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Global External Financing Mechanisms of the Health Sector in Mozambique

Overview, Case Studies and Analysis of Institutional, Financial and Political-Economic Issues

Final Report

Maputo, April 2022

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The views expressed in this report are those of the author and not necessarily coincide with those of N'weti and its leadership.

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ACA	Avaliação Conjunta Annual, Joint Annual Review
ACT	Access to Covid19 Tools
AECI	Spanish Agency for International Cooperation
AMM	Assistência Médica and Medicamentosa, Medical and Medicines Assistance
AP	Assembleia Província, Provincial Assembly
APE	Agente Polivalente Elementar, Community Health Worker
AR	Assembleia da República, National Parliament
ARPA	American Rescue Plan Act
ARV	Anti-Retro Viral
BIG	Basel Institute on Governance
BMGF	Bill and Melissa Gates Foundation (abbreviated to Gates Foundation)
BMZ	German Federal Ministry of Economic Cooperation and Development
BSC	Balanced scorecard
CCM	Country Coordinating Mechanism
CCS	Centro de Colaboração em Saúde, Centre for Health Collaboration
CDC	Centre for Disease Control and Prevention
CDS	Clinical Decision Support
CED	Classificador Económico da Despesa, Economic Expenditure Classifier
CEDSIF	Centro de Desenvolvimento de Sistemas de Informação de Finanças, Development Centre forFinancial Information Systems
CEmONC	Comprehensive Emergency Obstetric and New-born Care
CEP	Conselho Executivo Provincial, Provincial Executive Council
CF	Common Fund
CGE	Conta Geral do Estado, General State Accounts
CIDA	Canadian Agency for International Development
CMAM	Centro de Medicamentos e Artigos Médicos Central Store for Medication and Medical Items
cMYP	Comprehensive Multi-Year Plan
CNCS	Conselho Nacional de Combate ao SIDA, National Council for Fighting AIDS
COP	Country Operational Plan
CPF	Country Platform
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organizations
CSP	Cuidados de Saúde-Primários, see: PHC
CSS	Cuidados de Saúde Secondários -see SHC-
CUT	Conta Única de Tesouro, Single Treasury Account
DAC	Development Assistance Committee
DAF	Direcção de Administração e Finanças, Directorate of Administration and Finance
DFID	Department for International Development (UK)

DHHS	Department of Health and Human Services
DLI	Disbursement-linked Indicator
DNAM	Direcção Nacional de Assistência Médica, National Directorate for Medical Assistance
DNPO	Direcção Nacional do Plano e Orçamento, National Directorate of Planning and Budget
DNRH	Direcção Nacional de Recursos Humanos, National Directorate of Human Resources
DNSP	Direcção Nacional de Saúde Pública, National Directorate of Public Health
DNT	Direcção Nacional de Tesouro, National Treasury Directorate
DOD	Department of Defence
DP	Development Partner
DPC	Direcção de Planificação e Cooperação, Directorate of Planning and Cooperation
DPS	Direcção Provincial de Saúde, Provincial Directorate of Health Directorate
EFSS	Estratégica de Financiamento do Sector de Saúde, see HSFS
EPI	Expanded Programme of Immunization
EU	European Union
EUA	Estudos Unidos de América, see USA I wold prefer only US as this is what is used in the text– United States of America
FASE	Fundo de Apoio do Sector de Educação, Education Sector Support Fund
FBO	Faith-based Organization
FCDO	Foreign, Commonwealth and Development Office (UK)
FDC	Fundação para o Desenvolvimento da Comunidade, Community Development Foundation
FSI	Fragile State Index
GAVI	Global Alliance for Vaccination
GBS	General Budget Support
GDP	Gross National Product
GF	see: GFATM
GFATM	Global Fund for Fighting AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
GP	Governador da Provincia, Provincial Governor
GTC	Grupo Técnico de Coordenação, Technical Coordination Group
HCM	Hospital Central de Maputo, Maputo Central Hospital
HFS	Health Financing Strategy/ Estratégia de Financiamento do Sector de Saúde
HIPC	Heavily Indebted Poor Countries
HNM	Hospitais Nacionais de Moçambique
HP	Health Partner
HPG	Health Partners Group
HR	Human Resources
HRH	Health Human Resources
HSF	Health Sector Financing

HSFS	Health Sector Financing Strategy
HSS	Health Sector Strengthening
IBRD	International Bank for Reconstruction and Development
IC	Investment Case
ICAR	International Centre for Asset Recovery
ICC	Inter-Agency Coordinating Committee
ICS	Instituto de Ciências de Saúde, National Institute for Health Scieneces
IDA	International Development Association
IDP	Internally Displaced Persons
IFE	Inquérito de Fundos Externos, External Funding Survey
IG	Investors Group
IGEPE	Instituto de Gestão de Empresas Participadas pelo Estado, Institute of Management of State Owned Companies
INAE	Inspecção Nacional das Actividades Económicas; National Inspectorate of Economic Activities
INE	Instituto Nacional de Estatística, National Statistics Institute
IOF	Inquérito sobre Orçamento Família, Household Income Survey
KI	Key Informant
LMIC	Low- and Medium-Income Country
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MDTF	Multi-Donor Trust Fund
MEAE	Ministère de l'Europe et des Affaires Étrangères (France)
MEF	Ministério de Economia e Finanças, Ministry of Economy and Finance
MGCAS	Ministério de Género, Criança e Acção Social, Ministry of Gender, Children and Social Welfare
MHL	Mozambique Health Holdings
MIC	Ministério de Indústria e Commercio, Ministry of Industry and Commerce
MISAU	Ministério de Saúde, Ministry do Health
MoU	Memorandum of Understanding
MTE	Mid Term Evaluation
MTHAP	Medium-Term Health Action Plan
MZN	Metical (New)
NFM	New Funding Mechanism
NGO	Non Governmental Organization
NHA	National Health Accounts
NSA	Non-state Actor
ODA	Official Development Assistance
OE	Orçamento de Estado, State Budget
OECD	Organization for Economic Cooperation and Development

OGDP	Órgão de Governação Descentralizada Provincial, Decentralized Provincial Government
OIG	Office of the Inspector General
OOP	Out-of-pocket
P4H	Partnership for Health Financing
PAD	Programme Appraisal Document
PAF	Performance Assessment Framework
PAP	Programme Aid Partners
PARPA	Plano de Acção de Reducao da Pobreza Absoluta, Poverty Reduction Action Plan
PBF	Performance-based Financing
PDO	Programme Development Objectives
PECS	Pacote Essencial de Cuidados de Saúde, Essential Healthcare Package
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PES	Plano Económico e Social, Economic and Social Plan
PESO	Plano Económico-Social e Orçamento, Economic and Social Plan and Budget
PESS	Plano Estratégico do Sector da Saúde, Health Sector Strategic Plan
PFM	Public Finance Management
PFMRP	Public Financial Management for Results Programme
PforR	Programme-for-Results
PHC	Primary Healthcare
PHCS	Primary Healthcare Services Strengthening
PHCSP	Primary Healthcare Strengthening Programme
PIB	Produto Interno Bruto,see GDP
PMTCT	Prevention of mother-to-child transmission
PMU	Programme Management Unit
PO-OGDP	Plano e Orçamento dos Órgãos de Governação Descentralizada Provincial
POA	Plano Operacional Annual, Annual Operational Plan
PPB	Planning, Programming and Budgeting
PQG	Programa Quinquenal de Governo, Government Five Year Programme
PR	Principal Recipient
PS	Permanent Secretary
QAD	Quadro de Avaliação de Desempenho, see PAF
RBE	Results Based Evaluation
RBF	Results Based Financing
REO	Relatorio de Execução do Orçamento, Budget Execution Report
REP	Representação do Estado na Provincia, State Representative in the Province
RMNCAH-N	Reproductive, maternal, new-born, child, and adolescent health and nutrition
SAP	Serviço de Atendimento Personalizado, Personalized Customer Service

SBS	Sector Budget Support
SDC	Swiss Development Cooperation
SDG	Sustainable Development Goals
SDSMAS	Serviço Distrital de Saúde, Mulher e Acção Social, District Services for of Health, Women and Social Welfare
SDTF	Single Donor Trust Fund
SHC	Secondary Healthcare
SISMA	Sistema de Informação de Saúde para Monitoria e Avaliação
SISTAFE	Sistema de Administração Financeira do Estado, State Financial Administration System
SNS	Sistema Nacional de Saúde, National Health System
SPO	Sub Sistema de Plano e Orçamento, Subsystem for Planning and Budgeting
SPS	Serviços Provinciais de Saúde, Provincial Health Services
SSA	Sub-Saharan Africa
STA	Single Treasury Account
SWAp	Sector-wide Approach
SWOT	Strengths, Weaknesses, Opportunites and Threats /Risks
TA	Tribunal Administrativo, Administrative Court
TACBOR	Technical assistance, capacity building, and operations research
TAs	Technical Assistance
TF	Trust Fund
TFC	Trust Fund Committee
TWG	Technical Working Group
UGB	Unidade Gestora Beneficiária, Beneficiary Management Unit
UGE	Unidade Gestora Executiva, Executive Management Unit
UGEA	Unidade Gestora Executora de Aquisições, Procurement Unit
UHC	Universal Health Coverage
UK	United Kingdom
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
USAID	US Agency for international Development
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization

Índice

EXECUTIVE SUMMARY

This research report is the result of a consultancy study by the Mozambican non-governmental organization N'weti, financed by the P4H[1] Network with GIZ and SDC funding, P4H being a member of the Mozambican Health Partners Group (HPG). After the submission and approval of an Inception Report at the beginning of September 2021 and shared with the HPG, research was carried out from mid-September to mid-November. It included a review of relevant literature and documents from the Ministry of Health (Ministério da Saúde - MISAU) and its international partners, as well as interviews with 23 key informants, representing MISAU (5), the Ministry of Economy and Finance (Ministério de Economia e Finanças - MEF) (1), consultants and advisors in the sector (8) as well as representatives of external support programmes, i.e. MISAU's international partners (10). Priority was given to qualitative research methods, although limited quantitative data generated through the Mozambican PFM system was used, basically for illustrative purposes.

Box 1: Main Messages

- PROSAÚDE continues to have the confidence and preference of MISAU-linked key informants (KI), followed by GAVI;
- GFF and GF are less aligned with the Mozambican planning, programming and budgeting (PPB) system, despite being delivered on-CUT; GF follows the planning and fiscal cycle of the US government;
- GFF's innovative approach to performance-based finance (PBF) is relevant for government, PROSAÚDE and aid effectiveness in the national health system(SNS), but difficult to reconcile with established national public financial management (PFM) systems and the SNS administrative configuration. Interest and possibilities exist for accommodating it in this system;
- The study confirms observations elsewhere concerning transparency and accountability challenges in trust fund-based support modalities;
- A draft heath sector financing strategy produced in 2021 paves the way for health sector financing (HSF), but still lacks analytical underpinning regarding fiscal space;
- The diversity of funding modalities increases the complexity and fragmentation of the sector and decreases national ownership;
- A case has been made to seek to establish a hybrid programme led by MISAU, based on GFF and PROSAÚDE experiences, with a focus on MCH and on sub national level.
- The SWAp (sector-wide approach) is a necessary, but not sufficient, condition for increasing coherence and effectiveness gains in health financing.
- For addressing the challenges to HSF an analysis-based strategic approach to management and leadership appears more suitable than a conventional 'control' approach.

With this report, N'weti seeks to contribute to the ongoing debate on health financing and the need for a coherent system, seeking to assess MISAU's capacity to better orient and control the flow of funding in line with the priorities foreseen in its Health Sector Strategic Plan (PESS[2]) for the period 2014-2019 (extended to 2024). In a summarized form the study has the following objectives:

- To provide an overview of external health financing in Mozambique, with a focus on PROSAÚDE and selected global financing mechanisms for vertical programmes, notably the Global Fund for Fighting AIDS, Tuberculosis and Malaria (GFATM, also known as the Global Fund - GF), the Global Financing Facility (GFF) and the Global Alliance for Vaccination (GAVI);
- To analyse the results of these mechanisms in terms of support to MISAU/SNS in terms of implementing the national strategic health agenda; and,
- To analyse how the characteristics, priorities and procedures of these funding mechanisms have influenced the execution of the national strategic agenda in MISAU/SNS, addressing issues such as alignment with national procedures, efficiency, administrative and transaction costs, predictability, public finance management and financial control, etc.

1. Partnership for Health Financing

2. Plano Estratégico do Sector da Saúde (PESS)

The report is divided into five main parts.

The introduction (Chapter 1) sets out the purpose of the study, its structure and methodological approach, with an emphasis on qualitative methods and the need to combine both technical and political-economic aspects when analysing health sector financing (HSF) and its reform.

The second chapter describes the context for HSF in Mozambique. It looks at salient features of the health sector, i.e. the National Health System (SNS[3]), looking particularly at the challenges, the political economy of the sector, the trends in health financing, the way funding is managed and reported, and relevant global initiatives that impact on sector financing. It also sheds some light on the sector's ongoing reform initiatives, including decentralization.

The third chapter presents four case studies, describing their key features and analysis of their funding dynamics and relationship with MISAU, from the perspectives of both MISAU staff (and health consultants) and funding agencies. Although not required by the TOR, for didactical reasons there is a brief overview of the US government's support to the Mozambican health sector via the President's Emergency Plan for AIDS Relief (PEPFAR). This programme and its approach have a strong influence on programmes such as GF.

The fourth chapter addresses some of the challenges arising from Chapter 3 in terms of HSF and effectiveness. Topics discussed are the relevance of the Paris Agenda on Aid Effectiveness, the Sector Wide Approach (SWAp) and coordination, planning for health sector strengthening (HSS) and a coherent financing strategy, including the Performance-Based Financing (PBF) approach in external support programmes.

The final Chapter 5 draws a few overall conclusions with a focus on change management, with some specific recommendations.

The analyses contained in Chapters 2, 3, and 4 are summarized below.

Chapter 2. Context and salient features

Mozambique is among the countries in the world with high birth rates and low life expectancy. Maternal mortality and infant mortality are also very high. Major health challenges are the prevalence of malaria, tuberculosis, AIDS, respiratory infections (including through Covid 19) as well as waterborne diseases, including those related to poor sanitation. The conflict in Cabo Delgado Province and the high number of Internally Displaced Persons (IDPs) are an additional strain on basic healthcare, together with fighting the Covid 19 pandemic through vaccinations. Also, stark inequality in access to basic healthcare continues to be a major challenge in the National Health System (SNS).

In an export-oriented, foreign direct investment (FDI) and credit-dependent political economy built on resource extraction, rent seeking and consumption at the cost of domestic capital accumulation and production, the health sector is not an isolated case. Rising indebtedness and economic and fiscal stress weaken the state and its capacity to provide and finance basic services, not just in the health sector. Spending priorities on security together with capital outflows and 'tax dodging' directly affect the domestic fiscal space needed to improve health sector financing (HSF). The privatization, formal and informal, of the public health sector adds to the challenges of HSF, particularly from the perspective of a rural population and lower income strata, who have suffered significant impoverishment over the past ten years. A politically-driven decentralization reform from 2018 onwards may have increased fragility in the provision of basic healthcare services at provincial and district level.

It is concluded that:

- Health expenditure, funded by both external and domestic sources, is biased towards central government and includes not only medicine supplies, but also investment and construction of infrastructure health units - to the detriment of health units at subnational levels of the public part of SNS and their needs, and contrary to the objectives of decentralization in the sector as defined in PESS. They still do not have a decentralised budget.
- Although government sources, i.e. revenue from taxation, has become the main source of health budget funding, the sector's budget allocation as a percentage of the state budget oscillates around 9% during the past decade, and health spending as percentage of GDP is around 3%. Health financing will continue to depend both on domestic economic and fiscal factors, but also on external funding that, given long-term trends, may not be as forthcoming as expected. The US government, covering about 50 % or more of total health expenditure in Mozambique directly and indirectly supports the SNS, albeit mostly in line with US American planning and budgeting rules.

3. Sistema Nacional de Saúde (SNS)

- The many actors in the health sector, with their different approaches, resource endowments and funding modalities, have overlapping functions as providers, managers and spenders of funds. This creates a high degree of complexity in which government, i.e. MISAU, is just one actor among many, and not necessarily the one with the most leverage. Further, the ministry has no complete overview of NGO support to the sector.
- The resulting fragmentation is exacerbated by the fact that the key government institutions in health financing, MISAU and MEF, do not necessarily observe the rules established for the planning, programming and budgeting (PPB) process and its management.
- There are three separate reporting tools to track funding and expenditure, each with different qualities, advantages and disadvantages. It is unclear to what extent these can be aligned.
- Health financing outcomes are also affected by the dynamics of privatization within the health sector, the formal and informal ways of resolving conflict, competition among political and economic stakeholders, and the way major challenges arising from the ongoing decentralization reform are addressed.
- The ambitious PESS goals for health financing reform have only been partially addressed through rudimentary action, without being guided by an approved health sector financing strategy (HSFS).

Chapter 3: Case studies (PROSAÚDE, GFATM/GF, GAVI and GFF)

As defined by the TOR, the study concentrated on the four funding modalities / programmes where MISAU is the beneficiary[4]. The chapter's main points are:

PROSAÚDE, started in 2003 based on a SWAp and introduced the Common Fund (CF) concept, is still a firm pillar of support for the public part of SNS, despite its 'shrinking' funding volume and membership over the past nine years. The reasons are its embeddedness in the health sector, strong ownership by national stakeholders, full alignment with the national PFM system in the PPB process and reporting system, as well as its potential for decentralization (under PROSAÚDE III). In the opinion of most of the KIs, the programme is also open to addressing its deficiencies, notably in procurement, and to innovation - such as introducing PBF with a window of opportunity through the planning and budgeting subsystem (SPO[5]), resulting from the review of Mozambique's PFM legislation. Contrary to the opinion of a number of observers, PROSAÚDE is not to be written off, but could receive new 'life blood' through increased funding by international partners or even the return of former funders.

GFATM/GF – once a partner in PROSAÚDE's CF – has been supporting the SNS since 2004. The US government is the largest donor in this disease-specific vertical funding mechanism. Its financial contribution is considerable and tending to grow. Its cumbersome approach to management and partnership, based on a three-year 'replenishment' fund-raising and pledging mechanism, was replaced by the New Funding Mechanism (NFM) between 2012 and 2014. A Programme Management Unit (PMU) embedded in MISAU was established and funding channelled using the on-CUT approach. These changes are said to have improved local ownership, alignment, the management of programme implementation and the predictability of funding. Unlike PROSAÚDE, GF also emphasizes the role of NGOs in achieving its specific objectives, similar to GFF. From a Mozambican perspective, GF has the disadvantage that it follows the US budget cycle and administrative procedures, has top-heavy management through a Secretariat in Geneva and is very dependent on input by external consultants. Mainly for these reasons, it results in high transaction costs for MISAU staff. Its use of a PBF approach via the incentive funding stream is seen as less controversial than in the case of GFF. The programme's total funding between 2015 and 2020 shows a rising tendency. GF has the potential to access additional funding through the submission of well-prepared and justified applications.

GAVI, a vertical programme focusing exclusively on immunity and vaccination, is well embedded in the SNS, despite being managed from Geneva/Switzerland, i.e. with no PMU in MISAU. It is fully aligned with the government's comprehensive multi-year plan for vaccinations. With its well-defined 'niche' focus (complemented by HSS[6]), its long-term, market-oriented perspective, and the pooling of various resources (including from private companies and the pharmaceutical industry), GAVI is a programme and health financing modality that is appreciated by its Mozambican and international partners. GAVI's response capacity to the challenges posed by the Covid 19 pandemic is yet to be fully tested.

