial Planning process (IPP) to assist with resource management. Joint MoH-donor auditing began	1994/5
• donor co-ordination group started	1996
• pooling arrangements began for drugs and technical assistance, managed by donors, with financial support from SDC, Norway, Netherlands, Denmark and Canada	1996
• Ministry of Planning and Finance (MFP) began budget reform process at central and provincial levels, including introduction of MTEF; MoH began review of health policy at request of donors	1997
• SDC stepped down from the position of lead donor	1998
• the World Bank took on a less formal co-ordination role.	1999

In 1998, donors asked GoM to initiate development of a sector-wide approach for health:

• MoH and MFP started to develop a long term financing strategy	May 1998
• MoH accepted the recommendations of the Technical Advisory Group Policy Review which suggested the cautious development of existing initiatives into a sector-wide approach. MoH then signed a joint declaration of intent to this effect with donors	October 1998
• GoM/donor Health Sector Co-ordination Committee formed (CCS); GoM proposed terms of reference for developing a SWAp	November 1998
• MoH set up a Technical Support Unit for Strategic Planning	1998

to develop a strategic plan in the context of a SWAp and support the CCS	
• MFP established a unit to help line Ministries develop a SWAp	March 1999
• government – donor seminar to build consensus on the way forward in the health SWAp	June 1999
• a second workshop drafted a code of conduct	August 1999
• code of conduct due to be signed	March 2000
• first draft of the Health Sector Strategic Plan due to be completed.	April 2000

3.2 Proposed development process

In the course of the above process of discussion with donors, the Government of Mozambique has agreed that it will move towards a sector-wide approach by:

- completing the MTEF on an annual basis, with more attention paid to defining resource requirements of activities
- defining a vision of the sector and a strategic plan for the next 5 years
- transferring management of pooling arrangements into MoH
- continuing to develop the sub-sectoral working groups which are aiming to resolve their respective financial management problems e.g. pooling arrangements
- continuing to co-ordinate with donors[11].

As yet, no definite process for drafting and finalising the health sector strategic plan has been agreed between MoH and donors. There is, however, a draft proposal under discussion for how this could be done which was prepared by a WHO special advisor to MoH.

3.3 Managing the process

New structures have been put in place to develop the sector-wide approach. In addition to a core group of donors[12] who are convened by the World Bank and meet weekly with the Ministry of Health's Director of Planning and his technical adviser, there is a Health Sector Co-ordination Committee which has a steering function, meeting less frequently but with wider representation of MoH officials and donors. This is supported by the Technical Unit for Strategic Planning, set up in 1998 within the Directorate for Planning and Co-operation (DPC) of the MoH. Its main tasks are to prepare a strategic plan for 2000 – 2005 and to support the Sectoral Co-ordination Committee. The Unit is expected to facilitate the development process by organising consultation meetings and information seminars, participate in the planning activities of the DPC, follow up the health expenditure review and plan the development of Health Financing Strategy, and carry out some institutional capacity building

[11] Beattie (1999).
[12] In addition to the World Bank, donor membership consists of WHO, SDC, USAID and DFID.

activities. The main output is the strategic plan[13]. The unit is staffed by one expatriate technical advisor and national staff, and is financed by a small group of donors.

An annual management cycle has been agreed between GoM and donor partners. A meeting each May will review progress against the previous year's workplan based on a preceding joint appraisal mission. A forward workplan will then be developed and agreed. At the May meeting donors will also be expected to make financial commitments to the programme for the coming year. GoM and donors have also agreed that an agency will undertake the role of 'facilitator' for the SWAp process[14]. The World Bank has been chosen for the first year.

3.4 Programme financing

The first MTEF was completed in 1999, and whilst it projected a continued increase in government allocations to the health sector over the next five years, a funding gap still remains (see Table 2). Although it should be remembered that Mozambique, like many other aid recipient countries, suffers from a lack of information about future donor financing intentions so possible commitments for the end of the period are not captured, donor contributions have been declining for the reasons outlined in section 2.2.

Table 2 Projected financing gap (1999 – 2003)[15]

Note: this represents only the budget likely to be required if no further building is carried out, and no significant changes are made to the way health systems are operated.

In US$ millions

Expenditure	Source of funding	1999	2000	2001	2002	2003
Recurrent	Internal	45	47.3	49.8	52.5	55.4
	External	31.1	32.9	34.8	23.8	25.2
	Sub total	76.1	80.2	84.6	76.3	80.6
	% of total	*57%*	*58%*	*59%*	*67%*	*68%*
Investment	Internal	6	6.4	6.4	6.4	6.4
	External	51.2	51.3	51.2	30.9	30.9
	Sub total	57.2	57.7	57.6	37.3	37.3
	% of total	*43%*	*42%*	*41%*	*33%*	*32%*
Grand total		133.3	137.9	142.2	113.6	117.9
Estimate of minimum required resources		140	147	154.4	162.1	170.2
Financing gap		**6.7**	**9.1**	**12.2**	**48.5**	**52.3**
Gap as a % of secured funding		*5%*	*7%*	*9%*	*43%*	*44%*

[13] MoH (1999b).
[14] MoH (1999).
[15] From Beattie (1999).

Therefore whilst additional future funding may be secured it may well not be sufficient to meet the projected gap. The implication of this is explored in section 4.1.2. GoM will therefore need to make better use of existing funds, and mobilise those expended in the non-governmental sub-sector. There will also have to be a shift between capital investment as infrastructure expansion is completed, and the recurrent budget to support the increased running costs. An increased allocation to primary health care will also be essential.

Financial management arrangements have yet to be agreed, but it is likely that they will follow the same procedures as for other sectors. These are outlined in Annex 1.

4 KEY ISSUES

It is evident from reviewing the work outlined above that both GoM and donors have invested considerable time and energy in establishing the ground work for a SWAp. Despite this, however, there remain considerable difficulties in moving the process forward. This section attempts to review the current challenges for SWAp development and draw some lessons from past experiences.

4.1 Implementation tasks

MoH is still in the process of agreeing internally, and with donors, what the scope and content of the programme should be. At this stage it is broadly agreed that MoH has a number of key issues to address through the SWAp.