4. The fact that GF and GFF also funds several NGOs is acknowledged but not addressed in the analysis.

5. Sub Sistema de Plano e Orçamento (SPO)
6. Health Sector Strengthening

GFF has supported the SNS since 2016 / 2017 with a focus on healthcare for Women, Children and Adolescents. It represents an approach which can be dubbed 'diagonal', addressing certain diseases, service delivery at facility level, financing, information and monitoring in 42 districts (in 10 provinces) identified with deficient healthcare services. Coupled with the WB's Primary Healthcare Strengthening Programme (PHCSP) represents a Program for Results (PfoR) based on the Investment Case (CI) owned by the government of Mozambique. Results are periodically evaluated and financing is conditioned on the basis of 11 Disbursement linked Indicators (DLIs). Aligned with PES/OE, financing for PHCSP comes from IDA, GFF, PROSAÚDE and a Multi Donor Trust Fund(MDTF) and Single Donor Trust Fund (SDTF). This innovative programme which has produced some tangible results, is however, critically perceived by some observers interviewed, including by members of Trust Funds. They raise questions about the degree of government ownership, complex implementation procedures, lack of alignment with the national public finance management system regarding disbursements conditioned by results, as well as perceived deficiencies concerning transparency. A case has been made to seek to establish a hybrid programme based on GFF and PROSAÚDE experiences, with a focus on MCH and on sub national level.

As regards funding dynamics during the 2015 to 2020 period - in the case of donors that channel funding 'on-CUT' – PROSAÚDE funding fell dramatically between 2015 and 2018, by more than two thirds of its 2015 volume, to around US$ 20 million in 2020. GF funding rose steadily from low levels in 2015 and 2016, when a New Funding Mechanism was introduced and peaked in 2018. It has fluctuated and in 2020 approached the PROSAÚDE level of US$ 20 million. GAVI funding for the SNS has been growing since its low levels up to 2017, but has nevertheless remained modest, fluctuating around US$ 15 million per year between 2018 and 2020. The WB Primary Healthcare Services Strengthening Programme (PHCSP) only started in 2017, rising to approximately US$ 22 million in 2020. Neither the GFF nor the Multi Donor Trust Fund (MDTF) funding held in trust by the WB are reflected in this analysis. Considering the overall, cumulative contribution of the four programmes to health financing over the six-year period under observation, despite the declining volume and number of partners over the years, PROSAÚDE has maintained a solid position as an important pillar of health financing, contributing some 27% to overall on-budget funding in the cases studied, at par with the WB PHCSP and other funding sources taken together.[7]

7. Other WB sources, UNDP, UNICEF, bilateral donors including individual PROSAÚDE members

Chapter4: HSF and Effectiveness

Examining the relevance of the Paris Declaration on Aid Effectiveness, SWAp and coordination it is concluded, firstly, that the principles it enshrined (such as ownership, alignment, harmonization, mutual accountability etc.) have gradually lost their significance for the shaping of cooperation and development assistance, including health sector financing, with the exception of 'managing for results'. An expression of this is the popularity of performance-based financing, especially in vertical programmes such as GF and GFF. It was also found that the application of these principles in poverty reduction programmes and the health sector in Mozambique has had mixed results. Secondly, it is argued that SWAp has considerable potential for increasing aid effectiveness, but the realisation of this potential varies with the context and, the domestic and international environment, i.e. political economy factors. At best, a SWAp is a necessary, but not a sufficient, condition for increasing aid effectiveness. Thirdly, Mozambique's early experience with a health SWAp was encouraging and helped to increase effectiveness in the health sector, but over the years, there were signs of a certain SWAp 'fatique', due to the increasing fragmentation of the sector. There is currently a major effort by both MISAU and its partners to finalize a SWAp. This includes updating the 2003 Kaya Kwanga Code of Conduct. According to some KIs, there is a risk that the SWAp may serve implicitly, even if not by design, to shift control over policies and resources to either the government or the partner side. It is suggested that the SWAp should be cognizant of this issue and seek to address mechanisms for mitigating potential conflict. Finally, improving coordination is part of the SWAp agenda. There are several coordination mechanisms and 'coordination theatres' relevant to the health sector. Under these circumstances as just one instrument among various for increasing aid effectiveness in the health sector, coordination should also consider aspects of efficiency, productivity and the resulting transaction costs.

As regards planning for effective health sector financing, it was found that the PESS objectives and planned results for health financing in particular, are not adequately reflected in either the Government Five Year Programme (PQG[8]) or the annual Social and Economic Plan (PES[9]) and budget. Consequently, aligning the annual planning/budgeting process and thus external support via these instruments remains a challenge. It is argued that, in order to operationalise the PESS its long-term planned results should be 'broken down' into a Medium-Term Health Action Plan (MTHAP). In the opinion of MISAU

8. Programa Quinquenal de Governo (PQG)
9. Plano Económico e Social (PES)

KIs, this would be a way to improve the alignment of health plans with the general government planning instruments, including the Medium-Term Fiscal Scenario (CFMP[10]), with expected benefits also for forecasting the resources required for HSS. In addition, it could also help to align externally funded programmes with health sector plans, given that the former usually have short to medium term planning cycles. It is also concluded that 'embracing' and piloting the potential of subsystem planning and budgeting in the health sector as soon as possible is a way forward to merging planning and budgeting for programme support. This would require, among others, reinforcing the technical capacity of MISAU planning and, administration and finance staff. Finally, it is suggested that experimenting with and eventually adopting the WHO health building block approach in the analysis and planning of investment and resource needs at hospital level, will provide an opportunity for a significant contribution to improving the effectiveness of the Mozambican primary healthcare system (PHCS). Such an approach would bring to light, in a systematic way and at hospital level, the imbalance in resource use in favour of medicines and the work force, at the cost of investment in infrastructure and its maintenance, equipment and health information.

The study briefly analyses the content of the draft health sector financing strategy (HSFS) of October 2019[11], which is awaiting political approval. It foresees continued government responsibility for increasingly financing the health sector through the budget, its main source of funding. Diversified general taxation observing pro-poor policies, which minimize the fiscal burden on the poorer strata in society so they can access health services, are considered as well increasing 'sin taxes'[12] and user fees. The gradual introduction of a social health insurance system is also proposed. It was explained that the lengthy preparation was caused by, among others, political and technical controversies over three contentious issues: i) the underlying vision of the SNS and the cost of accessing it for different social strata, ii) the issue of the proposed rise in user fees for public health services, and iii) the effects of the proposed introduction of mandatory health insurance for access to, and the quality and cost of, health services. These issues are related to the need to better understand the dimension and dynamics of the fiscal space. The author has concluded that there is a need for an analysis that does not just use a technical approach, but also takes into consideration political economy factors and the sociological aspects of taxation for universal health coverage (UHC), such as the social distribution of the tax burden. Finally, the study assessed the challenges of introducing PBF into the Mozambican health system, e.g. via GFF, and harmonizing it with the established PFM management approach. Incompatibilities were noted, such as the health units' lack of autonomy and the different intervention logic in an input- and output-based funding approach. Identifying the Tanzania PBF approach to primary healthcare as a 'compass' for the reform of health sector financing, acceptable to different stakeholders, the study briefly looked at the benefits and challenges of this case. Finally, existing windows of opportunity for the gradual introduction of performance-based elements in the PFM system were identified.

In the final conclusion, the study draws attention to the challenges of managing the health sector strategically under conditions of tremendous domestic and global change dynamics. With a focus on boosting primary healthcare, the aim is to secure financial resources for the sector and avoid further fragmentation, safeguarding operational stability, and managing a smooth transition to quality care for all Mozambicans. MISAU has a special leadership responsibility in meeting these challenges. One of the challenging issues is finding a common platform or a hybrid modality which allows for a focus on decentralized interventions in PHC and allows for maximizing the strengths, a reasonable division of labour and effective coordination of both PROSAÚDE and GFF while respecting their differences in philosophy and approach. KIs both in MISAU and among representatives of HPs share this view.

Several recommendations are offered directed at three categories of stakeholders: i) Government and MISAU, ii) health partners and iii) Civil society Organizations (CSOs) working in the health sector, although implementation of the proposed recommendations would require interaction among them, particularly government and its partners.

I. Recommendations for MISAU and Government (MEF in particular):

a. Operationalize the PESS through a mid-term health action plan (MTHAP) to permit better dovetailing of planned PESS results with the annual plan and budget (together, the future annual plan and budget (PESO[13]) and the CFMP, for better forecasting of resources for the sector;

10. Medium-Term Fiscal Scenario (CFMP)
11. Although a more recent version of the document exists, the October 2019 version was used as it was shared with all partners in a session with the former Director of DPC, Dra. Marina Karagianis.
12. I.e. taxes on the consumption of substances such as alcohol and tobacco that are damaging to individual and collective health in society.
13. Plano Económico-Social e Orçamento (PESO)

b. Promote the introduction, testing and monitoring of subsystem planning and budgeting and the use of budget windows (janelas orçamentais) as a way of accommodating performance-based elements in the existing public financial management system, associated with the development of data bases for monitoring performance;

c. Consider giving Beneficiary Management Unit (UGB)[14]) status to selected health units and test and monitor decentralized financial management at hospital level;

d. Substantiate the EFSS through a technical and political economic analysis of the Mozambican fiscal space;

e. Consider a study on private business engagement in the health sector;

f. Enrich SWAp discussions by proposing a conflict mitigation formula and the need for donors to familiarize themselves with the capacity and opportunities offered by the national PFM system (e-sistafe);

g. Establish a health research and think tank unit in MISAU to support strategic health financing decision-making and health reform.

II. Recommendations for health partners:

h. Support implementation of the government initiatives recommended and enumerated under 1) above;

i. Promote interaction between GFF and PROSAÚDE towards a common platform (e.g. in the form of a technical working group to address the integration of performance-based elements in PROSAÚDE (in collaboration with government - see point b) above);

j. Share and discuss the results of the forthcoming GFF review;

k. Promote and introduce in at least two programmes, as a case study, the WHO building block methodology for the analysis of resource distribution at hospital level to increase effectiveness and efficiency in the delivery of primary healthcare services, as an input to medium-term health sector investment planning.

III. Recommendations for CSOs:

l. Support MISAU through research and evidence-based policy papers with a focus on HSFS, PBF and private business engagement in the health sector;

m. Conduct a study on the INGOs operating in the health sector, including on their thematic and regional focus and funding;

n. Promote debate and advocacy initiatives on socio-economic issues of health financing and fiscal space;

o. Disseminate the results of this study among health stakeholders.

14. Unidade Gestora Beneficiária (UGB)


RESPE

1. INTRODUCTION

1.1. Purpose and Objectives

This research report is the result of a consultancy commissioned by N'weti on behalf of the P4H Network with GIZ and SDC funding, P4H being a member of the Health Partners Group (HPG) in Mozambique. It seeks to contribute to the analysis and better understanding of the multiple external health finance arrangements and mechanisms for the Mozambican health sector and the associated challenges and, in particular, contribute to better aligned and coordinated planning, budgeting and implementation of those programmes under rules established by the Mozambican government and its financial administration.

Already in 2002, when Mozambique was on its way to designing and implementing a health SWAp, a study noted that the highly donor-dependent Mozambique suffered from

> a plethora of projects and financing mechanisms, often reflecting donor-driven agenda, despite the existence of the various pooling arrangements. This situation is viewed as a major obstacle to progress in the health sector, with fragmentation hindering attempts to plan, manage and monitor funding in such a way that it is used efficiently and equitably to support national priorities. Difficulties in consolidating either planned or actual spending within the sector due to such fragmentation also provides an opportunity for 'dubious practices' (Pavignani et al., 2002)[15].

Ever since then, the Ministry of Health (MISAU[16]) has continued to grapple with the coexistence of various financing modalities, a partial absence of a strategic understanding of the overall financial needs for strengthening and decentralizing the health sector, itself fragile in many ways. One reason has been the effect of the growing verticalization of programmes, to the detriment of a more integrated, horizontal and sector-wide approach and a better coordinated division of labour among the key stakeholders in HSF. As Gebre (2021: 221) has argued in analysing the effectiveness of vertical programmes aimed at eradicating specific infectious diseases, such programmes may have decreasing returns of investment over time and limited interfaces with national healthcare systems. Instead, this author calls for a shift from externally driven agendas reliant on partner and donor support to programmes better integrated in national health plans and budgets. In a similar vein, Roth (2022), a social historian and general medical practitioner, shows in his comprehensive analysis of the origins, effects and impact of Covid 19 of how the pandemic revealed the fragility of the health systems in the global South, already having been weakened to some extent by the focus on vertical programmes promoted by some donors, philanthropic foundations and the pharmaceutical industry.

In Mozambique where the health sector is supported by a variety of programmes, including vertical ones, the long-term national strategic health sector plan (PESS) has had the role of providing common strategic guidance and planning perspectives for the externally financed programmes in supporting the consolidating of the sector, which is generally considered fragile (Garrido, 2020). The PESS' 2019 Mid Term Evaluation (MTE) revealed some progress in outcomes and the impact of health financing on reducing the prevalence of and vulnerability to diseases in the country. However, it also highlighted weaknesses, including in the coordination of planning, budgeting and domestic and international resource allocation to the sector and in expanding and decentralizing basic health services. There is still no approved health financing strategy (HFS) subscribed to by all partners supporting the health sector in Mozambique, including the government. Given these shortcomings, it is difficult to assess the sector's present position on the trajectory towards universal health coverage (UHC), the Sustainable Development Goals (SDGs) and to achieve, in a sustainable way, the Abuja Declaration goal of earmarking 15% of the annual budget for the health sector[17].

With this study, N'weti seeks to contribute to the ongoing debate on health financing and need for a coherent health financing strategy, as well as the key role of the Ministry of Health in planning , budgeting, and execution of programmes, and in the coordination of externally supported interventions and funding. This study has the following objectives:

15. Lake, 2004.
16. Ministério de Saúde (MISAU)

17. In April 2001, the Heads of State of African Union countries met in Abuja, Nigeria and pledged to set a target of allocating at least 15% of their annual budgets to improve the health sector. 'At the same time, they urged donor countries to "fulfil the yet to be met target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries". This drew attention to the shortage of resources needed to improve health in low-income settings' (WHO, 2011:1).

Overall objective

Analyse the global scenario of external health financing in Mozambique, focussing on the PROSAÚDE Common Fund and selected global financing mechanisms, including two vertical programmes18, the Global Fund for Fighting AIDS, Tuberculosis and Malaria (GFATM/GF and the Global Alliance for Vaccination (GAVI). Also included is the Global Financing Facility (GFF) with its focus on funding in support of better coverage and outcomes in reproductive, maternal, new-born, child and adolescent health and nutrition19.

Specific objectives

a) Analyse the results of these mechanisms in terms of support to MISAU/SNS for the implementation of its strategic agenda;

b) Analyse how the characteristics, priorities and procedures of these funding mechanisms have influenced the execution of strategic MISAU/SNS agendas , addressing issues such as alignment with national procedures, efficiency, administrative and transaction costs, predictability, public finance management and financial control, etc.

1.2 Background

MISAU's Health Sector Strategic Plan (PESS[20]) 2014 -2019 (extended to 2024) seeks to address the issue of health financing by including this topic under its 5thStrategic Objective (Strengthen partnerships for health based on mutual respect).As the health sector is highly donor dependent, the indicator chosen to assess progress in health financing through partnerships, is the degree or proportion of external finance to the sector delivered to the Mozambican budget annually 'on-plan', 'on-budget', 'on-account', 'on-audit', etc. This process is henceforth designated in this report as 'on-CUT' (on-Single Treasury Account21)22.

Several strategic actions for the financing and financial management component of the health sector have been defined and include, as a priority, the elaboration and approval of a Sector Financing Strategy (MISAU, 2015). However, as the PESS Mid-Term Evaluating (MTE) (MISAU, 2019) concludes, despite MISAU's effort to draft such a strategy, this was not achieved during the period covered by the MTE (2014-2018). As the report bluntly states, the above indicator could not be applied due to 'lack of data' (MISAU, 2020: 40).

The absence of reliable data on the relationship between off-budget and on-budget is estimated to be between 40 and 60% of the sector budget owing to an obvious absence of harmonization of sector finance mechanisms that, in turn, according to the MTR report, is indicative of the fragmentation and verticalization of health financing (MISAU, 2020). Furthermore, ignorance of the volume of resources circulating in the sector limits the possibility of MISAU and its partners having a shared and realistic vision of the sector's needs, levels and funding gaps in the priorities and strategies defined in the PESS.

In this study it will be argued that key technical criteria and components for a health finance strategy, such as those highlighted by the World Bank's Practitioners Guide for Health Sector Financing (Cottret & Schieber, 2006) are reflected in PESS and the ministry's Health Sector Financing Strategy (HSFS), due to be submitted for Council of Ministers approval at the time of writing.

From a fiscal sociology perspective, a key question concerning which social classes and strata benefit from the preventive and curative services provided by a country's health sector, and to what degree, and the extent to which these classes pay for such services, both in terms of tax burden and out-of-pocket (OOP) spending (Reeves et al., 2015). What applies to one country also applies globally, according to research by Waris & Latif (2015: 378) stating that 'low-income countries carry 90% of the world's health burden, yet only 12% of global health spending occurs in these countries accounting for 12% of global GDP'.

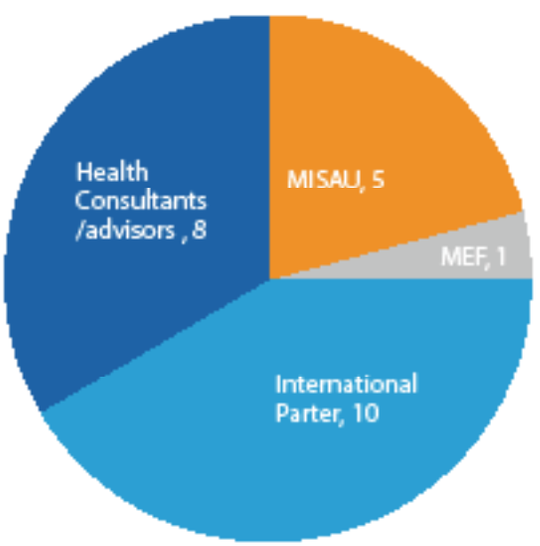
In this regard, a country's quality of governance and accountability is a critical determinant of health outcomes, particularly in primary healthcare and for mother and child health (MCH) (Hall et al., 2021). Furthermore, both the management of external contributions and the degree to which basic healthcare services are financed by a government's budget and private spending will depend on the extent of a country's fragility, particularly under adverse security conditions and war (Pavignani et al., 2013; Potenciar, 2021).

18. According to Caimcross et al. (1997), 'a vertical programme is a component of the health system which has specific, defined objectives, usually quantitative, and relating to a single condition or small group of health problems; [with] the objectives focus on the short or medium term, and [which]...has centralised management and discrete means (staff, vehicles, funds).'
19. In line with arguments advanced by Sepúlveda et al (2007), GFF may be plausibly considered a 'diagonal programme' which does not only focus on the elimination of certain diseases but adds value by focusing of certain target (women and children and adolescents), addressing performance issues at health unit level and by promoting leadership and public health policies, along with investments on institutions and human resources strengthening.
20. Plano Estratégico do Sector de Saúde (PESS)
21. Conta Única de Tesouro (CUT)
22. Please note that 'on-budget' may imply both on-CUT and off-CUT.

1.3. Methodology

The methodology chosen for this study emphasizes qualitative, non-numerical research methods deemed to be the most adequate approach to capture perceptions of different stakeholders on the challenges of HSF and the need for alignment of different support modalities. This is why, firstly, preference was given to semi-structured interviews with representatives of key stakeholders (key informants): i.e. senior civil servants in MISAU, managers of externally funded programmes and health finance consultants/advisers. These interviews produced insights into perceptions of the four externally funded programmes studied, as well as on perspectives for the changes needed to achieve a more comprehensive, coordinated and effective approach to health financing in Mozambique. Such interviews, often in the form of guided open-ended conversations[23] were conducted with 24 key informants (KI). The figure below shows the composition of KIs, by group of stakeholders. A complete list of KIs is given in Annex 6.2.