4.1.1 Health care delivery through a decentralised service

The current process of decentralisation and deconcentration poses some crucial questions for health service delivery. The process outlined in section 2.1.5 requires the 11 provinces to execute the national health policy through locally managed services. However, a lack of capacity has severely undermined this. Health administration is poor not only in terms of planning and management, but also implementation, so in order to make an appreciable difference to health service delivery, considerable investment will have to be made in further capacity building. The implementation of the Integrated Provincial Planning tool (see Box 1) has started this process and played an important part in improving capacity at province level[16]. Continuing the decentralisation programme will raise further issues about the limits of municipal authority in regard to their latitude for interpreting government policy to meet local needs and direct funds accordingly.

4.1.2 Addressing poverty issues

The poverty reduction strategy of the government focuses on:

- reducing maternal mortality by expanding coverage of basic obstetric services
- reducing infant mortality by expanding coverage of basic health services
- reducing the average distance to a health facility or midwife from 22 kms and 16 kms respectively to 10 kms and 8 kms
- developing and implementing a multi-sectoral strategy to address the HIV/AIDS epidemic
- spearheading activities aimed at ensuring adequate water supply and sanitation facilities for all[17].

[16] Technical Advisory Group (1998). The financial management reform programme has placed finance brigades in provincial Directorates of Health to develop budgets, administer funds, monitor and account for finances, and co-operate with joint audits. Although they have not always been well received because they have at times revealed mismanagement and malpractice, they have made an important contribution to improving financial management capability.

[17] Beattie and Kraushaar (1999b).

Box 1 'Building blocks' of a sector programme

Integrated Provincial Planning

This was initially introduced with the support of SDC and UNICEF in 1992 and by 1994/95 was in all the provinces. It is a planning tool which enables the review of expenditure and outputs in the previous year, plans the coming year through budgeting and programming exercises, and monitors progress in specific areas. In other words, it links activities and programme goals with resource allocations. It is done at provincial level as a bottom up programming exercise, using district data and when possible involving district officials. However, it is not fully integrated at higher levels because national goals are not usually based on a thorough review of available resources, and the government budget is usually allocated before the IPP generates information[18]. The IPP is now being used by the provinces more independently of MoH and becoming integrated with the financial management reform programme.

Earmarked budgetary support

This was started in 1990 with SDC, later joined by UNICEF, and was an important boost to the government health programme when the majority of aid had been going straight to NGOs. On average annual budgetary support totalled approximately US$5 million and by 1997 it had grown to include four other donors and represent about 40% of national funding (excluding drugs and salaries). The areas funded included the topping up of selected salaries in MoH as a capacity building method. Funds were channelled directly to MoH rather than to MFP because both donors and MoH believed the health sector needed this protection from competition from other powerful ministries[19].

Budgetary support has also been provided at province level by SDC and, since 1999, by Norway co-financing at national level. Other agencies support similar arrangements such as the EU in Zambezia, Danida in Tete, and in Niassa province there is a pooling arrangement being piloted with SDC, Norway, Ireland and UNICEF to support EPI, IMCI, and community participation.

Multi-donor joint audits

Joint audits have been carried out of government management of donor funds supporting recurrent budgets at both national and provincial level. Donors supporting programmes in the National Directorate of Health have funded a private firm to carry out audits to an international standard of their contributions since 1995. Audit at provincial level is also taking place.

Pooled funds

Two pooling arrangements are currently in place whereby MoH now specifies its needs according to agreed criteria, and these are met by the donor funds, which in 1997 totalled US$12 million.

- *Technical assistance*: This started to operate in April 1996, and is funded by contributions from Switzerland, the Netherlands and Norway. The fund is not administered by GoM, but by UNDP. Initially the pool only covered specialised clinical staff in an effort to increase the predictability of funding, prevent MoH from having to shop around to different donors, and to standardise terms and conditions. It is now being expanded to include other health personnel.

- *Drugs*: This programme is funded by Switzerland, the Netherlands, Norway, Denmark and Canada. However funds are kept in separate donor bank accounts. Planning is done jointly, but tendering, auditing and disbursement procedures are run according to the funding agencies' own rules. The drug pool covers approximately one-third of all donor resources in this area.

[18] ibid.
[19] Pavignani and Durão (1999).

In order to reach these targets, MoH will have to focus on the high levels of exclusion suffered by poor people due to the low level of service provision. Whereas 69.4% of the population are considered to be living in absolute poverty[20], state health facilities are geographically accessible by only about 39% of the total population[21]. Moreover, of recurrent expenditure on health care, at least 50% goes to hospitals for mainly curative services[22]. People are excluded by formal and informal user fees, high opportunity costs (especially for women), transport costs, simply being too far away to reach government services or living in the wrong province. There are also huge discrepancies between per capita expenditure in the provinces ranging from US$2.27 to US$9.33 in Maputo city (1997 figures[23]). It will be essential that the SWAp rationalises this situation.

The government has started to address these issues by asking the right questions: a series of health financing studies (of which Beattie and Kraushaar 1999 is one), conducted by MoH and Management Sciences for Health with USAID and Danida support, present a valuable analysis and show the areas where much remains to be done. The IPP is also a useful tool in support of rational allocation (see Box 1).

However, the overall scarcity of resources, even if better allocated, will still mean that GoM will have some very difficult decisions to make about who gets what care. Per capita expenditure on health in 1997 was calculated to be US$8.84[24] (see table 3), and this is for the limited coverage described above. MoH has set itself the target of extending coverage to 70% by 2001[25], and subsequently to the whole country - a huge undertaking. Even an increase to 70% will necessitate a major increase in the size of the infrastructure of about 350 to 400 more health care facilities[26]. There are as yet no estimates for the cost of national coverage, but it is likely to necessitate a major increase in funding which will not be available from either government or donor sources, even if the current decline in overall funding should reverse and aid contributions increase. This problem is in addition to the growing burden of disease presented by a rapidly growing HIV/AIDS epidemic, likely to reduce the average life expectancy and flood the health system. In response MoH will either have to ration services passively by ignoring the issue and simply improving what there is and expanding as it becomes affordable, or make some very hard choices about who will and will not be treated[27]. Not only would such choices probably prove to be politically unacceptable, but divisions within the MoH will probably preclude the issue being tackled directly. Other countries with further advanced SWAps and a more unified donor community have already had problems in solving this problem, so Mozambique is faced with a particularly difficult task.

[20] Devereux and Palmero (1999), quoted from *Understanding Poverty and Well Being in Mozambique: The First National assessment (1996-97)*, Ministry of Planning and Finance, Eduardo Mondlane University and the International Food Policy Research Institute (IFPRI), 1998.
[21] UNDP (1998).
[22] Beattie (1999).
[23] Beattie and Kraushaar (1999b) quoted from Yates, R. and Zorzi, N., *Health Expenditure Review Mozambique*, Management Sciences for Health, Boston, Draft version March 1999. Figures include government, international agency and NGOs contributions, plus medicines.
[24] Beattie and Kraushaar (1999b).
[25] Beattie (1999).
[26] ibid.
[27] Devereux and Palmero (1999).

4.1.3 Scope of sector

Given that MoH and donors contribute only about half of total national expenditure on health, it will be essential that the MoH defines the sector, and thus the programme, as being wider than the activities over which it has direct control. Per capita expenditure figures for 1997, the most recent year available, show that households carry a significant proportion of healthcare costs outside of the government sector.

Table 3
Per capita expenditure according to financing source or agent in 1997 (in US$)[28]

Source of funding	**$ per capita**	**% of total**
Government	1.97	22%
International Agencies*	2.92	33%
Government and international agencies total	*4.89*	*55%*
Employers	0.57	6%
NGOs funding from all sources	1.68	19%
Households	1.70	19%
Total per capita	**8.84**	**100%**

* Does not include funds directed to NGOs

Some household expenditure is clearly utilised in the private sector, including buying services from traditional healers. However, because informal user fees in the state sector also represent a proportion of household expenditure, it is difficult to calculate the value of the resource flowing into private and traditional services. Overall information on the private sector and expenditure within it is very limited, requiring further analysis before resources could be captured more efficiently and effectively.

Expenditure on services provided by NGOs is also unclear, exacerbated by the fact that the government has little information on what financing goes to them. Donor allocations are not reported to government so it is extremely difficult for MoH to get a picture of overall provision. It has recently started to tighten up the registration procedures in an effort to get a better grasp of what the NGOs are doing, and also because of MoH concerns about the quality of NGOs' work in the health sector. Despite this wariness, there are examples of how government and NGOs might work more closely together under a SWAp. There are a couple of government clinics which are run by NGOs in a partnership arrangement. Although the results have not been evaluated for cost effectiveness etc and MoH has limited capacity to manage the agreements, the fact that they exist indicates a flexibility and willingness to address joint service delivery.

4.1.4 Role of Government in SWAp implementation

The existence of a private sector which needs regulation, NGOs who could form valuable partnerships with government, and an ambitious decentralisation programme mean that MoH will need to reorient itself as more than a direct implementing agency. It needs to become a policy maker and technical leader, better able to regulate, monitor, facilitate, and legislate through service agreements, grants mechanisms and other collaborative arrangements. The Ministry currently has a mismatch of functions and places too much emphasis on direct service delivery. This will require

[28] Beattie and Kraushaar (1999b).

reorganisation and major capacity building as well as the development of a more appropriate legal and financial framework.

4.1.5 Encouraging wider participation with civil society

Involving NGOs in health care delivery will necessitate allowing them some voice in sector policy and programme development. However this is currently very limited, and is not likely to increase for the SWAp without a change in approach and increase in capacity in MoH, and encouragement by the donors. Interviews with various players suggested that although the government is not blocking participation in policy making by civil society, it is not actively stimulating it either. Some interviewees outside MoH[29] suggested that the government approach may instead become one of seeking to control participation rather than facilitate it. If so, this is probably a reaction to the autonomy that NGOs had enjoyed in Mozambique during and after the war, when donors channelled the majority or all of their aid through NGOs. As a result, NGOs have operated very independently of government plans or finance, and sometimes openly against the government[30]. 1998 legislation now requires a process of appraisal by government and stricter registration procedures for NGOs, especially international ones and those receiving foreign funds.

Senior MoH officials[31] are aware that participation has been lacking to date and wish to remedy this by widening the participatory process in policy and strategy formation. This would be done by consulting NGOs, health professionals, representatives at province level, and generally stimulating a wider public debate, perhaps through regional workshops and meetings. According to one non governmental interviewee[32], it is understood by some NGOs that MoH is intending to organised a seminar to discuss government-NGO relations in the health sector; however this has been repeatedly postponed, despite the enthusiasm some senior officials have expressed to move the debate forward. Pressure of work was suggested as the reason for the delay. The experiences from other sector programmes is not encouraging - NGO participation in the agricultural SWAp has been limited to date, although they were invited to comment (reportedly at the last minute) on the sector strategy. This may not bode well for health unless it is recognised that participation would improve the quality of the programme.

4.2 Lessons from the past

Since the early 1990s, GoM and donors have worked together to introduce a number of significant developments in health planning and expenditure management which can be described as 'building blocks' for a SWAp, as they have sought to rationalise the use of resources, increase government control of finances, improve donor co-ordination, reduce transaction costs and promote closer partnership between MoH and donors. These are outlined in Box 1 (p. 14). The Health Sector Recovery Programme has also been an important step along the way towards a SWAp, despite its problems (See Box 2).

[29] In interview.
[30] From interview.
[31] In interview.
[32] In interview.

Box 2 Health Sector Recovery Programme

The Health Sector Recovery Programme (HRSP) was developed as a US$100 million sector investment programme from the World Bank with funds (all investment) that were designed to be used as budget support; although they ran parallel to the state budget, they were controlled by MPF. It aimed to reconstruct the rural health system, improve health management at provincial and national level, and develop human resources capacity through training. The programme was seen as a step towards a sector programme and certainly represented a major contribution to financing reconstruction. Unfortunately, other donors were not keen to join, only being invited later in the process, and there were concerns from the donor community generally about MoH ownership - although the Ministry professed to own the process, it has clearly been dominated by the World Bank. Donors were also sceptical of MoH's capacity to implement a programme of this scale, and indeed by the end of 1997, after two years of operating, only 5% of the Bank's loan had been disbursed.[33] The programme is now felt to be very outdated, and it has left the donor community with a wariness of World Bank domination of the SWAp process. The fact that the Task Leader is well regarded and had managed his new co-ordination role well is perhaps an indication of the Bank awareness of previous problems.