Figure 1: Number of Key Informants, by cluster of stakeholders



Source: Author

23. The guiding questions were sent to the KIs before the date of the interviews.

In accordance with the wishes of most KIs, it was decided that all persons interviewed would remain anonymous, in line with current qualitative research practice.

Secondly, the methodology included a review of relevant official documents from MISAU and external health support agencies. Together with insights garnered through the review of academic literature it helped to comprehend the current state of affairs and the debate on health financing in Mozambique, partially also in a comparative perspective.

Thirdly, as the topic studied clearly also has a quantitative dimension i.e. the amount of funding for Mozambique's health sector, an effort was made to obtain basic financial data, if only to illustrate funding trends. As, from the outset of the study, N'weti stressed its interest in a qualitative analysis, it was agreed that data analysis would not be the main focus and there would be no major effort to obtain datasets from MISAU, MEF or other sources, given time and resource constraints. Nevertheless, early in the research work a request was sent to the MISAU PS, for access to public finance data on health financing, but there has been no reply at the time of writing. Consequently, the consultant made partial use of standard datasets generated through e-sistafe. It reflects budget allocations (updated allocations or dotação actualizada) from external sources for the years 2015 to 2020. The figures provided in Meticais (MZN) were converted into US$ using the annual average MZN-US$ exchange rate. This gives a more realistic picture of financial flows as the effects of the extreme exchange rate fluctuations between MZN and US$ during the period covered are minimized.

Finally, a sharing of the draft report with selected agencies associated with the programmes analysed was part of the methodology, which also implied a second round of interviews with additional KIs. Their comments were essential to rectify errors and clarify perceptions, as well highlighting differences in opinion.

In the sense of a disclaimer, it can be argued that a health sector financing study with a focus on stakeholder perceptions and without a thorough analysis of financial data is incomplete. However, given the time, budget and institutional constraints for the research and study, N'weti took a deliberate decision to opt for the methodology described above. It should not be interpreted by the reader as a substitution of quantitative by qualitative methods, despite the emphasis on the latter.

For the same reasons of constraints, the study also does not present the reader with an analysis of trends in health status, indicators by disease and services provided by health units. N'weti and the author of the study agreed that there is sufficient literature to demonstrate, that over the past two decades these have generally improved together with an increasing coverage of health services and programmes. The interested reader is referred to the official statistics produced by MISAU (MISAU, 2020b) and data produced by the MTR of PESS (MISAU, 2019), respectively.

Finally, it was agreed at the outset, that issues of decentralization related to the health sector , although considered highly relevant , should not be covered in the analysis. The fact, that the New Decentralization Paradigm (Impissa, 2020) certainly affects the sector in a profound and controversial way, particularly at sub-national level. This led N'weti to the conclusion that the objective of and the framework for the present study are inadequate to include a profound analysis of decentralization in the context of health financing, eventually preferring a separate study on this topic. For insights into this topic the interested reader is referred to a study commissioned by the Swiss Embassy in Maputo, which includes a section on decentralization and the health sector (Weimer, 2021).

1.4. Structure of Study

The study is structured in four main chapters. After the following chapter on the context of Mozambique's health sector and its financing arrangements, the third chapter analyses four case studies on PROSAÚDE, Global Fund for Aids, Tuberculosis and Malaria (GFATM/GF[24]), Global Vaccination Initiative (GAVI) and The Global Financing Facility (GFF). Although the analysis of US support to the Mozambican health sector was not foreseen in the TOR, it was deemed necessary to shed some light, in the first section of Chapter 3, on the President's Emergency Plan for AIDS Relief (PEPFAR). With an average annual commitment of some US$ 393 million over the past few years, it is by far the largest external funder of Mozambique's health sector. Other reasons are its impact on MISAU and SNS management capacity and on other programmes such as GF, which are partly financed by PEPFAR.

Chapter 4 takes up and addresses critical issues of external financing of the Mozambican health sector, arising from the case studies. They include topics such as alignment with national systems, coordination and the dynamics of moving towards a comprehensive health financing strategy, and includes critical issues such as effectiveness, fiscal space and performance-based financing (PBF). Although not part of the TOR, in response to an expressed interest by some KIs, there is a brief overview of the current decentralization reform under way in Mozambique, as it impacts unfavourably on the health sector and its financing.

The last chapter summarizes the conclusions and makes suggestions on a reform agenda that might help MISAU to better cope with the management of external financial support, and improved performance by the SNS, particularly in primary healthcare (PHC) services and improved mother and child health (MCH) at the subnational level.

1.5. Acknowledgements

This study would not have been possible without the generous support and ready availability of many personalities for interviews, particularly in government (MISAU and MEF), and the institutions representing externally supported programmes such as PROSAÚDE, GF, GAVI, GFF and the World Bank, some of which, including a group of WB/GFF officials, provided useful and much appreciated written comments on early drafts of the study. A draft was also discussed in a meeting at MISAU chaired by the Director of Planning and Cooperation, Ms Sãozinha Agostinho, which raised critical issues and generated useful comments. Expressing respect and gratitude to them in no way undervalues the contributions of all the other key informants, notably the highly experienced advisors and consultants working in the field of financing and financial management of the Mozambican health sector. The author is indebted to all the women and men in government and aid institutions who readily and openly responded to questions and addressed often delicate issues in the interviews. Particularly those who took their time to comment on earlier drafts of the report merit the author's gratitude. A warm Thank You is also due to all those who, during fieldwork in Maputo, facilitated the interviews, provided accommodation and food, and enabled the author to travel safely.

Last, but not least, the author would like to express his heart-felt gratitude to N'weti and, in particular, Mr Andes Chivangue. The author wishes to acknowledge the great confidence and support he received from this senior officer at N'weti and his team in all phases of the study. With his rich and varied experience in the health sector, in advocacy and academic analysis, Mr Chivangue provided invaluable support

24. For convenience's sake, and as it is generally known as the Global Fund, abbreviation GF (Global Fund) is used for GFATM.

to the author, e.g. guiding the report process, reading and commenting on some sections of the first draft and flexibly adjusting the agenda and timeline due to a health challenge faced by the author in the middle of the research work. Muito Obrigado. This 'thank you' is extended to N'weti's director, Ms Denise Namburete. The author's gratitude also includes Ms Pamela Rebelo, Maputo, and Ms Teresa Weimer, London, for proof reading the final draft of the report and for copy editing.

While the contributions to this study of all the above-mentioned persons is greatly and thankfully acknowledged, the author remains the only one responsible for its contents and any errors and omissions. It should also be emphasized that the study represents solely and exclusively the author's views and opinions, and not that of N'weti or any of its staff.

2. MOZAMBIQUE'S HEALTH SECTOR FINANCING – CONTEXT AND SALIENT FEATURES

This chapter highlights various aspects of Mozambique's health sector to provide an overview of the context in which the analysis of health financing takes place. The first section 2.1, contains a working definition of the understanding of the health sector and touches on the key challenges it faces. The following section 2.2 addresses relevant features of the sector's political economy and section 2.3, the financing trends of the sector. Section 2.4 aims to contribute to a deeper understanding of the complexities of financing the health sector, its delivery modalities and resource flows, as well as the extent of its alignment with established government rules on planning, programming and budgeting (PPB) and reporting (section 2.5). Section 2.6 attempts to systematize the global health financing initiatives, some of which operate in Mozambique in complex inter-institutional arrangements where the Mozambican government, i.e. MISAU, is but one actor among others, before section 2.7 sheds some light on key features of health sector reform in Mozambique. The final section sums up the main conclusions of the analysis.

2.1. Key Features of the Health Sector[25]

For this study, in line with official statistics, we distinguish between primary, secondary, tertiary and quaternary levels of healthcare units, whose distribution is given in the Table 1[26].

Table 1: Healthcare units, by level (2019)

Level	Primary	Secondary	Tertiary	Quaternary	TOTAL
Type of health units	Health Centres, Health Posts	District, Rural and General Hospitals	Provincial Hospitals	Central, Specialized, Military Hospitals	
Number	1,609	51	8	7	1,676

Source: Author, based on MISAU (2020b)

From a PFM perspective and in keeping with UNICEF (2019:4), the Mozambican health sector is defined as 'the set of entities which form part of the Ministry of Health (MOH), or which are subordinate to it, and which have their own allocations within the state budget'. Currently, the sector comprises 184 Beneficiary Management Units (UGB[27]), including the Ministry of Health (the leader, at national level), 11 Provincial Health Directorates (which coordinate the sector in each province) and 151 SDSMAS. The latter coordinate the sector at district level, since the primary, secondary and tertiary healthcare units do not have the status of UGB. The sector also includes the National Institute of Health (INS), the Central Medical Stores (CMAM) as well as the four Central Hospitals.

The units and their numbers given above represent what can be considered the functional units of public healthcare to which one would add private health service providers. Together with the regulatory and administrative superstructure (policies, programmes, strategies) these units make up the National Health System (NHS) (Sistema Nacional de Saúde - SNS).

The SNS may thus be summarized as to include the following healthcare providers:

Public health service providers. From a bottom-up perspective an important distinction is made between primary healthcare units (CSP[28]) and secondary healthcare units (CSS[29]), on the one hand, and the tertiary and quaternary level healthcare providers which correspond at provincial and central level on the other.

Community-based health services, notably via sub-district health posts (which are part of the CSP) and community health workers or Agentes Polivalentes Elementares (APE)[30] (which are not part of CSP) and the collaboration with practitioners of traditional and alternative medicine.

25. This subsection largely follows Weimer (2021), section 3.4.2.1
26. The reader interested in the distribution of units per Province and District is referred to Annex 3 of the GFF draft Investment case (GFF, 2017)

27. Unidade de Gestão Beneficiaria (UGB)
28. Unidades de Cuidados de Saúde Primários (USP)
29. Unidades de Cuidados de Saúde Secondárias (USS)
30. Under the Community Healthcare Subsystem Strategy, the APE will be upgraded to Agente Comunitário de Saúde. The pilot is underway and after the exams those who can master the new profile will transit to the new structure.

Private health service providers and clinics, differentiated between profit and non-profit[31] ones.

Mozambique is among the countries in the world with the highest birth rates (five children per woman) and gross mortality rates (11.8 per 1,000 inhabitants), a very high stunting rate and a low life expectancy (53.7 years). Maternal mortality (452 per 100,000 live births) and infant mortality (68 per 1,000 live births) are also very high (INE 2019)32. Major health challenges are widespread prevalence of malaria, tuberculosis, AIDS, respiratory infections (including through Covid 19) as well as waterborne diseases, including those related to poor sanitation. The war in Cabo Delgado Province places additional strain on basic healthcare, given that about one third of the health facilities there are not operating and almost 800,000 people have been displaced and temporarily resettled in safer areas. The WHO estimates that about 1.2 million people are in urgent need of medical assistance33.

Fighting the Covid 19 pandemic through vaccination is another major challenge. Even though the registered cases and infections are comparatively low, the pandemic has exposed the health sector's weaknesses. Testing capacities were limited and concentrated in the south of the country and many health facilities (and schools) in rural areas have no running water and sanitation facilities to assure a minimum of preventive hygiene. By the 10th of December 2020, the health authorities had registered 16,521 cases, with 1,663 persons quarantined, 14,715 infected persons recovering and 139 fatalities34. However, according to MISAU, by the end of January 2021 Mozambique had recorded more cases, more hospitalisations and more deaths from Covid19 in that month alone than in the whole of 2020,. In January 2021 the pandemic resulted in 201 deaths, more than half (54.7%) of the 367 that the country had officially recorded since the pandemic started. Although the rate of vaccination has accelerated, health staff are particularly at risk. The most detrimental effects are expected to hit children, who have lost valuable time at school. A UNICEF policy note warns that for 'ten million children of Mozambique who have already been living in some form of poverty, Covid 19 means a deeper and more prolonged poverty and the denial of their basic rights. A further reduction in access to essential health services due to a major disruption of the healthcare system could further aggravate the already existing vulnerabilities of children who need vaccinations, suffer from chronic illnesses, live with a disability or are affected by common infectious diseases such as malaria' (UNICEF, 2020a: 1).

Inequality of access to healthcare continues to be a major challenge for the SNS. As Table 1 above shows, there are only a total of 66 healthcare units with the statutes of 'hospital' in a country administratively divided into 10 provinces, 153 districts and 53 municipalities. The ratio of the number of inhabitants per health unit varies considerably across the 10 provinces and the City of Maputo, with the highest value for Maputo City (29,542), followed by Nampula Province (25,906), with the lowest value (9,708) for Gaza Province (MISAU, 2020 b: 10). At the national level, the increase in the absolute number of health units notwithstanding, the ratio of Inhabitants per health unit increased from 16,855 in 2018 to 17,514 in 2019, still far from the WHO recommendation (10,000 inhabitants per health unit).

Several studies over the past few years (Anselmi, 2015; Gironés et al., 2018) have found that

- The exclusion effects of social inequalities along different analytical 'axes'[35] largely condition access to healthcare;
- One out of three Mozambicans with a perceived health need did not use healthcare services, and this behaviour is more prevalent among people in the northern provinces, a rural environment, as well as the less educated and the poorer socioeconomic strata of society;
- Almost half of those not using healthcare encountered objective barriers hampering their access (in particular, distance or lack of transport to health facilities), even when suffering a comparatively severe health need;
- Social inequalities also condition certain aspects of access quality, the type of healthcare provider preferred as well as the prevalence and the intensity of health needs.

In another recent study on the need for bold institutional changes to the SNS in order to address Mozambique's challenges in access to quality service delivery, increased coverage and health governance. Ivo Garrido, a medical doctor

31. Examples of private profit health service providers are the private clinics that have sprung up in recent years, particularly in Maputo and major cities and towns, whereas an example of a non-profit private provider is the Maputo based ICOR (Instituto do Coração). It is said to represent a non-profit entity in the form of an NGO, providing the same or similar services as several of the other private for-profit clinics, but does not pay income tax on its revenue, so has a competitive advantage over the private profit health sector.
32. For details regarding the situation of Mother and Child Health (MCH) at provincial and district level, see Annex 2 of the GFF Investment Case (GFF, 2017: 106 ff).
33. Mozambique: More than 1.2 million need urgent medical assistance – WHO. Quoted by Club of Mozambique, https://clubofmozambique.com/news/mozambique
34. https://www.misau.gov.mz/index.php/COVID-19-boletins-diarios , accessed on 11/12/2020
35. Such as socioeconomic situation of the household, maximum educational level attained, sex, age, rural/urban environment, time to reach a healthcare facility and type of healthcare services provider.

and former Minister of Health, has stressed the overarching importance of the public part of the SNS as the backbone and largest provider of health services, particularly in rural areas. He argues that private providers of quality healthcare only cater for 5% of the population, i.e. for the small, wealthy and urbanized part (Garrido, 2020).

For a variety of reason discussed in his study - prominent among them the structural underfinancing of the health sector, a focus on curative rather than preventive health, corruption, lack of accountability and a donor preference for vertical approaches, Garrido concludes that the way the SNS is organized, and the sector's funding is allocated and distributed is incapable of addressing the healthcare needs of Mozambicans, particularly those living in rural areas. He makes it clear that primary healthcare and rural health units that are not yet UGBs s need to be boosted and budgets recalibrated for this purpose[36]. The APEs are not part of the salaried health staff paid for by government, and are considered the 'institutionally weakest, but most important local primary healthcare service providers in the SNS' (interviewee, quoted by Weimer, 2021). They are mostly financed by UNICEF, USAID, WHO and NGOs, according to their regional priorities and programmes. The number of registered APEs tripled between 2012 and 2018, with the highest numbers and most dynamic growth in Nampula and Zambézia provinces (MISAU, 2019). MISAU has been preparing a strategy, as yet not approved, intended to boost the community health subsystem (MISAU, 2021; see also N'weti, 2021). Among MISAU's challenges is to come up with an organizational and financing model for the community and ADE part of CSP and negotiate with key programmes adequate funding.

2.2. The Political Economy of the Health Sector – Selected Aspects

As pointed out above (section 1.3), the health sector, its financing and reform must be seen within the wider picture of the Mozambican political economy. Even from an epidemiological point of view (Marmot, 2005; Wilkinson & Marmot 2006), individual and public health are to a large degree determined by socio-economic relations and wealth distribution patterns as well as access to social services. Thus, the class, stratification and income structure of Mozambican society matter, as does the political administrative system across in a country. These are the determinants of the health of a society.

Mozambique's political economy has been studied from various analytical perspectives (Castel Branco, 2015; Orre & Rønning, 2017; Weimer & Carrilho, 2017; Mosca, 2019; Borowczak et al., 2020; Hanlon, 2021; Potenciar, 2021). There is a convergence of opinions that include the following key features:

- A hegemonic founding party, Frelimo, that has established and maintained a neo-patrimonial clientilist system in a highly centralized and increasingly authoritarian state. The party controls the country's natural and strategic resources, the commanding heights of the economy (including via state owned enterprises), the security apparatus and the public administration, together with the fiscal and policy instruments that determine the allocation and (sectoral and geographical) distribution of public and human resources;

- A structurally distorted, porous, highly indebted political economy focussed on the extraction and export of natural resources (mineral, energy, agricultural, forestry, fishery, etc.) at the cost of the family agricultural sector, security of land tenure and self-sufficiency in food production and supplies. This type of political economy does not produce what it consumes and does not consume what it produces. Nor does it generate domestic capital accumulation for a sustainable private sector and tax base (Castel Branco, 2015).

- The emergence of a 'narco sub-state' in which rents to members of the political elite are generated by turning Mozambique into a transit country for drugs from Asia and, increasingly, from South Africa, and to South Africa and Europe (Hanlon, 2021).

- Accentuated poverty, inequality in consumption and highly unequal access to private and public services, including in health. The trend of a declining overall rate of poverty in the decade 1996 to 2015 has been reversed. The recent household expenditure survey for 2019-2020 (IOF[37]) by the National Statistics Institute (INE[38]) shows a dramatic decline in the spending capacity of Mozambican families (INE, 2021). According to the survey, median spending fell by 17% between 2015 and 2020, making most people poorer than they were

36. In the education sector about 13,000 schools have separate budgets, even though registered in the respective District Services for Education, Youth and Technology (Serviço Distrital de Educação Juventude e Tecnologia -SDEJT); KI 16, 12/11/2021.

37. Inquérito sobre Orçamento Familiar (IOF)
38. Instituto Nacional de Estatística (INE)

a decade ago[39]. The total number of poor women, men, girls and boys has risen since 2000, particularly in rural areas and in the central and northern provinces (Mambo et al., 2018; Egger et al., 2020).

- A rent-seeking economy that is increasingly focussed on the elite's expected economic advantages in the extractive economy (in the broadest sense40) and its down and upstream sectors, seeking partnerships with foreign investors. This phenomenon is part of what has been described as a 'pre-source curse' (Cust & Mihalyi, 2017; for Mozambique, see: Orre & Rønning, 2017).

- Exacerbated intra-elite competition for power and resources accentuates regional cleavages among factions of the political elite, parts of which are defending their claims to power and rents by increasingly spending resources on security, as shown by both the political violence in central Mozambique in 2014-2016 and the spending on maritime security financed by illicit debts (Frynas & Buur,2020). The call for an 'elite pact' has been made in order to curb the inclination towards violent 'solutions' to intra -elite conflicts (OMR, 2021);

- The hidden debt scandal discovered in 2016 led to a drop in aid and foreign direct investment (FDI), the lowest possible credit rating, falling annual economic growth rates and employment, and a declining annual Human Development Index (HDI). It has also increased public indebtedness to unsustainable levels. Cortez et al. (2021) estimate that the direct, indirect and opportunity cost, and knock-on effects of the hidden debt scandal may have cost Mozambique at least US$ 11 billion – nearly the country's GDP in 2016.The Swiss-based International Centre for Asset Recovery (ICAR) of the Basel Institute on Governance (BIG) considers the scandal to be a case of illicit financial transfers and money laundering that directly and negatively affects human lives.[41]It contributes to Mozambique's ranking as one of the high-risk countries in the Basel AML Index, an independent annual ranking that assesses risks of money laundering and terrorism financing[42].

- The analysis of spending patterns on security versus selected social sectors demonstrates that, since 2018, spending on security has grown more than that of the social sectors: Since then, annual expenditure reflected in the state budget[43] was higher than on health[44], water and sanitation and social protection put together (Potenciar, 2021).

- The growing indebtedness and the economic, fiscal and investment knock on effects have led to a fragilization of the state, with reduced capacity to provide regular public goods and services (basic social and infrastructure services in education, health, water supplies and economic stability, security for citizens), let alone increasing coverage. Mozambique's score in the Fragile State Index (FSI) deteriorated by 10 points, from 81.7 to 91.7 and its position compared to all other countries deteriorated significantly.

- Finally, and particularly relevant for health sector financing, is the tendency for capital outflows and 'tax evasion', which have been observed globally and also for Mozambique. As studies such as that by Hare et al. (2021) show, there is a direct causal effect between, on the one hand, capital outflows and, on the other hand, tax evasion and underreporting of profits by multinational companies and, the negative impact on available tax resources, particularly in Low- and Medium-Income counties (LMICs) such as Mozambique, which could otherwise be spent on realizing children's social and economic rights, including adequate education and health services. Many enterprises in Mozambique, including in the extractive and tourism sector, are registered in tax havens such as Dubai or Mauritius, a strong sign of possible tax evasion.[45]

As part of the Mozambican political economy, the health sector is not immune to the dynamics outlined above. The possibility of access to aid rents generated through direct and sectoral budget support decreased substantially with the end of Programme Aid Partner (PAP) support to PARPA, the discovery of misappropriation of funds through PROSAÚDE (see section 3.3.) and the general decline of bilateral aid inflows, particularly after the discovery of the hidden debt in 2016. Rent seeking behaviour in the SNS has thus changed.

39. Urban spending fell 24% while rural spending dropped 13%. Gaza (down 42%), Maputo city (down 38%) and Cabo Delgado (also down 38%) were hit hardest. All spending, including on food, fell sharply. The survey shows that 75% of Mozambicans spend less than $1 per day, more than 90% are under the World Bank international poverty line of $1.90 per day. The survey also shows huge inequality, noting that the poorest '50% of the population accounts for 14.7% of the total expenditure. The share of the poorest 10% of the population is only 0.8% of total national expenditure, and the richest 10% of the population account for 43.1% of total expenditure' (Hanlon, 2021a).
40. Including mineral extraction, fisheries, forestry and large scale agro-business.
41. https://baselgovernance.org/blog/mozambiques-tuna-bonds-scandal-yes-its-about-money-more-its-about-human-lives
42. https://index.baselgovernance.org/ranking
43. One may reasonably assume that a considerable part of security spending, notably on military hardware, is not reflected in the budget
44. Except the major hospitals in Maputo
45. https://index.baselgovernance.org/ranking

According to N'weti(2021), the main sources of potential rent generation, embezzlement and other corrupt practices are in the procurement of infrastructure construction and, the supply and distribution of medicines and medical products. Several KIs see the procurement area as one of the weakest parts in the governance of the SNS[46]. As shown by N'weti (2021), governance issues in the health sector are also attributable to the blurred functional boundary between MISAU and the SNS, where responsibility for oversight and accountability procedures are not clearly defined. According to this study, this is the case in the relationship between MISAU and the central hospitals in Maputo, Beira and Nampula, which have a high degree of autonomy and little oversight.

Another aspect relevant to our analysis of health financing are tendencies of privatization of parts of public health services[47]. Given the character of the Mozambican political economy, it is difficult to make a clear-cut distinction between private and public interest in the health and other sectors. Therefore it is assumed that that in a 'grey zone' between members of the political elites, but also medical staff and nurses in hospitals use their public positions for private benefit, leading to non-transparent and corrupt practices in the provision of health services. Anecdotal evidence suggests that drugs and medical products acquired through public procurement end up in private clinics or are used by official staff in their private capacity, outside the health unit. The same is true for medical consultations. In both cases the patient pays the cost out of their own pockets (OOP), even if the SNS states that access to health service is free of charge (except for a symbolic fee of 5 MZN and 10 MZN for rural and urban dwellers, respectively). Even in a public health unit, such private services are rendered against payment, for example, to cut a long queue of patients waiting to be attended. In Maputo hospitals, the delivery of a baby by a government employed obstetrician can be arranged privately for the payment of 15,000 MZN, with a caesarean section and transport of the pregnant woman from her residence included[48]. The introduction of two-tier service provision in health facilities (Serviço de Atendimento Personalizado – SAP) risks deepening social stratification. Prices start at MZN 300 and this payment allows patients to skip the queue in primary health and diagnostics. Failure to pay does not mean immediate exclusion of the patient but may imply long waiting times and often negation of service justified by fake excuses (such as 'the x-ray machine does not work').

The dividing line between public and private health services has become increasingly blurred. Given the perception that the provision of health services is a way of making money, particularly in urban areas, private clinics have sprung up all over the country, and it is not always clear who the owners are and to what extent MISAU exercises its role in regulating and supervising the private health sector and setting professional standards and norms for fees. It is doubtful that MISAU can exercise strict control over private health services equivalent to that practised by the Ministry of Industry and Commerce(MIC) and its inspection department[49] (INAE) in the private commercial sector.

On a national scale, interest in privatizing public healthcare has been vented by a French publication on economic intelligence, Africa Intelligence[50]. It reports on an alleged planned takeover of public hospitals by Hospitais Nacionais de Moçambique (HNM) a 'mega-structure' in which the holding company, Mozambique Holdings (MHL), dominated by what has been labelled an 'Indian tycoon', accounts for 70% of the €4.2m capital, with its remaining 30% in the hands of the Instituto de Gestão de Empresas Participadas pelo Estado (IGEPE), under the tutelage of MEF. It is not known to what extent this 'takeover' is the result of a tender and whether an economic viability study has been undertaken, given that most of the enterprises managed by IGEPE are not known to be economically profitable, but depend to a large extent on state subsidies for their survival and recurrent costs. If this 'public- private partnership' takes off, it will certainly be a game changer for the way the Mozambican health sector is run and financed, and will certainly affect global support for the sector. It remains to be seen how the ever more impoverished population and national NGOs will respond to the privatization of public goods and services. The ongoing partial 'privatization' of the management of national highways, in which users at toll bridges are asked to pay a road maintenance fee to a private operator linked to the political elite[51], will be an initial test case of both the economic and political viability of this financing model.

46. KI 7, 13/10; KI 9, 26/10; KI16, 12/11/2021. According to these informants, the problem is not the 'system' or the regulations but the lack of or incorrect application of the regulations and the manifest lack of capacity of UGEA staff.
47. In this context we understand by privatization the involvement of the private sector (individuals, enterprises0 in providing healthcare services or parts thereof, including the transfer of functions and ownership of installations and or specific services for the purpose of making profit. Regarding the pros and cons, advantages and disadvantages of privatization, see: Adhikari , 2018.
48. The same service costs 90,000 MZN in a private clinic. Personal information.
49. Inspecção Nacional das Actividades Económicas (INAE)
50. Jose Parayanken embarks on major public-private healthcare venture. Filipe Nuysi's "One district, one hospital" initiative will benefit mainly the privately owned Mozambique Holdings, which has been selected to build and run the country's health facilities. Africa Intelligence, 19/11/2021.
51. See: https://www.facebook.com/CDDMoz/videos/lan%C3%A7amento-da-campanha-povo-diz-n%C3%A3o-%C3%A0s-portagens-na-circular/546223293064233/

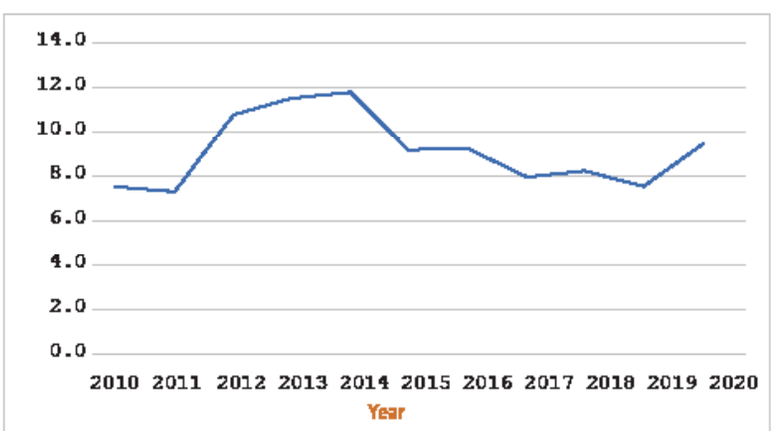
In sum, not only the intensity and viability of privatization drivers and their institutional dynamics will be major determinants of the outcomes for health sector financing, particularly from domestic resources (taxes, OOP), but also the often-conflictual interaction between key stakeholders in the health sector, the urban and rural users of health services, civil servants and the institutions they work in and private investors. The numerous advantages of the private healthcare services notwithstanding, its introduction will obviously increase OOP expenditure of patients, and is likely to increase the existing gaps in national quality healthcare services (see 4.4). Outcomes will also be shaped by the results of the decentralization reform under a new paradigm emanating from an elite settlement that does not just affect the health sector (see section 2.7).

2.3. Health Expenditure – Trends

Mozambique's government spending on the health sector occupies the third most important position in the annual budget, after education and public works, housing and water and sanitation.

As Figure 2 below shows, expenditure for health as a ratio of total expenditure varied considerably over the past decade, oscillating around 9% over a period of 11 years , well below the target of 15% of annual budget set by the Abuja Declaration.

Figure 2: Health budget as percentage of total budget , 2010-2020



Source: Observatório do Cidadão para Saúde (OCS), na base de CGE 2010-2019, Proposta de Revisão OE 2020 (CSO, 2022)

Health expenditure as a percentage of GDP has averaged around 3% over the past decade (UNICEF, 2019, 2020), a rate slightly higher than that for all Sub-Saharan African countries.

The mid-term evaluation of MISAU's Health Sector Strategic Plan 2014-2019 concludes that the cost estimate for the implementation of the plan - US$ 7.78 billion - is 'ambitious' and that, over the 2014-2018 period, 'the sector performed only the equivalent of one third of the budget estimate of the cost of PESS, which means that the greater part of the activities foreseen in the PESS will have been left without financing' (MISAU, 2019: 14[52]). This is particularly the case in infrastructure, equipment and health information (see section 4.3.3).

Despite the stagnating trend in overall budget allocations for health, domestic budget resources have risen in relation to foreign funding of the sector. In 2019, 79% of the health sector budget was financed by domestic, and 21% by foreign sources and the projected expenditure for 2021 will further change this percentage ratio to around 82%:18% (OCS, 2021). This ratio reflects a major change in financing patterns over the last decade, when the ratio was 60% and 40% respectively, for domestic and foreign funds. It is also noteworthy that both the nominal value of domestic funding (in MZN), as well as its share of all resources allocated to the sector in 2020 is the largest ever (UNICEF, 2020).

Like in the infrastructure sector (public works, water and sanitation), health spending is highly centralized, considering the ratio of spending at provincial level (both recurrent and investment expenditure) to total ministry spending (see Camões, 2020). According to health monitoring data published by a Mozambican CSO, around 50% is spent at central level, which includes MISAU (OCS, 2021) as well as construction of health infrastructure which is under MISAU's authority. Weimer & Carrilho (2017: 156) demonstrated that Maputo-based institutions receive more than the budgets allocated to the provincial and district levels combined i.e. for general, district and rural hospitals. Central institutions also accounted for two thirds of investment in the SNS, with approximately 90% of provincial and district expenditure comprising recurrent expenditure, with hardly any (domestic) investment whatsoever at district level. Their funding is left largely to donor programmes such as PROSAÚDE which, according to one key informant, is 'providing a lifeline of survival' for them53. The argument often heard in favour of centralized investment decisions is that of economy of scale and an alleged lack of investment management capacity at subnational level.

52. Translation from Portuguese by author
53. KI 15, 15/11/2021

As regards distribution, spending on recurrent expenditure (salaries, consumables, purchase of goods and services) by far outweighs that on investment at all levels of government, district level in particular (see: Weimer, 2021). This represents a structural pattern and confirms Garrido's verdict cited above. Over the past few years, an average 75% of the budget has been spent on recurrent cost items, and only 25% on investment54, and this impacts negatively on SNS capacity to provide primary healthcare services at the local government level. A UNICEF study concluded that access to health facilities is lowest in Cabo Delgado where only 39% of households have a health facility within 30 minutes' walk from their residence as opposed to Maputo, where the corresponding rate is 96%, with Zambézia and Nampula having the lowest per capita health spending among all of Mozambique's provinces (UNICEF, 2018).

The mid-term evaluation (MTE) of the Ministry's PESS (2014-2019) mirrors the low expenditure for infrastructure, concluding that the objective of expanding services, as measured by inhabitants served per health unit and by hospital beds per 1,000 inhabitants was not achieved (MISAU, 2020: 11).

The under-resourcing of the health sector is exacerbated by the fact that, on average, budget execution over the past 10 years has been consistently lower than budget allocations. A 25% difference between the planned and the executed budget over the past decade, only partially remedied in 2019 to 2020, points to major challenges in planning, programming, budgeting and execution of the provision and delivery of health services, including procurement55.

2.4. Financing Modalities, Budget Cycle Management and Flow of Funds

In principle, since Mozambique's adherence to the 2005 Paris Declaration on Aid Effectiveness all external funding contributions to the sector should be aligned with national systems used for planning, budgeting and reporting. According to a key informant in MEF, this criterion continues to be the official government position in order to avoid a myriad of financing modalities incurring high transaction costs (not only for government[56]). Yet, in practice, the reality in the health sector is quite different. Roughly speaking, there are three types of financial support modalities via:

a) Projects managed by the donor, or its (sub) contractor(s), outside the economic and social plan (PES) and the state budget (OE) i.e. 'off-budget' and consequently off the Single Treasury Account (off-CUT). One example is the health sector support provided by the US government, which is not a party to the Paris Declaration on Aid Effectiveness (see section 4.2.1).

b) Bilateral and multilateral individual and joint programmes and projects aligned with the government system (on-plan, on-budget, on-CUT, on-audit[57] etc.) which follow the governmental planning, programming and budgeting (PPB) and use the national PFM system based on the electronic public financial management platform, e-sistafe, and legislation that was updated in late 2020/early 2021, to also include municipalities and the newly created decentralized government provincial entities, the OGDP[58]. Examples include sector-wide programmes such as PROSAÚDE, individual health support projects of PROSAÚDE partners (e.g. Ireland, Italy, Switzerland) as well as vertical programmes focusing on specific diseases such as the Global Fund.

c) Programmes/projects registered in the PES and OE (on-plan, on-budget), but executed outside the government system i.e., off-CUT. Examples are specific projects by international NGOs (e.g., CUAMM[59]), providing technical support, training of health staff and funding to increase hospital capacities in various parts of Mozambique. One interviewee in MISAU maintains that the ministry has neither a sufficient overview on the INGOs operating in the health sector in the country and their funding, nor on the degree of alignment with national health policies and PESS, thus stressing the need for a study for this purpose, deemed to be relevant also for the HPG[60].

A distinct subgroup referred to in point b) is represented by programmes financed through a common fund, as in the case of the multilateral PROSAÚDE with its Common Fund approach established in the early 2000s (see section 3.3.).This subgroup also includes a Multi-Donor Trust Fund (MDTF) managed by the World Bank (WB), with the Netherlands, Canada and the United Kingdom as contributors. Focussing

54. https://observatoriodesaude.org/deviations-between-the-planned-and-the-execution-undermine-the-health-budget/
55. See: https://observatoriodesaude.org/deviations-between-the-planned-and-the-execution-undermine-the-health-budget/
56. KI 15, 19/11/2021
57. I.e. audited by the supreme Mozambican audit agency – Section III of the Administrative Tribunal (Tribunal Administrativo (TA).
58. Órgãos de Governação Descentralizada Provincial (OGDP)
59. Doctors with Africa CUAMM is an Italian based NGO focussing in Mozambique on training future doctors in Beira and the health of mothers and children in several districts of the country. https://www.mediciconlafrica.org/en/what-we-do/in-africa/our-work-in-mozambique/
60. KI 17, 26/04/2022

on Primary Healthcare Services Strengthening (PHCS) it is complemented by the Global Finance Facility (GFF) with its specific focus on women, children and adolescents, sub-national health units and, partially, a performance-based financing (PBF) approach.

Irrespective of whether sector support is on-budget/off-CUT or on-budget/on-CUT, the governments' approach to planning, programming and budgeting (PPB) and the corresponding planning and budget cycle must be observed.

The government's planning cycle has the following four key moments:

- Five-year Government Programme (PQG)[61]
- Medium-Term Fiscal Scenario (CFMP)[62]
- Annual Economic and Social Plan (PES)[63], and
- Annual State Budget (OE)[64].

The reform of the public financial management system will eventually combine the PES and OE into the Economic and Social Plan and Budget (PESO)[65]. These planning instruments are further analysed in section 4.3.1, from the point of view of sector planning.

Returning to the diversity of funding modalities for the health sector, the rising domination by vertical programmes is one factor that explains what is sometimes called the 'fragmentation' of external support (MISAU, 2020).

However, the past separation of PES and OE and the roles played by MISAU on one hand, and MEF on the other, have also contributed to fragmentation. Not only the formal PPB rules affected how external resources were allocated and accounted for, but sometimes also the often antagonistic relations between MISAU and MEF. In principle, the two ministries have different functions. MEF has a say on how and when funds are channelled, whereas MISAU decides on what the funds are used for.

In reality, these relations can be seen as key determinants for the smooth - or not so smooth - flow of funds from external sources to the health sector. In line with the SWAp principle of alignment with national systems (see sections 4.2.1 and 4.2.2), external funding for any sector should be reflected in the government's annual plans and budgets and be delivered on-CUT, and thus traceable. As a precondition, this requires channelling aid on-budget, on-CUT via e-sistafe. However, this is not the case for all funding inflows. In its analysis of the 2019 general state accounts[66] the Administrative Court (TA) [67], whose Section 3 is the government's supreme audit institution, states that 63.8 % of aid inflows ('external investment') i.e. almost two thirds, are off-CUT, 'in violation of' the principle of 'unity of the treasury'[68]. The health sector is no exception, although it is not easy to establish the exact on-CUT vs off-CUT funding percentages in order to validate them such that they are publicly known. A large part of US support to the health sector is delivered off-CUT (see section 3.2) and there is also reason to believe that the recent considerable EU support for anti-Covid 19 measures to MISAU has been channelled off-budget[69].