There are a number of lessons to be drawn from these experiences:

- *where donors worked together in supporting joint initiatives, there were clear benefits to GoM.* The Pooled Fund (PF) agreements led to harmonisation of donor procedures for recruitment, remuneration, monitoring and reporting, lessening discrepancies between donor rates and systems[34]. The PF also created a platform to discuss policies, as well as set priorities between the two parties, allocating funding accordingly[35]. Overall the PF improved the predictability of funds and therefore of drugs and personnel[36], and budget support had a similarly positive effect, lessening periodic liquidity crises in MoH brought on by the infrequency of funds being disbursed from MoF and the cash budgeting system[37]
- *single donor dominance was not welcomed either by MoH or the wider donor community.* MoH saw the IPP very much as a SDC led exercise as that agency had closely managed and funded the process of development[38]. SDC had trained MoH cadres of staff to implement the IPP, who subsequently moved to an SDC office, outside MoH. A number of donors regard this management arrangement as having had a seriously negative impact on MoH capacity and ownership. Also some donors were concerned at the World Bank's dominance of the HSRP, because the complexity of Bank procedures was seen to hamper programme *implementation*, and MoH ownership[39]
- *where donors do not all support joint initiatives, there is a negative impact.* In 1998 the drug pool only covered approximately one-third of all donor resources in this subsector, and the technical assistance pool even less. The

[33] Pavignani and Durão (1999) quoted from Landau L, *Rebuilding the Mozambican economy: Assessment of a Development Partnership*. Washington: The World Bank.
[34] Technical Advisory Group, (1998).
[35] Pavignani and Durão (1999).
[36] Technical Advisory Group, (1998).
[37] From interview.
[38] From interview.
[39] Pavignani and Durão (1999).

limits of the pooling arrangements undermined their effectiveness and perceived legitimacy as government policy. The TAG suggested that not only did this problem "*allow actors to circumvent*" the system[40], but non-participating partners were sceptical of government commitment seeing it as having been set up to satisfy certain donor requirements. Similarly, not all donors have bought into the IPP exercise, and use it as a basis for determining provincial level support, which weakens it as a universally applied tool. The value of the HSRP was weakened from the start by limited involvement by the wider donor community:

- *transaction costs can be reduced by joint working.* Although it was time consuming to go through the negotiation process of developing systems and formalising management agreements, once in place the transaction costs have reduced. Ongoing management costs have been higher than expected[41]
- *close donor involvement in decision making about funding allocation presented problems to MoH.* The level of donor intervention about funding decision for the PF was sometimes seen as intrusive by the MoH. The TAG report agreed that "*in principle this is right*" but argued the need for close involvement during a transition period until reporting gained credibility[42]. Pavignani and Durão (1999) went further and suggested "*by introducing clear norms and transparency, (donors) limited officials' freedom and prerogatives.*"[43] Similarly MoH was also uncomfortable with the budgetary support management arrangement: "*Some health officials ...were resentful of the increased financial discipline, the obligation to honour agreed plans and the loss of perks attached to projects*"[44]. In particular, they were unhappy at having to meet the condition of opening government books for donor audit. Similarly where the PF arrangements were set up to take over some of the financing and management decisions of vertical programmes, some government officials were resistant[45]
- *passing donor funds through government systems improved GoM financial management.* The fact that budgetary support *already* flows through all provinces[46] is an indication that, whilst much remains to be done, systems are in place that can manage funds to some degree of donor acceptability. Although donors had experienced problems with government financial accountability, they were philosophical about them and were open about having lost funds as a result of systems that did not work perfectly. UNICEF, for example, was clear that although "*government systems are not good enough it is our job to strengthen them, so we must use them*"[47]. Donors also felt that providing budgetary support improved relationships between themselves and MoH because it provided a concrete sign of donor trust in government capacity[48]. It also made the Ministry perform better and had a

[40] Technical Advisory Group, (1998).
[41] ibid.
[42] ibid, p16.
[43] Pavignani and Durão (1999), p250.
[44] ibid, p249.
[45] ibid.
[46] Budgetary support is channelled to each province unless the IPP indicates one is comparatively well funded. EP note.
[47] In interview.
[48] Pavignani and Durão (1999).

positive impact on improving health outcomes[49], despite the weaknesses that became apparent in the capacity to implement programmes. Similarly the TAG report concluded that, as a result of the audits, "*transparency in total public resource use is vastly improved*", accounting systems became more robust, and technical managers were handing their accounting duties over to specialist staff which freed them up to concentrate on their main tasks[50]

- *capacity building through salary top-ups was not a long term solution.* A number of donors, wishing to build and sustain capacity in MoH to manage joint initiatives, enhanced basic salaries. Although they found that there were short term gains in productivity and commitment, it was difficult for donors to exit from the arrangement. There were also ongoing problems over who was and was not included in the arrangement.

4.3 Government commitment to a SWAp

There are positive signs that the Ministry of Health has at least some commitment to developing a SWAp:

- the Minister and Vice Minister of Health are both regarded by donors as supportive of proposals to move to a SWAp and have met with development partners to discuss progress
- donors identified a change in attitude to the SWAp since October 1998 when MoH took responsibility for developing the process
- MoH has started to create a structure and process for development of a sector plan
- in interview, senior MoH officials stated the advantages of a SWAp - that it had come at the right time to tie in the various policy and programme issues that were under discussion, and that unified donor support for this process and its outcomes were essential
- officials also recognised[51] the importance of obtaining wider political commitment beyond the ruling party, in order to lessen the likelihood of major redirection should there be a change of government in the forthcoming election[52].

4.4 Barriers to SWAp development

There are clearly some serious technical issues to be addressed which cannot all be answered in the course of development and early implementation stages of a SWAp. Much will need to be done as the programme gains momentum, and some of the issues outlined in section 4.1 will require a long term approach to resolution. Of more pressing concern are the constraints to development of the SWAp in the short term, which will have to be addressed soon in order to allow the process to move forward.

[49] ibid.
[50] Technical Advisory Group, (1998) p17.
[51] In interview.
[52] In fact anticipation of the election in late 1999 had delayed progress in developing the sector strategy and generally moving the SWAp forward. However the election did not lead to a change of party nor policy, and SWAp development activities have since resumed. Recent floods will however no doubt cause further, understandable delay.

4.4.1 Consensus within MoH

Although there is commitment at senior political level, there may be insufficient consensus within MoH to carry through the development of a SWAp. Parvignani and Durão in their article on managing external resources in Mozambique describe a view of the Ministry in 1997, in which

> *Departments and officials appeared to be pursuing their own agendas, hindering co-ordination as a whole. Many technical departments linked to outside technical partners were not interested in developing a global strategy. The MoH political leadership made commitments which at times, were neither shared nor understood by mid-level management*[53].