With the exception of PEPFAR support, the off-CUT preference, in fact, appears to often result from a choice by MISAU. Why? According to a key informant in MEF[70], as MISAU (and other sector ministries) often have to co-finance commitments and action plans agreed with partners, they try to avoid the time-consuming bureaucratic procedures involved in the on-CUT modality, particularly compliance with established procurement norms of competitive bidding. In other words, they see the off-CUT modality as a shortcut to funding and a way of avoiding stringent and time-consuming procurement rules. The other reason for preferring the 'shortcut approach' is to avoid being 'held hostage' by MEF's spending priorities under situations of severe fiscal constraints and lack of financial resources for what MEF considers priority expenditure, such as civil service salaries or expenses for ongoing security operations in Cabo Delgado. Since MEF needs to address and manage several budgetary functions - stabilizing the economy, allocating and distributing public resources - its spending priorities tend to be substantially different to those of MISAU that is 'only' interested in the timely allocation of funds negotiated with donors, but not disbursed in a timely manner. This dilemma arises even in the 'on-CUT' external funding modality when the National Directorate of Treasury (DNT)[71] faces a mismatch between, on the one hand, the

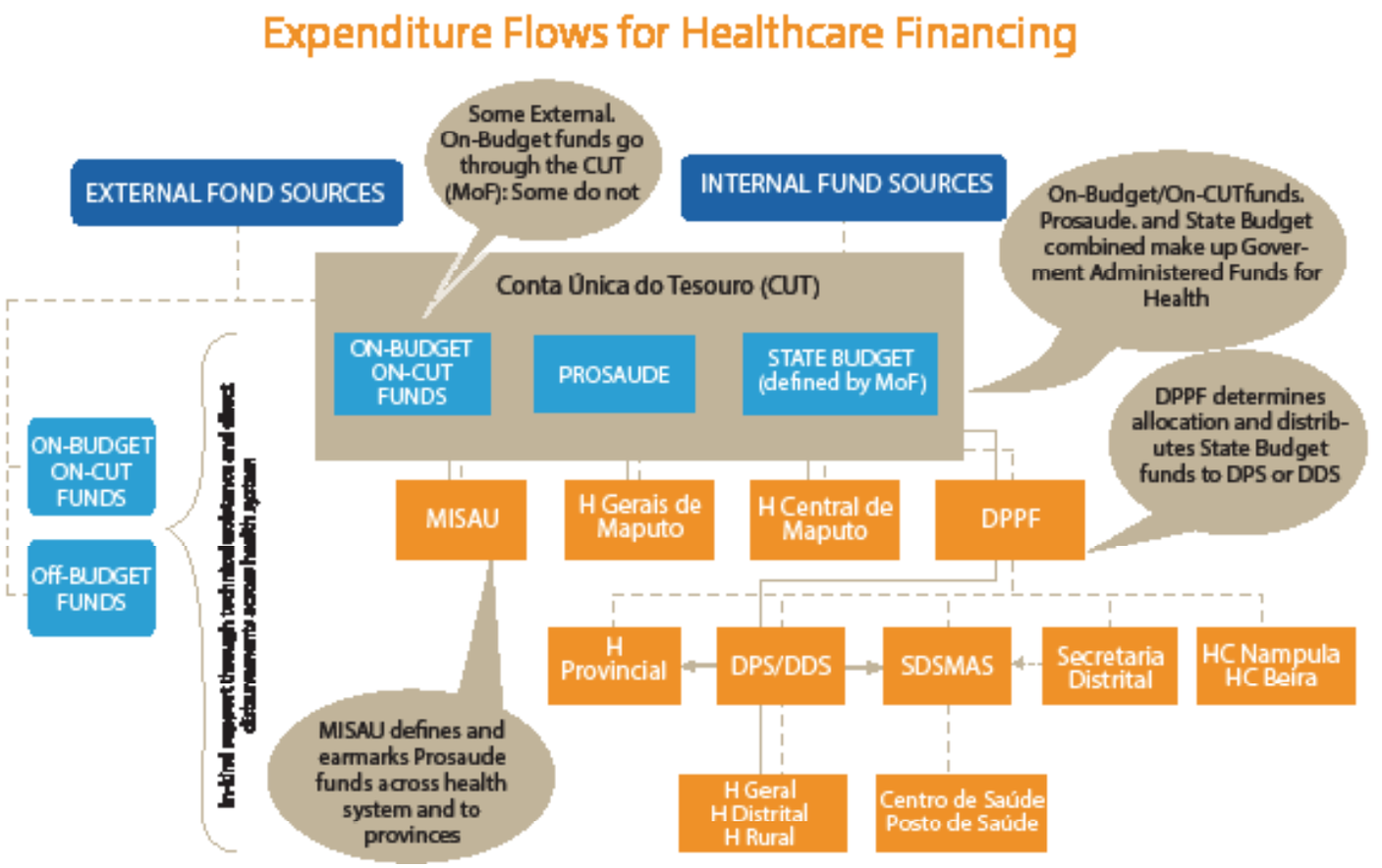
61. Programa Quinquenal do Governo (PQG)
62. Cenário Fiscal de Medio Prazo (CFMP)
63. Plano Económico Social (PES)
64. Orçamento de Estado (OE)
65. Plano Económico Social e Orçamento (PESO)
66. Conta Geral do Estado (CGE)
67. Tribunal Administrativo (TA)
68. The Administrative Court considers public debt over limits. cited by Club of Mozambique, 18 November 2021. https://clubofmozambique.com/news/mozambique-administrative-tribunal-considers-public-debt-over-limits-204909/?utm_source=The+Mozambican+Investor_&utm_campaign=424e3e5061-EMAIL_CAMPAIGN_2017_05_25_COPY_01&utm_medium=email&utm_term=0_d3b369a42d-424e3e5061-237799545
69. K14, 15/11/2021
70. KI 15, 19/11/2021
71. Direcção Nacional de Tesouro (DNT)

timely availability of domestic fiscal resources of domestic (tax) revenue and on external origins and, on the other hand, MEF's expenditure commitments. These factors may explain the frequent and often substantial delays in allocating and disbursing funds for health sector programmes (on-CUT), as reported by KIs in MISAU and in the health partner community[72] and which affects, in particular, primary healthcare at district level during the first months of each fiscal year.

As will be seen in section 3.3, PROSAÚDE has found a practical way, within the health sector to, at least partially, resolve the scarcity of funding for district health institutions cause by delayed budget disbursements in the early months of each fiscal year. Nevertheless, a more systemic solution to the problem would lie in a joint MISAU/MEF alignment of spending priorities whereby financial allocations to the health sector, and particularly for district primary healthcare would receive the same high priority as spending on salaries and security[73]. To safeguard, in the health sector, the principle of 'unity of the treasury' stressed by the TA, the establishment of clear and transparent criteria for using the off-CUT funding avenue should be defined, as an exception from the rule which requires external financing to be channelled on plan, on budget and on-CUT.

From the point of view of national budget cycles management and reporting the complexity of health sector financing is reflected in Figure 3 below.

Figure 3: Resources Flow in the Health Sector - Schematic



Source: MISAU (2015): 4 (Figure 1).

72. KI7, 13/10; KI 12, 01/11; KI 14, 15/11, KI 1, 19/11/2021

73. KI 15, 19/11/2021

2.5. Reporting

When reporting on total external funding to the sector, and also for transparency and accountability purposes, MISAU faces the challenge of capturing the flow of funds resulting from different financing modalities and by-passing the rules of the game via off-CUT modalities. The main instruments available to meet these challenges are the following:

- Various standard e-sistafe reports, generated weekly;
- The annual and quarterly Budget Execution Reports (REO)[74] produced by e-sistafe;
- The annual External Funds Surveys (IFE[75]) conducted by MISAU;
- National Health Accounts (NHA), also produced by MISAU from time to time.
- Annual State Accounts (CGE[76]), produced by the Supreme Audit body, the AT.

Each of these instruments has its own advantages and disadvantages.

Of the many standard e-sistafe reports the following are essential for analysing budget execution:

- The Consolidated Statement (DC)77 that includes budget and execution per BMU, function, programme, resource code and Economic Expenditure Classifier (CED)[78].
- Financial Flow (FF)[79] that includes information on the opening on-CUT balance, funds received, execution by implementing unit and closing balance. (available for CUT MZN and CUT USD).
- Payments Made[80] –a list of all individual transactions for the period. The report includes date, Payment Order (OP)[81] the classification code the amount, CED, beneficiary, etc.

The Budget Execution Report (REO) is considered the main instrument for reporting on what funding, by source, the health sector uses annually and for tracking the sector's financial evolution. It permits an assessment of spending by government and donors providing on-budget support (on-CUT or off-CUT), broken down by institution and geographical unit. For example, REO makes it possible to see which provincial and district units, e.g. by District Services for of Health, Women and Social Welfare (SDSMAS[82]), usually have a higher budget execution rate than central government units. However, REO has the disadvantage that it is not able to provide information about the purpose and results of the funds executed and thus, is unable to contribute to the performance-based funding approach promoted by GFF. It also cannot gauge whether the expenditure is producing 'value for money'[83]. Nor does it provide explanations for changes (increases/decreases) in budget execution levels (MISAU, 2020). And, for obvious reasons, it cannot track off-budget spending, which, as we have seen, makes up a considerable part of external financing. According to an official in MISAU's DPC, it would be ideal for gauging both impact and management performance if the annual REO could be dovetailed or aligned with MISAU's annual sectoral balance report[84].

According to the MTE of PESS (MISAU, 2019), for the time being the External Funds Survey (IFE)[85] is a good complementary instrument for assessing the evolution and trends financial dependence on external funds and for assessing financial gaps between the budget (on-budget) and the real costs (on-budget + off-budget) of delivering health services. However, it is said to be an inadequate instrument for fully capturing information on external 'on-budget' but 'off-CUT' flows to the sector. The main reason is that donors are not always obliged to provide budget execution reports in the form of quarterly balance sheets to the National Directorate of Public Accounts (DNCP[86]).

The figures provided include indirect costs (overheads, administrative costs), which makes it difficult to gauge the net value of support to the SNS. Furthermore, IFE does not permit the quality of disaggregation typical for REO. As such, it is of limited use for assessing progress in PESS implementation against objectives and planned action.

74. Relatorio de Execução do Orçamento (REO)
75. Inquérito de Fundos Externos (IFE)
76. Conta Geral do Estado (CGE)
77. Demonstrativo Consolidado (DC)
78. Classificador Económico da Despesa (CED)
79. Fluxo Financeiro (FF)
80. Pagamentos Efectuados (PE)
81. Ordem de Pagamento (OP)

82. Serviço Distrital de Saúde, Mulher e Acção Social (SDSMAS)
83. In the view of KI 16, the problem is not the REO as such. If the programmatic classifier is properly designed and implemented, REO can also report on this. It is up to the MEF to decide what to include in the REO (KI, 16, 12/11/2021).
84. KI 17, 26/04/2022. For an example of this type of report, see MISAU, 2021c.
85. Inquérito de Fundos Externos (IFE)
86. Direcção Nacional de Contabilidade Publica (DNCP)

The National Health Accounts (NHA) provide a comprehensive framework for measuring the total volume of expenditure and tracking the flow of funds in a country's health system. The input/output tables provide comprehensive country-level information on the generation, allocation and utilization of health system resources. They chart the flow of actual expenditure on health from different financing sources (e.g. donors, MEF) to funding beneficiaries such as MISAU, and other implementing partners. Furthermore, they 'break down expenditure by end-user, the providers who delivered the service and the population sub-groups who benefited' (MISAU, 2015).

As they are much more than a resource-tracking tool, the NHA would be a useful instrument for the elaboration of a health financing strategy because they can answer essential questions, including who pays for healthcare, how much and for what services. This would allow national decision-makers to prioritize funds, design policies that promote a more sustainable, equitable, and efficient allocation of resources and provide the necessary evidence base to implement policies aimed at easing the household financial burden on health, and guide government in adjusting its health sector investments in response to inflows of external assistance (MISAU, 2015). Their disadvantage is that they are not an annual tool and require a major investment in terms of funding and human resource commitment. Furthermore, there are doubts about the veracity and reliability of the national health accounts data, even among MISAU technical staff [87].

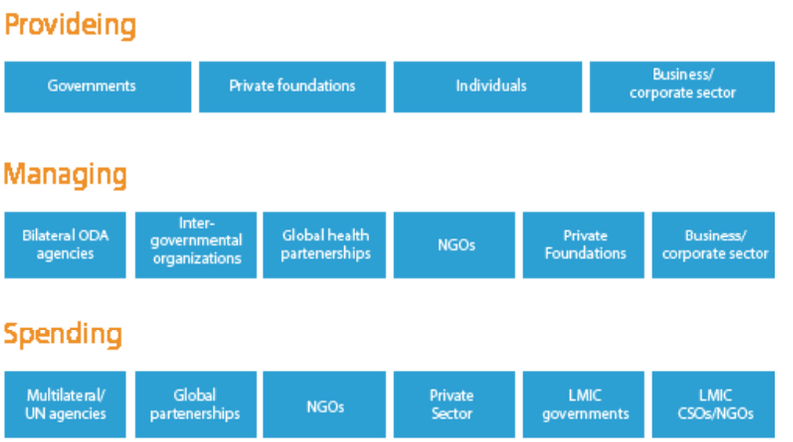
At present it is unclear to what extent these reporting tools can be aligned with each other.

2.6 Global Health Sector Financing Initiatives – an Analytical Overview

Universal health coverage (UHC) is defined by the World Health Organization (WHO) as ensuring that all people have access to promotive, preventive, curative and rehabilitative health services of quality, when and where they need them, without financial hardship. UHC is related to the concept of health system strengthening (HSS) in which robust financing structures for health services are key. Both UHC and HSS are reflected in the 2030 Sustainable Development Goals (SDGs) subscribed to by all UN member states, including Mozambique, in 2015[88].

There are many global initiatives, networks and agencies seeking to support UHC actively and financially, as well as health sector strengthening. Some of those supporting the SNS are described in Chapter 3. Figure 4 gives a systematic, analytical overview of the type and functions of these agencies.

Figure 4: Schematic of the Global Health Financing Landscape



Source: McCoy et al., 2009: Figure 1

While the functional distinction between providers, managers and spenders of funds for HSS is an analytical one, the realty in a given country such as Mozambique is much more complex as, for most programmes, the above functions may overlap. This is certainly true in the case of PROSAÚDE and the vertical GF, GAVI programmes and of GFF that are involved, simultaneously, in providing, managing and spending money in the health sector. The illustration above makes it clear that in this complex network of actors where management and spending sometimes coincide in the same cluster of funding sources. The national governments in LMICs, and certainly in Mozambique, play a dominant role, amongst many other actors, in providing budgetary resources as well as managing and spending them.

The picture gets even more complex with the inclusion of cross-sectoral initiatives or networks that support not just the health sector. One of them is the WHO (Geneva)-based Partnership for Health Financing (P4H) network, which considers itself to be the only global institutional network specialized in health financing with a combined approach that includes health, social protection and public finance. According to its website[89],

87. KI 13, 11/11/2021
88. See: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
89. https://p4h.world/index.php/en/who

it currently has 18 members[90]. The P4H network aims to connect institutions involved in health financing in order to promote inter-institutional dialogue, exchange of experiences, sharing data and expertise, knowledge and actions, thereby triggering 'operational collaboration to improve the efficiency of health spending and promote financial risk protection for health to those who need it the most'. In this case, too, the functional boundaries between funds providers, managers and spenders becomes blurred.

From a long-term perspective, taking into account both domestically generated resources and the effects of resource mobilisation by global health financing initiatives, a study covering the years 1995-2015 concluded that:

> 'Financing for global health has increased steadily over the past two decades and is projected to continue increasing in the future, although at a slower pace of growth and with persistent disparities in per-capita health spending between countries. Many low-income countries are expected to remain dependent on development assistance, although with greater government spending, larger investments in health are feasible. In the absence of sustained new investments in health, increasing efficiency in health spending is essential to meet global health targets' (Chang et al., 2019: Summary).

Another study, a literature review with a focus on Sub-Saharan Africa (SSA), concludes that more innovative health financing approaches are needed to bridge the gap between required and available (domestic and external) resources for achieving universal health coverage in SSA countries (Ifeagwu et al., 2021). The World Bank's business branch, the International Finance Corporation (IFC) claims that such innovative approaches also must include private sector business investment in healthcare (IFC, 2008).

2.7. Towards Health Sector Reform

MISAU's PESS 2014-2019, extended to cover another five years up to 2024, provides the framework for the reform of the health sector, aimed at broadening and deepening the SNS. It features decentralization as one of its two strategic pillars (Pillar II). Pillar I focuses on improving the quality and efficiency of health services. A reform unit has been established for these purposes but, as acknowledged by the PESS 2014-2019 MTE, 'structural aspects related to ... the deepening of decentralization processes have yet to materialize' (MISAU, 2019:14[91]). The Reform Unit and MISAU are also said to have largely missed the opportunity to contribute their own ideas and conceptual thinking to the drafting of legislation for the new decentralization paradigm driven by MAEFP, and to some extent by MEF. This initiative, driven by an elite settlement between Frelimo and the Renamo party (in the form of a partial constitutional reform that creates decentralized provincial governments with a certain degree of autonomy) has overtaken MISAU's slowly forthcoming reform initiative.

Responsibility for primary healthcare is now formally in the hands of the OGDP (Law 1/2018, Art. 270 J). It is limited to primary healthcare (PHC)[92], which includes the approximately 1,500 rural health posts outside municipal areas. However, the division of functions between the Provincial Directorate of Health (DPS)[93] in the Provincial Executive Councils (CEP)[94] under the elected Provincial Governor and the Provincial Health Services (SPS)[95] under the Representation of the Central State in the Province (REP)[96] is not clear-cut and has created cleavages and competition over power and scarce resources, a major source of concern for both senior MISAU officials and international health partners. Both warn of the risk of the sector's fragmentation at provincial level[97].

PROSAÚDE partners, in particular, on whose crucial support MISAU increasingly depends for health financing at sub-provincial level, have long argued in favour of the sector's reform, with a focus on decentralization and have signalled continued support (see section 3.3). Mozambican NGOs have also contributed to the debate, with a focus on health sector strengthening and financing at community health level (N'weti, 2021). A decentralization reform agenda would lead to a reappraisal of current spending patterns, based on a paradigm and strategy of significantly expanding primary healthcare and the assumption that donors would contribute to gap financing in the event of underfunding of the sector98.

Other issues to be considered in a MISAU-driven health sector reform agenda include:

90. The major bilateral agencies include the French Ministry of Europe and International Affairs (MEAE), the Swiss Agency for Development Cooperation (SDC), the Spanish Agency for international Cooperation (AECI), the German Federal Ministry of Economic Cooperation and Development (BMZ) and the US Agency for International Development (USAID) whereas P4H also has multilateral agency members such as ILO, WB and WHO, ABD, ABfD as well as the GF, GAVI and GFF. See: https://p4h.world/index.php/en/content/why-p4h

91. Translation from Portuguese by author
92. Cuidados de Saúde Primários (CSP)
93. Direcção Provincial de Saúde (DPS)
94. Conselho Executivo Provincial (CEP)
95. Serviços Provinciais de Saúde (SPS)
96. Representação do Estado na Provincia (REP)
97. KI 6, 30/09; KI 13/01/11/2021. See also: Weimer (2021).
98. opinion expressed by the representative of a PROSAÚDE funding agency to the author, Maputo 19/05/2021.

- Addressing the unequal geographical distribution of health expenditure, which partially results from an incremental budgeting approach that does not take into account the real cost of providing health services;
- Using a formula for budget needs-based allocations and vertical and horizontal distribution of PHC expenditure;
- The structural bias of budgeting towards recurrent expenditure and salaries, at the cost of investment;
- The economic and public health impact of the Covid 19 pandemic; addressing technical and governance 'bottlenecks' that impact negatively on the efficiency of the health sector;
- Addressing health financing and financial management through a heath sector financing strategy, among others.

Regarding the last item, the reform-oriented PESS 2014-2019 established three main objectives:

a) Increasing financing and the use of own budgetary resources for wider access to quality basic health services.

b) Reforming and restructuring the Directorate of Administration and Finance (DAF) in MISAU to improve economic and financial management;

c) Improving the staff hiring process and reducing single-handed procurement acquisitions outside the established plan by 80%.