The view of MoH as a institution without coherence is one still held by several donors as well as some inside the Ministry, and there are concerns that middle ranking civil servants may undermine the efforts of senior levels where understanding and commitment currently lie. Senior officials recognise this as a problem they have to address, but also appreciate the problems of changing people's mentality when they are afraid their influence and importance is going to be diminished by programme changes. The fact that some do not understand the importance of having a plan, reflects the lack of shared vision and commitment.

4.4.2 Donor relations with MoH

There is a sense held by some within MoH that a significant barrier to developing the SWAp lies in the nature of the GoM's relations with donors. A senior government official suggested that MoH needed help in a way that allowed the government to have more latitude - in other words MoH should be allowed to decide the policies, even if they run the risk of making mistakes. At the moment, however, there is the view that there is little real scope for developing internal direction and vision when the donors hold the purse strings. Although some donors dispute this on the basis of the increasing strength of state funding, it is a view that is strongly held, and is partly born out of MoH discomfort at the close relationship it has had with members of the donor community in the past (see Box 3) and the reaction to some of the planning and financial management initiatives which had had strong leadership by a small group of donors (see Box 1, p. 14). An analogy aired in interview by an MoH representative, which had also been used in other fora, was that dealing with the donors was like trying to drive a taxi with the owners sitting in the back: they are all sure they want to get somewhere but they can't agree where and if the driver doesn't take them to the right place they won't pay the fare. This view of the relationship suggests that MoH has been placed in the position of being responsive and unable to resist a strong donor line, rather than having the space to develop an internal sense of direction and become proactive.

At the same time, however, there is a healthy realism (or some would say cynicism) from the driver about the donors' unwillingness to get out of the taxi altogether. There is a view in MoH[54] that Mozambique is seen as an attractive success story by the international community who will want to continue to be associated with it. One possible interpretation of past events, therefore, is that when one group of donors was unhappy, there were others behind them ready to step in, a situation the MoH was

[53] Pavignani and Durão (1999) p251.
[54] In interview.

able to take advantage of, for example when SDC and others giving budgetary support became more demanding in their expectations of how MoH should improve its financial management practices[55]. As the 'like-minded group' imposed tighter conditions, but lost its influence, newer donors have been ready to take a different approach. Whether they will reach a similar sticking point remains to be seen. If this is to be avoided, greater unity within the donor community will be essential.

All the members of the donor community and MoH interviewed in the course of field research are agreed that many aspects of the current relationship between them are not particularly positive or conducive to the partnership needed to develop a SWAp, and there is a clear wish to move on from the problems of the past. One step towards doing so has been the development of a Code of Conduct which established principles and mechanisms on which SWAp development is to be based (see Box 4). This represents an important step forward because it was produced in a process facilitated by the donor co-ordinator (World Bank) which aimed to air some old grievances and current perceptions about the government/donor relationship, and try to create more harmony between the two. Despite this process, considerable scepticism remains about the value of the document. Some donor interviewees, with a longer experience of Mozambique, said that they doubted the code of conduct would be binding, because there had been too many government violations of other written agreements. They also doubted its efficacy without an arbitration arrangement identified; nor could they see how one could be made to work. One donor advisor pointed out that "*transparency, openness and honesty*" had been strategies employed by some of the 'like-minded' donors in the past, and had made them very "*unpopular*".

Box 3 The donor community in Mozambique

A number of bilateral and multilateral donors have had a long term relationship with the health sector in Mozambique including the Italians, Canadians and UN Agencies, with the World Bank providing the first loan in 1989. Most notably the Swiss, Nordic agencies, and the Netherlands were key partners from the early 1990s and it was this core group of 'like-minded donors' who developed close relationships with Ministry of Health officials and were intimately involved with the development of policies, and programme implementation, with the assistance of budgetary support and the creation of pooled funding arrangements. The selection by the Ministry of Health of SDC as focal donor in 1992 facilitated an especially close relationship between the two. The role expanded from being one of administrative convenience to both MoH and donors which reduced the communication and co-ordination burden on the government, to one which placed SDC in a position of considerable influence with both parties and gave it a greater role in policy formulation and programme implementation. In the process, however, SDC and some of the other 'like-minded' agencies became disillusioned with MoH's commitment and capacity to undertake real institutional change to facilitate budget support - this soured relationships between the government and those donors. MoH began to look elsewhere for financial assistance and technical support. At the same time, donors outside the 'like-minded' group felt that they were under represented by SDC and questioned that agency's agenda. By then MoH was also uncomfortable with the relationship and eventually agreed to the Swiss request to be allowed to step down from the role in 1998[56]. The World Bank has since assumed the role of 'facilitator' for the donor community, and agreement has been reached that this responsibility should be reviewed each year. (See section 3.3)

[55] See also Pavignani and Durão (1999).
[56] Pavignani and Durão (1999).

4.4.3 Capacity of Ministry of Health

A key difficulty in the development of the SWAp, and in all the initiatives that went before it, has been the capacity of MoH. Both the Ministry itself and the donors are agreed that this is a major problem, although opinions vary on how to improve the situation. Everyone, including the MoH, sees it as thoroughly overstretched, and some donors expressed the opinion that it was already showing signs of cracking under the pressure, with too many tasks to carry out. One donor[57] commented that, whilst the MoH was concentrating on developing a SWAp, the building blocks that had been achieved so far were falling apart because the Ministry could not attend to them. On the other hand, an MoH official painted a picture in which the day to day demands of budgetary support, pooled funds and other initiatives left insufficient time for taking a more strategic view and developing policies.

Whatever the manifestation of the capacity problem, the result is low morale and continuing staff departures. One interviewee suggested that the remarkable achievement of the MoH in keeping the health sector afloat throughout the war, under extremely difficult political and financial conditions, was because of the commitment and skill of a select group of top civil servants. They were now becoming sufficiently disillusioned and worn out to leave, thus eroding valuable institutional memory and technical ability. Donors are agreed that to rush the SWAp development process would be to exacerbate an already critical situation, and this has prompted differences of opinion between donors on the scope of the sector strategy plan. Some are concerned that the proposals currently under discussion are overly ambitious and, without sufficient focus and ownership, will become a way of avoiding difficult decisions. The eventual plan may also be just too big to implement. A perceived solution has been the setting up of a Technical Support Unit for Strategic Planning to

Box 4 SWAp Code of Conduct

Government and donor negotiated a draft code of conduct in June 1999. Called the *Kaya Kwanga Commitment*, the final version confirms the intent of both parties to pursue a sector-wide approach, and defines the principles and mechanisms by which this will be done.