To achieve these goals, a series of strategic actions for financing and financial management are defined that include, among others: i) the elaboration of a health sector financing strategy (HSFS), ii) the organizational restructuring and capacity building of units responsible for budget management and accounting at central and provincial levels; iii) the operationalization of e-sistafe in various key SNS units e.g. CMAM, ICS, INS, and in provincial, rural and district hospitals, and v) improving procurement mechanisms and monitoring processes in SNS procurement units (UGEA)[99].

As will be seen in section 4.4., there has not been much progress to date and the health sector financing strategy, although drafted, has not yet been approved at the time of writing.

2.8. Conclusions

Summing up on health financing:

- Health expenditure, funded by both external and domestic sources, is biased towards central government to the detriment of health units at subnational levels of the SNS and their needs, and contrary to the objectives of the sector decentralization defined in PESS.
- Although, by 2019/20, government sources (i.e. revenue from taxation) had become the main source of funds for the health budget, the budget contribution as a proportion of both the state budget and GDP is declining. Health financing will continue to depend on external funding that, according to long-term trends, may not be as forthcoming as expected.
- The presence of many actors in the health sector, with different approaches, resource endowments, funding modalities and overlapping functions as providers, managers and spenders of funds, creates a high degree of complexity, in which government (MISAU) is but one actor among many, and not necessarily the one with the most leverage.
- The resulting fragmentation is exacerbated by the fact that key government institutions in health financing, MISAU and MEF, do not necessarily apply the rules established for the PPB processes and their management.
- There are separate reporting tools to track funding and expenditure, each with different qualities and, advantages and disadvantages. It is unclear to what extent these can be aligned.
- Health financing outcomes will also be affected by the dynamics of privatization of the health sector, the formal and informal ways of resolving conflicts and competition among political and economic stakeholders and the way major challenges for the health sector arising from the ongoing decentralization reform are addressed.
- The ambitious PESS goals for health financing reform have only been partially addressed through rudimentary, partial action, with no approval of a financing strategy as yet.

99. Unidades Gestoras Executoras de Aquisições (UGEAs)

3. EXTERNAL HEALTH SECTOR FINANCING FOR MOZAMBIQUE – CASE STUDIES

3.1. Introduction

The case studies presented here reflect the complexity of the aid architecture in the health sector. Its main features have been succinctly described by Guambe et al. (2018), who also present their readers with case studies on PROSAÚDE and GFF. The recent verticalization of programmes poses a major challenge, not only for government and the SNS as a whole, but also for Mozambique's international partners. They wish to develop and improve the performance of the SNS through their financial, technical and material support, including for a higher degree of decentralization to boost quality health service provision at district level, particularly in remoter and hitherto neglected areas. However, instead of transmitting a strong message of consolidation of the SNS and harmonizing external support, the PESS MTE alerts to the risk of fragmentation, especially when it comes to health financing.

In line with the TOR, this section analyses four externally financed health support programmes and their funding modalities: PROSAÚDE, GF, GAVI and GFF. Other forms of support to the SNS, such as through WB-financed IBRD funded programmes, or the USAID support, are not or only cursorily considered in this study. The same is true for individual programmes of PROSAÚDE members such as Ireland, Italy and Switzerland, which complement their support via the CF through individual programmes and projects delivered on-CUT[100]. Excluded are also partnerships between MISAU/ selected health units and foreign NGOs of a humanitarian or religious nature.

Although not required by the TOR, and for illustration purposes rather than analysis, section 3.2 sheds some light on US government support for the health sector, with a focus on the President's Emergency Plan for AIDS Relief (PEPFAR). The reasons for doing so are four-fold. Firstly, the total gross volume of US support to the Mozambican health sector is estimated to be equivalent to 50% or more of total health expenditure in Mozambique[101]. In the words of an official of the United States Agency for International Development (USAID), PEPFAR represents the 'elephant in the room'[102]. Secondly, unlike the other cases, this stand-alone programme is not aligned with Mozambican health financing, its rules and practices. The US planning cycle and fiscal year are fundamentally different from those in Mozambique. Thirdly, as the US is the major contributor to the Washington-based WB, there is some degree of affinity between the latter's legal and administrative organizational culture (including rules and practices) and those of the US administration. Given the WB's growing role in health financing, particularly via Trust Funds (TFs), the 'American influence' is, willingly or unwillingly, also felt in US co-financed health support programmes and the health sectors in the recipient countries.

Each of the following subsection (with the exception of the first one) is structured in the same way: firstly, the key features of each programme, followed by an assessment of relations with MISAU, with a focus on funding and the perceptions of key informants (within MISAU, funding partners and health consultants) and there is a concluding section highlighting challenges and perspectives.

3.2. US Support to Mozambique's Health Sector – The Case of PEPFAR

3.2.1. Introduction

In a very simple way, the MTR-PESS (MISAU, 2019: 158) explains that the contribution of the US government, implemented through various channels and partners, is only vaguely known, as are the budgets implemented by the various US-financed contractors and subcontractors. Since most US support is off-budget and thus off-CUT, it is difficult to trace. The US funding is part of the so-called vertical programmes that do not directly fund the health sector as a whole but target specific purposes such as fighting defined epidemic diseases such as HIV/AIDS. These funding modalities account for between one third to half of annual total expenditure in the Mozambican health sector, with PEPFAR being the

100. See annex 6.4.
101. N'weti estimates that up to 62% of total health expenditure in Mozambique comes from US sources. (See: N'weti's TOR for this study).
102. KI 5, 24/09/2021

largest vertical programme (PEPFAR, 2020). In other words, it is difficult to quantify the US contribution and to estimate the actual running and opportunity costs incurred by US-financed vertical programmes in the health sector. A recent assessment of the human resources benefitting from PEPFAR funding estimates that the programme currently finances approximately 31,000 people in the health sector. Approximately 27,000 of them are working with US-based NGOs notably at health facility level, and mainly consist of community/ancillary health workers (peer educators, lay staff, etc.). these are funded off-CUT and not accounted for in national health worker statistics. Of these 27,000, some 1,000 persons are clinical staff (nurses, doctors, técnicos de medicina, etc.[103]).

In an unlikely worst-case scenario, the Mozambican government would not know the dimension and impact of the avalanche that would hit the SNS, should the US, for whatever reason, withdraw or substantially reduce its financing for the sector.

Globally in 2019, the US was by far the leading DAC funder for health, in terms of both volume (indirect multilateral and bilateral programmes amounting to US$ 8,1 billion) and the relative weight of the health sector in total ODA (24%)[104]. PEPFAR includes both US bilateral funding for HIV/AIDS as well as US contributions to UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM/GF) through regular appropriations. The US is the single largest donor to GFATM/GF. Appropriations for its contribution to the Global Fund totalled some US$24.6 billion from FY 2001 through FY 2021. The Global Fund provides another mechanism for US support by funding programmes developed by recipient countries, reaching a broader range of countries, and supporting TB, malaria, and health systems strengthening (HSS) programmes in addition to (and beyond their linkage with) HIV.

The following section sheds some light on the key features of US government support to the health sector, addressing the possibility of better aligning its support with Mozambican financial management tools and highlighting the policy implications for Mozambique.

3.2.2. Key Features[105]

Most of the US support globally to health and fighting disease is part of the annual budget appropriation process, which involves the federal government and parliament (Senate and Congress) in Washington D.C. Funding for direct bilateral support is allocated to various agencies of the US public administration, such as USAID, Department of Health and Human Services (HHS), Department of Defence (DOD), Centres for Disease Control and Prevention (CDC), US embassies and Peace Corps, and targets specific programmes. The annual budget planning and appropriation process also includes funding for presidential initiatives in support of the global fight against the spread of HIV/AIDS via PEPFAR, launched by President Bush in 2003. Supervised by the Global AIDS Coordinator in the US Department of State and administered via US agencies, since it started this programme has globally spent some US$ 90 billion. PEPFAR funding for HIV/AIDS treatment, prevention and research administrated via US agencies, making it the largest global vertical health programme in history focused on a single disease, until the Covid 19 crisis. It absorbs a considerable share of annual budget appropriations for bilateral health support, and is showcased as a prime example of 'the American people's generosity' and the 'power of what is possible through compassionate, cost-effective, accountable, and transparent American foreign assistance'[106]. Another presidential initiative funded the annual budget appropriations is the US President's Malaria Initiative (PMI) which, since 2005 has focussed particularly on Sub-Saharan Africa.

US resources are earmarked for multilateral support and benefit GFATM/GF where PEPFAR is the most important contributor, GAVI (via USAID), the World Bank, GFF and the global COVAX initiative driven by the Coalition for Epidemic Preparedness Innovations (CEPI), GAVI, WHO and UNICEF. The programme aims to contain the spread of the Covid 19 through supplies of vaccines to countries in the global South with limited procurement and production capacities.

The process of mobilizing, planning, programming and budgeting for bilateral US support is highly centralized and bureaucratic and corresponds to American legal norms and procedures governing the annual fiscal cycle, which runs from 1 October to 30 September. These are epitomized by voluminous annual planning guidelines and require an annual Country Operational Plan (COP) for the receiving country to become operational. Furthermore, the planning, elaboration

103. KI 5, written communication, 03/03/2022.
104. https://donortracker.org/sector/global-health

105. The following considerations are to a large extent based on an interview with KI 5, 24/09/2021.
106. https://www.hiv.gov/federal-response/pepfar-global-aids/pepfar

and monitoring of all specific health programmes defined in the COP require annual consultations with MISAU, and meetings among the partners (USAID, MISAU, health related NGOs, Instituto Nacional de Saúde (INS)) to set and agree upon priorities, budgets and implementation modalities. The planning process usually takes place in April and May each year. The national partners are required to prepare and propose a workplan as the basis for the operationalization of the COP. Following the laborious and time-consuming planning process and, in the case of AIDS programmes, vetting by the Office of the Global AIDS Coordinator, the planned and negotiated packages become part of the US annual bilateral support for the health sector, approved and legislated by the US parliament. Only thereafter, can funds be released.

The strict adherence to the US 'rules of the game' has additional implications, including:

- Resources allocated for a specific purpose or programme usually cannot be used for others, funding is hardly fungible;
- Different types of US funding have different degrees of fungibility. In most cases funds not spent during the fiscal year cannot be carried forward to the next period and are lost or subtracted from new allocations;
- Regarding the purchase of goods and supplies (medicines, laboratory equipment, contraceptives, etc.) US government rules stipulate pool procurement via a tender in the US. The winner[107] is awarded a multi-million contract for between 5 to 10 years and thus holds a monopoly in the procurement of US-financed supplies.
- Programmes are implemented though contractors involving prime contractors and subcontractors – with the latter implementing parts of a prime contractor's programme. Prime contractors can be US-based entities (such as universities), international organizations such as UNICEF and IOM, but also national entities such as MISAU, the Ministry of Gender, Children and Social Welfare[108] (MGCAS) as well as NGOs such as N'weti. Individual health units, provincial, district or municipal governments may be procured as sub-contractors[109]. All contractors are chosen based on capacity assessments conducted by US agencies such as USAID. The threshold for selecting international and government institutions as programme implementing partners is lower than in other cases. However, there is growing pressure to increase the partner mix away from a focus on government in favour of local organizations, both for-profit and non-profit. This trend is illustrated by the fact that PEPFAR has approved for 2021 what is referred to as a People's COP (PEPFAR 2020a).
- The annual budget also includes the funding of positions to implement the programmes. In 2020 a total of 201 positions for PEPFAR Mozambique implementing agencies were foreseen in its COP 2020 (PEPFAR, 2020).
- Conditions, or rather, performance criteria attached if the PEPFAR Minimum Requirements are interpreted as such.

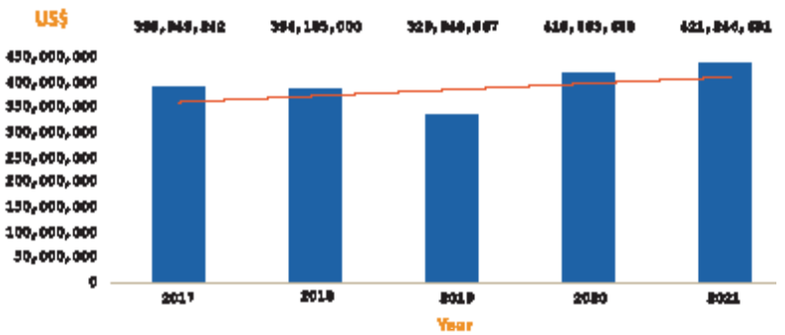
3.2.3. Relationship with MISAU and Funding

Without doubt the US government financed support is of major importance to the SNS, particularly in the field of HIV/AIDS treatment and prevention. PEPFAR is a major and reliable partner on which MISAU is almost entirely dependent for funding for HIV/AIDS prevention and treatment, together with the GF, which also receives PEPFAR funding for the same purpose. This is particularly true when it comes to clinical and community-based care, treatment and prevention and the prevention of mother-to-child transmission (PMTCT), surveys and surveillance in which the two vertical programmes finance up to 90% of the required annual investment (PEPFAR, 2020: 22). The same is true for the procurement of essential commodities such as antiretrovirals (ARV), rapid test kits and laboratory reagents.

The figure below gives the annual average spending on Mozambique by PEPFAR, which averaged US$ 392.6 million a year over the period 2017-2021.

107. At the moment the consulting company Chemonics is the contractor for pooled procurement in Mozambique
108. Ministério de Género, Criança e Acção Social (MGCAS)
109. See, for example, for the year 2020, PEPFAR (2020). Appendix C

Figure 5: PEPFAR annual budget, 2017-2021 (in US$)



Source: author, based on PEPFAR, COP, various years.

Note: the amount for 2017 includes 'central spending' of US$ 36.3 million

Also not considered in this figure is US funding for the other health areas such as PF (US$ 40 million), TB (US$ 20 million), Nutrition (US$ 20 million) among other areas. Further, this figure excludes potential additional funds emanating from the American Rescue Plan Act (ARPA), which aims to protect PEPFAR gains from Covid 19 through ARPA funds estimated at US$ 20 million for 2021, for prevention, mitigation and repair (PEPFAR, 2021a). The total annual amount the US Government contributes to the Mozambican health sector is approximately US$ 600 million.

3.2.4 Conclusions

This brief description of the PEPFAR approach shows that the US, through PEPFAR and other programmes, has a major role in addressing HIV/AIDS and financing corresponding programmes, a role on which MISAU is crucially dependent, without being able to exert much leverage. The main reasons are:

- The sheer volume of funding available, which may exceed more than half the annual SNS health expenditure;
- The planning/programming/budgeting system which is highly centralized with the strong political weight and policy decision-making power of the White House and the US Congress, and which follows exclusively the American budgetary and legislative framework and fiscal year;
- The prevalence of US strategic and policy interests beyond the health sector, which puts MISAU's strategic interests, expressed in PESS, at the margin of health finance support to Mozambique;
- The designation of the Mozambican government as a prime contractor, among others, NGOs universities, etc., could challenge the government's understanding of its role as representative of a sovereign state;
- The fact that all contractors, primary and secondary, have to undertake more or less the same laborious, time consuming and highly bureaucratic procedures prescribed for elaborating an annual COP, the planning guidelines which comprise a document of some 400 pages[110] written in a technical language that is difficult to understand for non-American English speakers. It is only through this process that MISAU has a limited choice to shape PEPFAR support in line with the PESS priorities;
- The fact that the government may not know the net value of PEPFAR support to Mozambique, given that it is difficult to assess the overheads (running costs, salaries, etc.) and, in the case of companies, the profit margins contractors charge for implementing the COP and procuring goods and services.

These conclusions suggest that MISAU has little choice and leverage to shape US PEPFAR support to its needs. This does not mean, however, that MISAU has no room to manoeuvre to generate benefits from PEPFAR and other US-financed programmes for the SNS and HSF. According to one key informant familiar with US support for the health sector, in order to take advantage of that space, a better understanding of the US 'rules of the game' is required in order to detect and use opportunities for negotiating complementary US support in line with Mozambique's own priorities. These are important conclusions also relevant for other programmes, and this topic is revisited in section 5.1.

110. KI 5, 24/09/2021

3.3. PROSAÚDE

3.3.1. Key Features

PROSAÚDE is a basket fund developed by a group of donors from 2002 onwards, based on a health sector SWAp that emerged in the late 1990s, with the 'rules of the game' defined by the Kaya Kwanga Code of Conduct agreed upon by all external funders and Government in 2003. In its formative years PROSAÚDE was also strongly influenced by the principles of the emerging Paris Agenda for Aid Effectiveness (OECD, 2005) and the subsequent Accra and Busan declarations (see section 4.2.1). At the time, the SWAp-based PROSAÚDE with its common funding pool attempted to replace a plethora of individual, discrete donor driven health support projects with a better coordinated and harmonized approach that considered the whole SNS (and not just areas of interest to a specific donor). Typically for the Paris Declaration agenda, PROSAÚDE donors also put the 'government in the driver's seat' for planning and management and encouraged external partners to increasingly use national PFM systems and (mutual) accountability procedures based on improved coordination. From the late 1990s onwards, the initiative was driven by a small group of donors informally led by SDC, before MISAU took over leadership, initially hesitantly. And it eventually got dovetailed with the new institutional aid architecture established in support of PARPA, with a focus on aid effectiveness, although it maintained its sectoral perspective and sector budget support approach (see section 4 4.2.).

Through its various phases PROSAÚDE (I-III) has been supporting areas of interventions and activities defined in the National Health Strategic Plans 2008-2014 and 2014-2019[111] with the goal of strengthening the state's ability to manage its healthcare system. This includes regular monitoring of progress of the various activities, and mechanisms for regular dialogue between donors and government through a formally established coordination system (see section 4.2.3). In a nutshell, PROSAÚDE had, in principle, all the necessary ingredients to meet the requirements for a modern health sector support according to the SWAp and Paris Declaration 'textbooks', although some building blocks were, and still are, in need of improvement, such as the health information and management system, and the introduction of performance-based financing (PBF), which have not been tackled with rigour so far. PROSAÚDE was also innovative and successful in introducing the pool financing modality through its Common Fund (CF), adhered to by a growing number of donors in order to increase aid effectiveness through alignment, better coordination and economies of scale. Initially, three common funds were established: the main CF (PROSAÚDEI), a provincial CF and a CF for drug acquisition. At some stage, even the pooling of Technical Assistance (TA) found its way into the reform agenda (Pavignani & Hauck,2002), but then disappeared again.

PROSAÚDE started in 2003 with nine partners[112] and rose to 15 in PROSAÚDE II[113]. From 2017 onwards, this number fell to five external partners (Italy, Ireland, Spain, Switzerland and UNICEF).

PROSAÚDE has operated in phases. The first phase, PROSAÚDE I, running from 2003 to 2008, saw the institutionalization of its key features and operating mechanism, including the establishment of the CF. According to advisors at the time (Pavignani & Durão, 1999) this process was not linear and used trial and error to consolidate the SWAp approach established in 2000. From 2008 to 2013 PROSAÚDE II became the one and only CF, through a merger of the three separate CFs of the previous phase. PROSAÚDE III represents a revised funding mechanism resulting from a thorough reform in 2015/16 and with a focus on decentralization. A Memorandum of Understanding (MoU) was signed in 2017 between MISAU and the PROSAÚDE partners[114]. The priorities were defined as:

- Primary Healthcare;
- Provision of maternal, newborn, child, nutrition, sexual and reproductive health services (including family planning), prioritizing primary and secondary levels;
- Support for systems to strengthen planning, budgeting and public finance management, human resources, procurement at all levels of government and reform of the SNS.
- Support for decentralization.