Management of the annual programme as outlined in the Commitment is summarised in section 3.3. The agreement also establishes the primacy of the sector plan as the framework for the programme, and the expectation that government systems will be strengthened and used for financial management accounting and auditing, as well as national planning and budgeting.

The key principles are the most important element of the agreement, because they attempt to rectify some of the problems of the past and prevent them from happening again. The most telling ones state that all partners should be committed to:

- encouraging national staff to remain in government posts with donors avoiding contracting them for consultancies
- adhering to agreed national rates for remuneration and allowances for civil service employees, consultants, and payment for workshops
- developing and maintaining a climate of transparency, openness, accountability and honesty in relations and transactions
- being flexible and willing to adapt to change
- adhering to collective decisions by the GoM/donor group.

[57] In interview.

develop the strategy (see section 3.3). Although there may be short term benefits from having a separate team take on the role of writing the strategic plan, it may also have the result that MoH is not sufficiently tied into the process and ownership will be lacking.

Another key problem is that MoH is having to undergo a transition from being the reactive crisis manager needed for immediate post war reconstruction, an approach appropriate and necessary at the time, to becoming a long range policy maker and regulator, a role that many officials are unfamiliar with. It is less a lack of technical knowledge than of management skills. A senior government planning official[58] identified that what MoH needs is more qualified and motivated people skilled at managing change, and a good incentive and management structure to keep them there. Practical assistance from donors could come in the form of training, and incentives to attract and retain staff. The incentives should be applied with transparent and equal criteria, and awarded consistently by donors instead of according to the varied terms and conditions allowed by different agencies. This consistency has since been agreed in the joint Code of Conduct (see Box 4), but it remains to be seen whether incentives are still regarded by the donors as contributing constructively to long term capacity. It is likely that they will be avoided, given that there is continued ill will remaining over the earlier scheme to pay salary top ups.

The capacity problem now shows signs of having reached a critical situation. For example, the long term plan for management of the pooled fund had been to relocate it in MoH and channel funds through MoF, thereby effectively making it earmarked budgetary support. In anticipation of this, the mandate for external management of the pooled funds was due to expire in early 2000. However, donors supporting the pools have been frustrated by what they perceive to be MoH's delay in preparing for the change over, and are becoming increasingly anxious that the good work of the last few years will be undone[59]. This would be at substantial risk for the health service, as the pool now covers two-thirds of the country's specialist medical posts.

4.4.4 Relations within the donor community

One of the major problems in Mozambique in developing and implementing a SWAp has been the lack of unity within the donor community about the way in which it should be done. However, the results from a survey conducted at a workshop among donors (and senior government officials) in 1999[60] suggest that there may be more potential for harmony within the donor community than is immediately apparent from listening to donors talk about the process to date. It is broadly agreed that something major needs to be done about the fundamental problems in the health service, that donors should work together on this, that common procedures for monitoring and procurement should be attempted, and that a SWAp is needed, although there is less agreement about how that SWAp should be defined. The problem lies in part in the fact that some donors have little faith in current health policy as something that could form the basis for a SWAp, and most lack confidence in the present approach of MoH to policy development as a whole. Some also hold very low opinions of their colleagues from other agencies, accusing each other of lacking important technical knowledge, being naïve, ignorant, or unrealistic, only concerned with disbursement

[58] In interview.
[59] Reported in interview.
[60] Kaya Kwanga workshop June (1999).

and not the quality of programmes, or suggesting that they should not be at the SWAp negotiating table without money to spend. In terms of drawing the two camps together, the lead donor role is not acceptable to anyone after the SDC stepped down from that position. Therefore the World Bank, despite mixed donor experiences with the Health Sector Recovery Programme (see Box 2, p. 18), has taken responsibility for donor co-ordination at the donor community's request. It has had to tread a difficult line between facilitation and leadership. Fortunately, the Task Manager leading the process is well respected by all the donors interviewed, and is felt to have made a valuable contribution already by taking donors and government through a process at two key workshops which aimed to air concerns and opinions anonymously, and build consensus on the way forward.

5 PROGRESS AND PROSPECTS

5.1 What has and has not changed

In considering this question, it is difficult to distinguish between progress because of a move to a SWAp (of which there is not a great deal as the process is in an early stage) and changes in the health sector generally brought about by recent initiatives. For the sake of getting an overall view and not being too legalistic about 'when is a SWAp not a SWAp', the broad view has been taken.

5.1.1 What has changed

What has changed is that:

- there is a growing link between resources and activities enabling better planning and budgeting
- various useful initiatives have been underway for some years such as the substantial experience of budget support and pooled funds
- there is increasing appreciation of the possible role of the NGO sector by MoH
- sector priorities are becoming clearer
- there is increasing agreement in the donor community about the way forward on the SWAp
- a donor co-ordination mechanism is back on its feet, and is broadly accepted by all
- there is evidence of some political commitment to the SWAp process
- there is increased appreciation at MOH of the need for wider participation
- there is better understanding in MoH of its role in health delivery
- better and more information on health financing is available
- there are the foundations of a monitoring system
- there is increased concern for capacity building at all levels.

5.1.2 What has not changed

What has not changed is that:

- capacity at MoH is still a major problem
- ill will still exists between some at MoH and some donors
- there is no sector strategy and much remains to be done before one could be formulated that is acceptable to all parties
- difficult decisions lie ahead in setting priorities and acknowledging the limits to service provision. MoH is not ready to make these yet
- transaction costs show no prospect of lessening
- donor commitments are still off budget, and contributions to NGOs still present problems of co-ordination for MoH and MFP.

5.2 Prospects

There are clearly many positive things happening in the health sector in Mozambique which could lead to the implementation of a sector-wide approach. Various initiatives have been underway which many other countries, with a SWAp further advanced, would probably be pleased to have achieved and there is evidence of benefits to the management of the sector beyond the immediate scope of these initiatives.