PROSAÚDE partners had argued for a long time in favour of reform of the sector, with a focus on primary healthcare and decentralization, in line with the priority pillars of PESS. The 2017 acceptance by MISAU of a vertical sharing formula for budget support to the sector, as part of the MoU,

111. Extended to 2024.

112. Canada, Denmark, European Commission, Finland, Ireland, The Netherlands, Switzerland, and UK.
113. In addition to the 'founding members' enumerated above, the Catalan Agency for Development Cooperation, Belgian Development Agency / Flanders, French Development Agency, Norway, Spain, United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) joined PROSAÚDE.
114. A good overview of the main differences between PROSAÚDE I, II and III is given by Guambe, et al. (2018): 44 (Table 3).

is symptomatic thereof. It was proposed by the PROSAÚDE donors, and its operation modalities specified in a procedural manual. It foresees that 20% of funding is allocated to the central level (MISAU) and 80% (now 85%) to the subnational levels (province and district). At subnational level, decision-making power over resource distribution is shared between provincial and district health authorities at a ratio of 20:80, respectively.

Due to a profound crisis in the late 2000s affecting the financing of the health sector (see section 4.2.1), PROSAÚDE partially lost its reputation as the flagship for an innovative, harmonized, effective and mutually accountable joint endeavour by government and the community of health donors. The crisis was triggered by an audit which brought to light misappropriation of funds (see section 3.4.2). In addition, a series of further audits revealed that senior staff in MISAU were paid substantial topping up of their government salaries[115]– a politically delicate matter as, at the same time, doctors and health staff were threatening a strike motivated by low salaries and irregular payments. The resulting profound 'crisis of confidence', acknowledged by various sources interviewed in MISAU and the donor community,[116] damaged MISAU's authority, reputation and leadership quality, of central importance to the successful reform of aid management processes. For donors to continue their support to the sector they needed to have assurance that agreed plans and expenditure programmes were consistently and correctly implemented and accounted for in an open and transparent way. In addition, in 2010/2011 'confrontations' between government and the Programme Aid Partners (PAP) arising from the annual review of PAP's direct budgets support (DBS) produced spillover effects in the health sector, thus exacerbating the crisis of confidence.

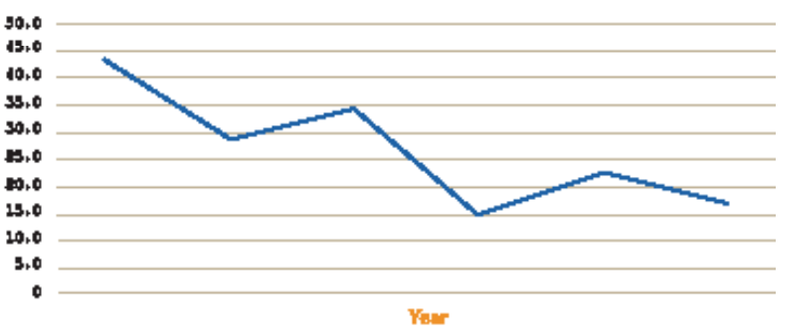
For these and other (domestic) reasons, there was a gradual withdrawal of some important PROSAÚDE donors such as the EU, UK's Department for International development (DFID[117]) and the Canadian Agency for International Development (CIDA), and their switch to other financing mechanism such as GFF in the latter two cases. There was a significant decline in PROSAÚDE financial support for the SNS (see Figure 6 below). Other PROSAÚDE donors such as Denmark, a long-standing supporter of the health sector (both within and outside of PROSAÚDE), exited from development cooperation with Mozambique altogether for political reasons, closing their embassy in Maputo in 2019. It cannot be excluded that other embassies running support programmes for the health sector may follow the Danish example. Some of the exiting agencies, the two aforementioned included, rallied behind the WB with its trust funds (TF) supporting the health sector, seeking to minimize fiduciary risks by using the WB's well reputed management capacity[118].

For example, looking at DFID's motives for exiting PROSAÚDE, an institutional analysis in 2015 flagged risks related to a) a lack of accountability and effective oversight by MISAU, b) the fragmentation of donor and financing modalities, resulting in a health management and governance structure in MISAU that had little control over spending and funds, and c) a serious drain of qualified personnel (management as well as operational) from the public health subsector to the private sector, the many NGOs working in vertical programmes and PEPFAR supported projects. Under such circumstances, DFID's preferred support focus on what is known as technical assistance, capacity building, and operations research (TACBOR) in MISAU, provinces and districts targeting community health and APE would be difficult to achieve, with the link between resources and results becoming blurred (Weimer, 2015). Consequently, it joined the MDTF set up under WB trusteeship within the PHCSP and GFF.

The loss of PROSAÚDE's relative weight in relation to the total external funding for investment in the health sector, is shown in Figure 6 below.

Looking forward, this trend may be reversed from 2021 onwards. PROSAÚDE donors such as Switzerland and Belgium have plans to increase their contributions, even if only marginally, and former HPs such as Canada might return into the PROSAÚDE fold[119].

Figure 6: PROSAÚDE investment funding's relative weight in relation to total external 'on-budget' support 2015-2020 (in %)



Source: Author, based on e-sistafe data that reflect the updated budget allocations

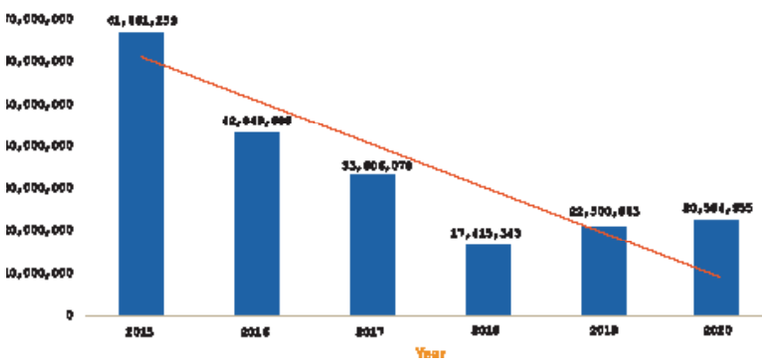
115. KI 6, 30/09/2021
116. KI 5, 24/09/2021, KI 6, 30/09/2021, KI 9, 26/10/2021, KI 13, 01/11/2021
117. now Foreign, Commonwealth and Development Office (FCDO)
118. KI 5, 24/09,2021 and KI 6, 30/09/2021
119. KI 14, 15/11/2021

3.3.2. Relationship with MISAU[120]

3.3.2.1. Funding

As s a result of the crisis and the exit of several donors, PROSAÚDE's annual contribution to the health investment budget declined, with the numbers given in Figure 7 below.

Figure 7: PROSAÚDE contribution to the health sector (updated allocation), 2015-2020 (in US$)



Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

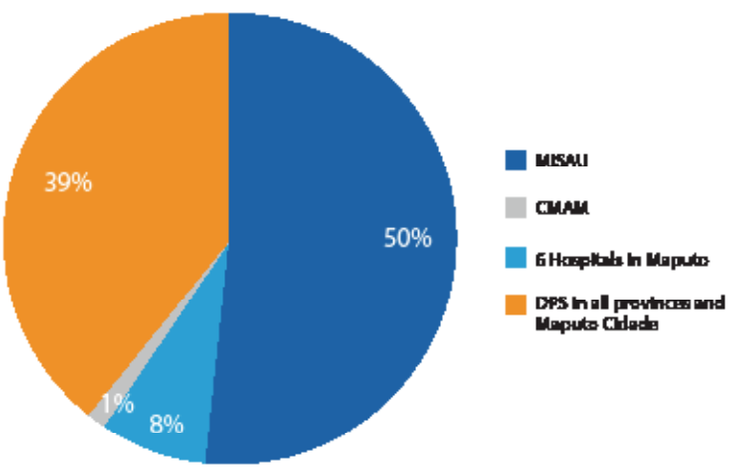
The average yearly investment spending via the PROSAÚDE CF was US$ 33.2 million. The programme's relative weight in all external funding for investment over the period 2015 to 2020 was around 27%.

Despite the decline of PROSAÚDE's overall contribution to the health sector up to 2020, the programme continues to be a decisive pillar of the SNS, particularly for SDSMAS and district health units because the government hardly allocates budget investment funds to districts and often disburses funds for recurrent expenditure late in the fiscal year[121]. PROSAÚDE funds represent what a key informant referred to as a 'lifeline for the survival' for these health units, particularly in remote areas, without which they would 'simply collapse'[122]. This is particularly true for the first months of each fiscal year (up to May) when the budget allocation has been set, but not yet disbursed. This is why PROSAÚDE deliberately holds back funding for any fiscal year x, to be spent at the beginning of year x+1[123]. This affects the annual statistics on spending and absorption capacity in a negative way because the practice produces, per completed fiscal year, a big difference between allocated and executed budgets. It hides the fact that up to one third or even more of budgeted funding is deliberately not spent, in order to ensure that funds are available in the first months of the following fiscal year.

As mentioned above, PROSAÚDE III in particular has been promoting the idea of decentralized spending at district level. This is a matter of some urgency as district health units suffer not only from systematic underfunding and a decline in funding (both from government and external sources except PROSAÚDE), but also rising demand due to population growth and the spread of diseases, including through the Covid 19 pandemic[124].

Nevertheless, a considerable part of PROSAÚDE funding is being spent at national level (N'weti, 2021). Looking, for example, at the distribution of the PROSAÚDE investment budget for 2020 by major institutions within the SNS it can be seen that over 50% has benefitted MISAU in various ways, whereas around 40% has been allocated to the provincial level (see Figure 8 below).

Figure 8: PROSAÚDE budget (2020) - Distribution by major budget units, in %



Source: Author, based on e-sistafe data.

120. For further details see: Guambe et. al. (2019).
121. KI 14, 15/11/202KI 7, 13/110/2021
122. KI 14, 15/11/2021
123. KI 14, 15/11/2021
124. KI, 14, 15/11/2021

3.3.2.2. Management

PROSAÚDE is managed by MISAU with the co-participation of international partners. The rules are stipulated in the Procedures Manual which is part of the 2017 MoU. Unlike its predecessors, PROSAÚDE III established a Technical and Programme Unit (UTP)[125]. It is composed of contracted specialists attached to MISAU's National Directorates of Human Resources ((DRH)[126], Planning and Cooperation (DPC)[127], Administration and Finance (DAF)[128], Public Health (DNSP)[129] and Medical Assistance (DNAM)[130]. This arrangement led to what has been labelled a 'co-management approach' and a reduction in the exclusive decision-making powers of national directors that they had wielded under PROSAÚDE I and II (Guambe, et al., 2018: 45f). The priority funding areas in PROSAÚDE's Annual Operational Plan (POA[131]) are defined jointly by MISAU and the PROSAÚDE partners. They are derived from the priority areas defined in PESS.

Regarding financial management, as an 'on-CUT' financing modality, PROSAÚDE follows the rules established in the PFM system, e-sistafe. This means that approved funds are channelled via e-sistafe to all eligible Beneficiary Management Units (BMUs) at all levels. The amount assigned to each BMU according to the allocation criteria is registered, so that it can be used directly by the beneficiary in the province and/or district. A precondition is that MEF releases the funds in time, although this is not always the case (see section 2.4).

Monthly partner meetings 'govern' and monitor the planning, budgeting, disbursement and execution of PROSAÚDE funds. Each year, one member of the funding group is chosen as the focal point, to coordinate the group and liaise with government, supported by the UTP. Frequent topics on the agenda of partner meetings are issues such as accountability and 'eligible, ineligible and regular' expenditure categories according to the established priorities and rules (N'weti, 2021a: 16ff). The basic assumption is that, as a matter of principle, PROSAÚDE partners do not want to pay, for certain types of recurrent expenditure, such as salaries, (particularly for personnel outside the public administration staff establishment (fora do quadro), topping up salaries and consumables[132]. Given the 'dire straits' in district health units, PROSAÚDE also extraordinarily considers funding running costs and repair and maintained work[133]. Regular and irregular audits are agreed upon to establish what is eligible and what is not, with the necessary adjustments made a posteriori. An audit of the 2018 accounts showed two major and frequent deviations from the rule book. These are firstly, financing human resources, especially the salaries and remuneration component and, secondly, unauthorised use (desvio de aplicação) due to weak internal control (N'weti, 2021a).

Apart from this, both MISAU and the PROSAÚDE partners remaining after the programme's profound crisis, acknowledge its virtues, thereby avoiding 'throwing the baby out with the bath water' associated with the earlier crisis of confidence. PROSAÚDE is, and remains, a strong pillar of support for the SNS, particularly at provincial and district level.

This does not mean that all components are fully developed and could not be improved and consolidated. A balanced and fair assessment of PROSAÚDE as a SWOT[134] exercise would certainly identify areas of fragility, particularly in terms of transparency and accountability, procurement and the lack of a built-in results-based approach to financing (RBF). The management, tracking and reporting system cannot inform the PROSAÚDE managers and partners about the purpose of the expenditure and the results. In other words, it lacks a constitutive element or building block linking financing to activities, results and outcomes, such as the systematic use of a programmatic classifier[135]. One example given was the financing of MISAU's recent Coordination Council, held in Lichinga, Niassa Province, in October 2021. Expenditure tracking showed that air tickets, fuel, accommodation, etc., were financed with PROSAÚDE funds, quite outside its scope and focus on supporting primary healthcare units at district level[136].

The programme's strengths are clearly its decentralized approach, efficient expenditure tracking and reporting via e-sistafe (with the caveats mentioned in section 2.5), and the fact that it represents a technically well-established and mature practice with which managers at various levels of the health sector are familiar. Whether this is also true for PROSAÚDE donors depends to a high degree on whether they have the human and technical capacity to understand and use e-sistafe standard reports for their monitoring of budget execution[137]. Different partners are differently endowed with this capacity.

125. Unidade Técnica e Programática (UTP)
126. Direcção Nacional de Recursos Humanos (DRH)
127. Direcção de Planificação e Cooperação (DPC)
128. Direcção de Administração e Finanças (DAF)
129. Direcção Nacional de Saúde Pública (DNSP)
130. Direcção Nacional de Assistência Médica (DNAM)
131. Plano Operacional Annual (POA)
132. For details, see N'weti (2021a).
133. KI 14, 15/11/2021
134. Strengths, Weaknesses, Opportunities and Threats (risks)
135. KI 16, 12/11/2021
136. KI 14,15/11/2021
137. KI 16, 12/11/2021

3.3.3. Perceptions

3.3.3.1. MISAU

For all key informants representing MISAU technical staff interviewed during the research for this study, the PROSAÚDE approach to external health financing has several advantages. Particularly for MISAU technical staff, it is 'the best and only point of reference'[138] representing a home-grown system that health staff are familiar with and, technically speaking, 'we never had a problem with'[139], despite its demonstrated occasional lack of good and transparent management. In their opinion, this shortcoming can be remedied through better internal control and improved procurement processes as well as field and financial monitoring. This is also the prevailing opinion at the decentralized levels of PROSAÚDE implementation, as shown by interviews conducted for an expenditure tracking study, when it states: 'despite all the setbacks, PROSAÚDE has been the best instrument of cooperation between funders of the health sector and government entities in Mozambique' (N'weti,2021a:14[140]).

The main reasons for this preference clearly lie in the programme's above-mentioned comparative advantages. Clearly, there is a recognition that PROSAÚDE has weaknesses and must be developed further together with the promotion of changes within MISAU, that are beyond the PROSAÚDE framework. Issues mentioned for much needed change include improving the quality of plans (PES) with a stronger link to PESS, or the institutional strengthening of MISAU's Procurement Unit together with a review of procurement procedures for medicines[141]. These measures are aimed at reducing corruption and overpricing[142]. Other suggestions concern better use of the e-sistafe subsystem for planning and budgeting (SPO)[143], for more effective planning, programming and budgeting (PPB) and making better use of e-sistafe's programmatic classifiers in order to improve the tracking of programme funding results[144]. Expectations also hinge on including a results-based framework into PROSAÚDE. The results of testing a performance-based approach, promoted by DNPO, and its eventual mainstreaming and integration into the health sector is eagerly awaited, according to two key informants in MISAU and a PROSAÚDE donor[145]. Moreover, a substantial strengthening of MISAU's Directorates of Planning and Cooperation (DPC) and Administration and Finance (DAF) with qualified human resources is called for, as reflected in PESS. As one KI put it, the DPC needs 'stronger national human resource capacity and ownership by MISAU – and fewer consultants[146]. The KI also stresses the importance of better integration of and dialogue with non-state actors (NSA) working in the health sector, seen as a force for advocacy, monitoring and 'moderation'. The latter is clearly a reference to the absence of total trust between MISAU and external health financing partners.

Forward-looking, PROSAÚDE should enhance its commitment to decentralization and resource allocation at subnational levels, particularly the health units, by considering splitting and earmarking funding for both recurrent expenditure and for investment, e.g. at a ratio of 30 : 70 percent of total allocation to district level. This is seen as a pragmatic way out of the existing dilemma between a programmatic focus on results, outcomes and impact of investment in health on the one hand, and an efficient management of resources on the other[147].

Finally, MISAU would obviously welcome back former PROSAÚDE partners such as Canada and UK who had left the programme for the reasons alluded to above. Their experiences with GFF could represents fruitful inputs into readjusting PROSAÚDE and for establishing a necessary common platform for different modalities[148].

3.3.3.2. Donors

Health partner group's views on PROSAÚDE are somewhat ambiguous. For some donors the PROSAÚDE modality has a tarnished image arising from the past, with the associated challenges of accountability and observation of fiduciary standards[149], whereas for others this funding modality has shown its strengths as a viable approach to health sector funding, despite its acknowledged weaknesses. The occasional misuse of funds (má aplicação de fundos) may not always be rigorously contained[150], e.g. by external audits. Consequently, donors such as the WB hold the view that PROSAÚDE continues to be vulnerable to abuse and thus

138. KI 2, 17/09/2021
139. KI 9, 26/09/2021
140. Translation by the author from Portuguese.
141. according to KI 17 and KI 18 (26/04/2022) in MISAU, the challenges regarding procurement can be overcome by adequate and systematic forms of institutional capacity building.
142. KI 9, 26/09/2021
143. Sub Sistema de Plano e Orçamento (SPO)
144. KI 9, 26/09/2021, KI 13, 01/11/2021, KI 16, 12/11/2021. According to a senior staff member in MISAU, this cannot be the panacea for a solution since it would require laborious adjustments to planning at provincial and district level, including priorization of activities, for which capacities are limited (KI 17, 26/04/2022).
145. KI 2, KI 3, 17/09/2021, KI 14, 15/11/2021
146. K 13, 01/011/2021
147. KI 17, KI 18, 26/04/2022
148. KI 17, 26/04/2022
149. KI 6, 30/10/2021
150. KI 7, 13/10/2021

pool funding support represents a high fiduciary risk. A past situation mentioned was the ineligible topping up of salaries for the MISAU leadership and senior staff in Maputo under PROSAÚDE I. After an offer of fiduciary oversight proposed by the WB was rejected, PROSAÚDE turned into an 'audit-intensive' programme[151], with the audits causing delays and high transaction costs in programme implementation. This eventually contributed to the exit of major funders[152]. A key informant representing a vertical programme holds the even more radical opinion that PROSAÚDE 'is a slush fund' that, at least in its early stage, benefitted more the MISAU leadership and officials 'rather than serving the people' in need of a good health service, particularly at district level[153].

Nevertheless, the virtues of PROSAÚDE are being recognized, particularly by the donors who have stuck with the programme, despite its setbacks. In particular, smaller partners like Italy, which joined the PROSAÚDE CF in 2016, clearly see an advantage in becoming and remaining a member. According to one key informant, Italy joined PROSAÚDE following a 'strategic choice' to support the SNS. The programme's advantages were seen as being 'on-CUT' and managed via e-sistafe, a reasonable planning framework (PESS), the high degree of coordinated policy and technical dialogue with MISAU and the regular and timely on-budget execution reporting through budget execution reports (REO)[154] [155]. Certainly, its focus on primary healthcare at subnational level i.e. the decentralization of the health sector, is one of the programme's assets[156].