Unfortunately, in the process of achieving these 'building blocks', government and donor relations have worn thin in some quarters. MoH has clearly found the close relationships intrusive and disabling, and at times has actively sought to avoid their demands. In return there is a strong sense of some donors having become disillusioned by their experiences and very sceptical of the likely success of new 'ambitious' ideas. These donors have had the closest relationship with government and speak with the most knowledge so it is hard to disregard their concerns, even though what they say is clearly unwelcome at times to the donor group as a whole. As a result, senior government officials have become wary of hurrying to become involved in something as demanding as a SWAp where they lay themselves open to criticism and have to take on an even bigger workload. Clearly then, improving government-donor relations will continue to be a key issue in the development and implementation of the SWAp - the approach is likely to stand or fall on whether it restores or further destroys the faith each party has in the other. The Code of Conduct could play a valuable role in drawing the parties together, but the test will be in whether it is sufficient to help all participants through future problems, or merely serves to remind everyone of the hopes that had been invested in the programme. It may be that what has been seen in Mozambique in the past is where other sector programmes may end up in the future if there it too little ownership by government, and too much pressure by donors.

Although there is need to address some key issues in the health sector which could conveniently be helped by a SWAp, it would seem wise to listen to the advice of some donors that to push too hard at this stage may be damaging in the long term. Similarly the concerns of MoH about its lack of capacity and ability to cope under pressure must also be listened to, because without these being addressed in a sustainable way, then the ability of MoH to develop, implement and maintain a SWAp will be severely compromised even more than it is already. The location of technical assistance within MoH is no doubt welcome to all parties because it holds the prospect of a sector strategy being developed, but there is a long history of TA being 'given' to GoM without the capacity problems being resolved. Donors are clearly concerned to have something to fund in the near future, but this will increase short term transaction costs, and worsen an already severe situation. A more valuable approach to the process may be to see the development of the SWAp as capacity building in itself, even if this means the sector strategy takes longer to design, and does not address all the key implementation issues in the near future. The cost of this may be that donors do not spend as they wish, nor does MoH extend its infrastructure and swiftly improve access, but such an approach may ultimately ensure that when the sector programme is implemented, it is sustainable and effective.

ACKNOWLEDGEMENTS

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The views expressed in this case study are those of the author and should not be taken to be representative of any other party. Responsibility for any remaining errors of fact or interpretation are also those of the author.

Annex 1 Common Financial Management and Disbursement in Mozambique Sector Programmes

Financial Management Committees have been established for education and agriculture sector programmes, involving senior Ministry of Planning and Finance (MPF) and line ministry staff, responsible for approving fund release and international procurement. Arrangements are identical for both: education is described below.

Key Features:

- approval of annual work programs by government and donors, including costings and disbursement plan
- transfer of Q1 donor funds to common forex account for the Sector Programme (SP) 60 days in advance
- funds are released 30 days in advance
  a. for international procurement to approved procurement plan, and procedures
  b. via Central Treasury to Ministry Central to meet their costs with respect to the SP, releases subject to assessment of satisfactory implementation in Q2
  c. via central and provincial Treasuries to provincial departments of the sector ministry, subject to implementation in Q2
- 30 days in advance, the Ministry also requests MPF release of government contribution, merged with donor funds from the forex a/c at Central Treasury, channelled to central and provincial education departments as above
- target times have been established for completion of onward transmission of funds between each level.

Control Mechanisms:

- signatories of forex account are determined by MPF and MINED
- all transactions must be authorised by MINED
- all transactions on forex and Treasury accounts must be supported by documentation, made available to MINED and MPF 'as appropriate'
- monthly reconciliation to bank accounts
- monthly status of funds report
- provincial MPF maintains specific account records for SP funds, distinguishing those from centre from those received direct. All transactions must be supported by documentation giving authority.
- MINED/Department of Accounts and Finance centrally will monitor all provincial transactions related to the SP, and reconcile these on a monthly basis with records from the provinces
- provincial data are included in monthly and quarterly Statement of Funds and Project Monitoring Report.

Provincial Accounting:

- separate bank account requiring dual signatures in department of provincial education
- cash book, vote book (showing state of commitments against each approved budget line item), debtors register
- vote book, cash book, bank statement reconciled monthly in writing
- monthly financial statements within 10 days of month end, these to be verified by provincial MFP and stamped within 21 days, signed by the accountant preparing them and provincial director of education
- original payment vouchers and supporting documents filed at provincial education department
- funds advanced for activities to be accounted for within 48 hours of completion of the activity, unused advances returned to bank or petty cash book
- government auditor to commission independent audit, by a private company due to capacity constraints, to do annual audit, plus quarterly limited reviews, to check expenditures in line with annual work plans and donor financing agreements
- line ministries also undertake to ensure donor projects are in line with annual work plans.

Comments:

- uses government financial and accounting systems, but with some additional safeguards. Not yet tested: some payments into the PROAGRI account, with no disbursements yet (September 1999)
- capacity to prepare annual work plans linked to costs is weak in the education sector, partly capacity but also problems of budget classification and budget process not linked to activities
- it is not clear what happens if reports are not prepared on time, or major problems are experienced in accounting
- potential for large cash balances to build up: is quarterly deposit too large? Liquidity and cash-flow problems throughout the system, with temptation for government staff to move funds to meet needs outside the SP
- there is clearly a need to build capacity in financial management, which will take time. Proposals exist for overall capacity development linked to the medium term budget process, but not yet under implementation. Agriculture has a substantial EU project proposed to strengthen financial management; There is no proposal yet for education
- the temptation is for donors to continue with a project approach or to set up parallel arrangements, e.g. one idea envisages planning, procurement, finance and HRD teams, consultant managed, at provincial level. This would by-pass government systems, and would not build sustainable capacity.

Annex 2 Terms of Reference

Background

The Partnerships for Health Sector Development Project seeks to commission a consultant to carry out and report on a series of country case studies - and subsequently to prepare a synthesis paper - on current issues in sector programmes and development assistance in the health sector.

The work will be carried out on behalf of *Inter-Agency Group on Sector-Wide Approaches and Development,* for which WHO provides the Secretariat. The purpose of the assignment is to provide insights and recommendations relevant to the policies and practices of agencies which are members of the group, as well as to the governments with whom they interact.

The scope of work which follows is based in part on discussions and issues arising at a preliminary meeting of the Inter-Agency Group (1 June 1999). It will be further refined following the completion of a preliminary desk study by the Centre for Aid and Public Expenditure (to be completed by 31 July 1999), and comments received from members of the Inter-Agency Group (IAG).

Countries

Case studies will be carried out in Mozambique, Tanzania, Uganda, Cambodia and Vietnam. These countries have been selected because of their engagement in the development of sector approaches as well as the nature of their cooperation with international financial institutions (CDF, ESAF). Their physical proximity within Eastern and Southern Africa and South East Asia will allow efficiencies in travel. Work in additional countries may be financed by other partners in the IAG. In preparing the synthesis paper the consultant will also draw on relevant experience from other countries. The studies in each country will take the form of policy analyses and will be based on interviews with key actors and reviews of documents. Given the breadth of the concerns set out below, the aim will be to make well informed judgements, rather than collect large amounts of quantitative data.

Scope of work

Reports should assume an understanding of the rationale for and basic concepts of sector-wide approaches. They will focus on issues emerging as sector programmes are implemented in practice. In each of the country studies, and in preparing the synthesis paper, the consultant will pay particular attention to the following questions:

- **policy quality and policy process:** what evidence is there to suggest that the process of developing sector programmes has influenced the content of sectoral policies? Most agencies supporting SWAps see them as a way of promoting pro-poor health policies: how has this intention been expressed in practice? Is there any evidence to suggest that sector programmes have been successful in promoting a greater concern for health outcomes? To what extent do donor concerns about ownership and national concerns about consensus limit the scope for real policy negotiation?

- **managing relationships between governments and development partners:** what have we learnt about the negotiation/transaction costs of SWAps? How effective are the various types of accord/compact / MOUs? What conclusions can be drawn about the need for and effectiveness of, conflict resolution systems? Is there any evidence that processes such as UNDAF have increased the effectiveness of UN agencies as participants in sector programmes?

- **planning:** a great deal of emphasis has been placed on the preparation of sectoral plans of different kinds: what conclusions can be drawn about sectoral planning processes? Are sector programmes over-determined? Is there a risk that the focus on planning reduces flexibility and the need to adjust policies in the light of changing levels of performance? Do donors demand too much detail in preparing programmes work and operational plans? How much variation in planning processes is beginning to emerge between countries?

- **scope of sector programmes:** does it remain true that many SWAps constitute a discrete programme *within* the sector? To the extent that this hypothesis is correct, what elements of sectoral spending tend to be omitted? With what implications? What needs to happen to move on toward time-slice funding of national sectoral budgets? What evidence is there to suggest that sector programmes have been successful in influencing intra-sectoral resource allocation in line with stated policies?

- **links with the PFP and medium-term budget frameworks:** to what extent are sector programmes fully reflected in overall budget plans? Is new thinking on the comprehensive development framework likely to influence this process? Where is there scope for more effective macro-sectoral dialogue?

- **preconditions and conditionalities:** do we need to revisit the whole idea of preconditions for SWAps if it is a term that is increasing being applied indiscriminately? To what extent do donors still impose conditionalities within the context of sector programmes? What form do these conditionalities take? Is there any evidence for their effectiveness?

- **capacity building:** to what extent does adequate capacity in national management systems have to be in place prior to the implementation of pooled funding arrangements? Is there a risk of a hiatus in the provision of essential services when moving toward a SWAp?

- **sector performance:** have we got any further in developing manageable ways of monitoring performance? Does monitoring improve over time? Does it take into account distributional issues which are often overlooked by routine systems?

- **decentralisation**: it was predicted that designing sector programmes in decentralised systems would be difficult - what has been the experience to date? To what extent have fears about SWAps acting as a centralising force been realised in practice? What national approaches to earmarking of sector priorities have been agreed and applied by central and local governments?

- **civil society and NGOs:** most governments and development agencies emphasise the importance of broad participation in the development of sector programmes: how has this intention been reflected in practice? with what effects?

OUTPUTS AND TIME FRAME

The consultant will submit draft reports and make a presentation to the Inter-Agency Working Group in November. Final reports are to be completed by 31 December 1999.

Additional ToRs on debt relief (added later)

1. Is there a government policy on poverty reduction in place or in the process of production?
2. Are there plans for the production of a poverty reduction strategy paper (PRSP)? If the answer to 1 is yes, what is the relationship between the government policy and PRSP?
3. If the answer to 2 is yes, what is the process for producing it - who will? Government? IMF, Bank, all three? Others? Time frame?
4. Is the MoH involved in writing/advising on the health component of the PRSP? If not, why not? If so, how?
5. What do we know about negotiations (if any) and about conditionalities (if any) attached to HIPC Initiative II?

How is the poverty focus reflected in the health policy and in the health sector expenditure framework?

Annex 3 List of people met

Organisation	Name	Position
Government		
Ministry of Health	Dr Humberto Cossa	Director of Planning and Co-operation
	Dr Alexandra Manguele	National Director for Health
Technical Planning Unit (GTP), MOH	Dr Marco Gerritson	Adviser
	Mr Rob Yates	Economist
Ministry of Finance	Francisco Fernandes	Advisor, DNPO
	Abilio Gune	Head, Marco Economic Programming
	Lydia Cabral	ODI economist
Bilaterals		
European Commission	Ms Jenny Eklund	EC Delegation Maputo
	Dr Herve Le Guillouzic	Project Manager
	Ms Brigitte De Ulsters	STD/AID adviser
DFID	Dr Allison Beattie	First Secretary, Education and Health
Royal Norwegian Embassy	Ms Ann Helen Perez Azedo	Programme Officer
USAID	Dr Okey Nwanyanwu	Chief, Office of Health, Population & Nutrition, USAID
Swiss Development Corporation	Dr Enrico Pavignani	Adviser
Embassy of the Netherlands	Mr Joris W.P. Jurriens	Second Secretary
IFIs		
World Bank	James Coates	Representative
UN Agencies		
WHO	Dr Carlos Tiny	Representative
	Dr Thiery Mertens	Special Adviser
	Dr Eva Pascoal	Technical Officer
UNDP	Marienne Ooma	Technical Adviser
UNFPA	Rachel Ploem	Technical Adviser
UNICEF	Mr Mark Stirling	Representative
	Dr Ivone Rizzo	Chief, Health & Nutrition Programme
Other		
LINK	Ms Bodel Winkman	Country Director

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