From a PROSAÚDE donor perspective[157], PROSAÚDE can and must be improved by:

- Considering, as a priority, the need for introducing a results based financing (RBF) framework like the one piloted by GFF. As one key informant put it: 'we need to combine our strengths, including expenditure tracking, with that of GFF to compensate for each other's weaknesses. PROSAÚDE and GFF need and complement each other's approach'[158];
- Contributing to the operationalization and budgeting of the primary healthcare strengthening programme (PHCSP), with the new e-sistafe subsystem planning/ budgeting instrument (SPO), which represents a promising medium-term strategy, but seems unrealistic in the short-term;
- An even more rigorous focus and support for primary healthcare decentralization, particularly at district and sub-district level, as 'MISAU and other donors are too focussed on Maputo and neglect those areas where need is greatest'. This includes addressing the need for human resource development, better equipment and regular maintenance of existing infrastructure, equipment and vehicles. This would require a shift in the allocation and distribution of resources from central government to subnational levels and changes in current allocation and distribution criteria;
- Promoting improved coordination among health partners based on a new SWAp;
- Investing in a communication strategy that provides timely information on the programme's approach, priorities, expenditure, results of coordination meetings, policy changes, etc.

The source also believes that the MISAU leadership needs to demonstrate its ownership of PROSAÚDE and promote its continued utilization for health financing. An example given, was the fact that substantial EU funding in the range of € 30 Million to fight the Covid 19 pandemic was not channelled via PROSAÚDE, despite an offer to this effect[159].

3.3.4. Conclusions

PROSAÚDE is facing a dilemma. On the one hand, according to MISAU and its staff interviewed for this study it is clearly the preferred financial support modality for the SNS. The same holds true for donors who stick to this modality. On the other hand, it has had to face, swallow and digest the exit of partners and the associated decrease in funding levels, as well as competition from vertical programmes that attract the same (scarce) MISAU resources and push for their agendas and health financing modalities. A study by Guambe et al. (2018:6) concludes that 'PROSAÚDE has been gradually transitioning from a prosperous and stable fund to a fund with limited resources, contested credibility and little consensus among cooperation partners' whose number has significantly

151. Reference is particularly made to external audits by private companies contracted by donors.
152. KI 6, 30/09/2021
153. KI 7, 13/10/2021
154. Relatorio de Execução do Orçamento (REO)
155. KI 4, 24/09/2021
156. KI 9, 26/10/2021, KI 14, 15/11/2021
157. KI 14, 15/11/2021
158. KI 14, 15/11/2021
159. KI 14, 15/11/2021

declined[160].The PROSAÚDE CF, once the preferred financing model, has also been questioned.

Other factors mentioned in the PESS MTE (MISAU, 2019) to explain the decline in PROSAÚDE's attractiveness are stakeholder mobility and international changes in approaches and policies, including reservations about CF mechanisms. In addition, domestic political shifts in ideology and economic priorities in donor countries, together with the financial challenges of containing the social and economic effects of the Covid 19 pandemic have also affected funding levels and may produce exit strategies not just from the health sector, but from development cooperation altogether. Certainly, the discovery of the 'hidden debts' in 2016 has not only ended the direct budget support modality but has also further undermined the credibility of the CF approach that by making aid money fungible, the fiduciary risk of GBS and SBS increases.

The causes and consequence of the decline of PROSAÚDE are succinctly summarized in a study by N'weti (2019):

- Weak institutional control, and accountability permitted the capture of PROSAÚDE by central administrative elites and, decentralized and deconcentrated State structures.
- The collapse of PROSAÚDE produced a considerable increase in transaction costs in the health sector i.e. a remarkable effort by the sector to articulate, coordinate and be accountable in response to the complexity of donor agendas (N'weti, 2019: 8);
- The definite departure from the principles and mechanisms of the Paris Declaration and PARPA;
- The lack of harmony among donors, who face increasing coordinating challenges;
- The inadequate substitution of PROSAÚDE by other modalities, such as GFF.

Nevertheless, while some of these issues warrant further discussion in Chapter 4, this picture may not be complete. The programme has shown a considerable degree of resilience and a degree of ownership by SNS technical staff, and is open to adaptations while maintaining its strategic orientation.

160. Translation from Portuguese by the author

This is why key PROSAÚDE donors such as Switzerland, Ireland, Italy and Belgium continue to 'stick to their guns'. According to one partner, brighter prospects are on the horizon, funding volumes are expected to rise again and agencies that had left, such as CIDA, may return to the PROSAÚDE fold[161].

Whatever its degree of sustainability and the quality of its reputation, the fact remains that it is perceived as a viable[162] form of programme support that has revealed its merits and is appreciated by MISAU, possibly also for reasons of national pride. It is uncertain whether the dilemma alluded to above can be resolved by reforming and adjusting the system to respond to the attested weakness and improve its management. This would require strong leadership and convening powers on the part MISAU and, at the same time, substantial progress in addressing the issue of overall health sector financing and a corresponding sector financing strategy. These issues are discussed in section 4.4. As if addressing these challenges were not enough, MISAU faces additional challenges of an exclusive domestic nature: the potentially fragmenting impact of the 'New Decentralization Paradigm' (Impissa, 2020). If not adequately addressed, this could lead to ruptures or delays in funding SNS at subnational levels.

3.4. The Global Fund for AIDS, Tuberculosis and Malaria (GFATM)

3.4.1. Key features

The GFATM or Global Fund (GF), with its secretariat in Geneva, Switzerland, is a vertical programme based on the private-public partnership model. Founded in 2002, through an initiative by the then UN Secretary General, Kofi Anan, and with seed money provided by the Gates Foundation, it aims to help countries prevent, diagnose and treat HIV/AIDS, TB and malaria, by strengthening local health systems and providing crucial inputs and finance. It is part of a world-wide group of health systems supporters with similar features, referred to as global health initiatives (GHIs). They use a common approach – or one-size-fits-all strategy – to be implemented across a range of countries to target a specific disease, group of diseases or a global health challenge such as HIV/AIDS or the Covid 19 pandemic.

161. KI 14, 15/11/2021
162. The difference between financial sustainability and institutional viability is that, in the former case, a system dies if the necessary financial flows are not minimally guaranteed, whereas viability implies a robust and healthy system with the flexibility to contract or expand, according to changing environments and circumstances, while maintaining key functions. See: Saviano et al. (2018).

Backed by the G8 meeting in Genoa, Italy, in 2001, and funded to various degrees by its members, it is considered the world's largest financing mechanism for fighting these diseases, with expenditure of some US$ 4 billion a year. The Global Fund's single largest donor is the US. The budget appropriations for the US contribution to the Global Fund was around US$24.6 billion from FY 2001 through FY 2021. In collaboration with local partners in recipient countries – both governments and NSA – the programme complements other US global health support mechanisms such as PEPFAR, PMI and USAID's TB programme. Health sector strengthening (HSS) is an important part of it (KFF, 2021). According to the GFATM/GF website, millions of lives have been saved through the United States' support to that programme. Thus, in a way, the GF can be considered as an instrument of the US government's foreign and trade policies. The bulk of the funding comes from the public sources of some 80 donor countries163. Initially, GF raised and spent funds during three-year 'replenishment' fund-raising and pledging periods. Typically, these started with donors making their pledges and the GF calling for proposals from potential recipients. GF also collaborates with faith-based organizations (FBO), and receives generous financial support from Catholic Relief Services, Caritas, World Vision and the United Methodist Church.

The GF was conceived as a vertical mechanism providing funds to governments and local NSA based on demand ('call for proposals') and complementing other funding sources, including the governments of beneficiary countries. As a funding mechanism it is not involved in implementation, the reason why the GF has no country office anywhere in the world. Instead, its interventions are planned, managed and implemented through seven core structures: the Board (where representatives of industry also have a voice), the Office of the Inspector General (OIG), a Technical Review Panel, the Principal Recipient (PR), the Country Coordinating Mechanism (CCM), the Fund Secretariat and the Local Fund Agent (Warren et al., 2017). The Principal Recipient (PR) is responsible for grant implementation and can be part of the public sector e.g. a health ministry, or an NGO (including FBOs) or even a private company. It is under the direct supervision of the Country Coordination Mechanism, which ideally should reflect the Fund's commitment to local ownership and decision-making. The Global Fund Secretariat headquarters in Geneva is responsible for daily operations, primarily grant management. The GF's key features include its emphasis on performance-based finance (PBF). This means that continued financial support for recipients depends on proven results and grant management that considers impact and 'value for money' criteria. In practical terms, it means measuring results by using baselines, indicators and investment in data systems for monitoring. In this process external consultants are often involved in health systems with insufficient capacity of their own. Transparency in financial management is emphasized.

From 2009 onwards evaluations and studies produced insights into possible flaws in the underlying logic of the GF's strategic approach, and also the conclusion that GF's mode of operation was prone to misappropriations and corruption in receiving countries (Brown & Griekspoor, 2013; Handfield, 2014). The authors also recognized a mismatch between, on the one hand, the scale of the disease-specific programmes and, on the other hand, the structural frailty of health systems in many recipient countries, particularly in Africa, as well as limited absorption capacity. These weaknesses may be due to lack of physical health facilities (health units and hospitals), low salaries and poorly qualified health staff, challenges in the supply chain of medicines and medical items, as well as poor health information systems. A further matter of concern was flagged: a tendency for public health staff to seek employment in GF and other externally-financed projects enticed by better salaries, working conditions and career possibilities, weakening even further the already structurally fragile national health systems.

Taken together, these factors led to the temporary withdrawal of funding by a few GF donors in 2011 and a temporary suspension of activities in a few countries, Mozambique included. They also triggered a restructuring process and changes in the approach to planning, funding, managing and monitoring the individual programmes covered by the GF. The cumbersome and GF-dominated 'pledging round', based on a model with little predictability and local ownership was replaced by a new funding mechanism, with three-year indicative allocations in line with locally defined needs and priorities (for details see Warren et al., 2017, Figure 1). This new mechanism has what is considered to be a more effective and inclusive proposal process with enhanced guidance on the required levels and the availability of funds, a simplified grant application, improved audits and accountability for the use of funds to minimize financial irregularities, and greater coordination and harmonisation with other funding agencies (Handfield, 2014). Performance-based financing and the country coordination mechanisms (CCM) with GF key stakeholders, including government actors and NSAs, have been maintained.

163. At the end of 2020 the list of (cumulative) donations was headed by , the United States, France, United Kingdom, Germany, Japan, Canada, European Commission, Sweden, Italy and the Netherlands. The list also includes countries such as China, the Russian Federation and Saudi Arabia. https://www.theglobalfund.org/en/government/

3.4.2. Relationship with MISAU

3.4.2.1. Funding

The GF started operating in Mozambique in 2004, roughly a year before the adoption of the Paris Declaration on Aid Effectiveness, whose principles of ownership, alignment, improved aid quality and its impact on development were also reflected in the GF approach. At that time the GF was integrated into PROSAÚDE and considered 'a good example' of how global, disease-specific vertical funding mechanism with a unique business model could be adapted and fitted into Mozambique's country system under harmonisation and alignment arrangements (Dickinson et al., 2007).

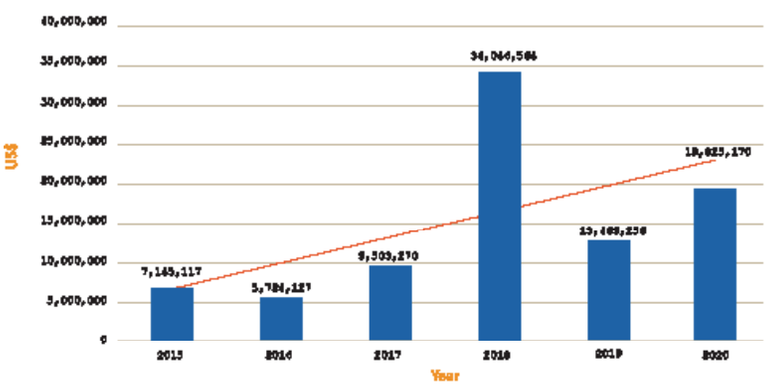
Between 2004 and 2008 the GF supported the SNS in its specific area of intervention with grants amounting US$ 135 awarded to MISAU via the PROSAÚDE Common Fund, using its characteristic on-CUT modality, fully in line with the established Mozambican planning, programming, budgeting, allocation and accounting system, e-sistafe. Up to 2016 the GF disbursed over US$ 972 million (AIDS), US$ 802 million (tuberculosis) and US$ 620 million (malaria). Until that year, 86% of the total disbursements benefitted MISAU, the Principal Recipient (PR). This should have ensured national ownership and adherence to the Mozambican SWAp that had been developed from the late 1990s onwards. The remaining funds benefitted the Community Development Foundation(FDC)[164], the National Council to Combat AIDS (CNCS)[165] and Centre for Collaboration in Health[166](Warren et al., 2017)[167]. Additional funding initiatives targeting NSA such as the Breaking Down Barriers initiative using a human right based (HRB) approach fighting the stigmatization of HIV and TB infected citizens were neglected (for details see: GFATM, 2021).

The gradual introduction of the new funding mechanism (NFM) between 2013 and 2016 meant that a recipient country would have access to two funding streams: an indicative funding stream and a competitive incentive funding stream[168]. While the former is larger and more predictable, the second will reward ambitious, high-quality investment cases based on coherent national strategic plans such as PESS. This stream represents the GF's performance-based element where, unlike the GFF, the evaluation criteria are verified at the SNS macro level, not the micro or meso levels.

Both streams are based on the CCM submitting an application to the Secretariat that reflects the applicant's prioritized needs. The total value of funding for a given country is determined by an allocation formula that considers the country's share in the global disease burden, differentiated by the three GF diseases and the country's gross national income (GNI) per capita. Further qualifiers, such as past programme reform, absorptive capacity and fiduciary risks can be used by the Secretariat to make adjustments.

The GF spending pattern from 2015 to 2020 of the GF is shown in Figure 9 below:

Figure 9: GFATM budgets - Updated allocations (dotação actualizada), 2015-2020 (in US$)



Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

According to these figures, total GF allocations to the health budget over the period 2015 to 2020 amounted to some US$ 90 million (equivalent to MZN 5.5 billion), an average annual budget contribution of approximately US$ 18 million, with a growing trend.

The spending pattern by category of support over this period is given in Figure 10.

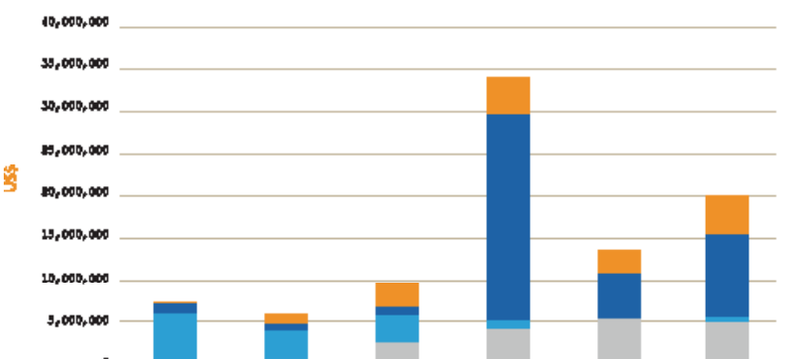
The dramatic increase in spending in 2018, particularly on AIDS prevention and treatment, was the result of both updated

164. Fundação para o Desenvolvimento da Comunidade (FDC). One of FDC's several intervention areas is community health aimed at 'reducing the incidence and impact of endemic diseases such as HIV/AIDS, tuberculosis and malaria among vulnerable groups' (https://fdc.org.mz/pt/portfolio-items/saude/).
165. Conselho Nacional de Combate ao SIDA (CNCS)
166. Centro de Colaboração em Saúde (CCS). The CCS was established in 2010 as a local partner of the Ministry of Health (MISAU) through support from ICAP (International Centre for Aids Program) and PEPFAR. for details, see https://ccsaude.org.mz/
167. Today, the NSA World Vision International also receives GF funding.
168. For details see GFATM (2012).

targets and a rise in the number of patients being treated, reflected in the CCM application. The minimal spending on TB in 2015 and 2016 was because, during that period, the pledging round approach transited to the NFM. The necessary adjustments to the planning and budgeting process i.e. the 'transitional' NFM, for which no extra funding was available, was financed through recourse to the TB budget line[169].

Considering the period 2021 to 2023, at the beginning of 2021 the Government of Mozambique and its health partners[170] began implementing six new grants to fight HIV, TB and malaria and build resilient and sustainable health systems. The new grants aim to expand access to HIV, tuberculosis, and malaria prevention services, particularly for key and vulnerable populations. According to the press release, the new grants, worth US$ 773.9 million, represent a 49% increase over the previous allocation cycle and are the result of a rigorous and inclusive country dialogue and grant-making process[171].

Figure 10: GTATM annual budget - Updated allocation (dotação actualizada) by type of disease, 2015-2020 (in US$)



	2015	2016	2017	2018	2019	2020
Malaria	388,448	1,224,240	2,302,817	4,205,014	2,979,786	3,771,031
HIV	1,008,798	396,188	880,627	24,276,825	4,184,361	10,055,312
FSS	5,654,828	3,367,092	3,074,512	1,495,403	0	962,101
Tuberculosis	85,647	345,118	3,034,946	4,109,823	5,805,172	3,036,024

Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

169. KI 7, 13/10/2021
170. I.e., Ministry of Health, Community Development Foundation (FDC), Centre for Collaboration in Health (CCS) and World Vision International.
171.https://www.theglobalfund.org/en/news/2021-02-05-mozambique-and-global-fund-launch-new-grants/

3.4.2.2. Management

In response to calls for greater accountability, the Officer of the Inspector-General (OIG) conducted audits of Global Fund grants to the Ministry of Health in 2008, 2009, and 2010 in parallel with an audit of PROSAÚDE by the KPMG audit company. The audits revealed weak financial management in MISAU resulting in poor financial accountability for the resources used as well as difficulty tracking PROSAÚDE funds, often resulting from what in Mozambique is termed desvio de aplicação (misuse of funds). Some US$ 3.32 million were said to be inadequately accounted for. The audits also concluded that there were insufficient control mechanisms, resulting in a lack of accountability. The OIG recommended that the Ministry of Health should repay PROSAÚDE. Together with major challenges in the effective and transparent management of medicines by the Central Stores for Medicines and Medical Items (CMAM)[172], and a strike by doctors and health staff for better salaries, this had a damaging impact on the SNS and damaged confidence in the relationship between health donors and the Mozambican government (Weimer, 2012).

An independent study conducted in 2013 entitled 'Global Fund's paradigm of oversight, monitoring, and results in Mozambique' revealed additional concerns, expressed as 'perceptions', by both the funders and of MISAU (Warren et al., 2017)[173]. Among others, the study highlighted three main failings: a) the performance based financing(PBF) mechanism[174], b) not having a country office affected coordination with other programmes[175] and c) little national ownership[176](Warren et al., 2017: 6, Table 2).

As a consequence of the earlier experience, the introduction of the new funding mechanism (NFM) and the review of the management approach emphasising improved accountability, including regular independent external audits, some of the issues raised above have been addressed. Under the NFM regime, the Programme Management Unit (PMU) is now fully embedded in the DPC, with a team of local staff on MISAU's payroll, and the position of the coordinator funded by GF. This manager has a highly valued professional profile and experience. Topping-up of salaries determined by the programme management is not permitted, except in duly

172. Centro de Medicamentos e Artigos Médicos (CMAM)
173. The qualitative study was based on 38 interviews with key informants representing GF stakeholders based in Switzerland and Mozambique.
174. 'Recipients focus on disbursement rather than results', 'burdensome administrative requirements'; 'duplication of reporting efforts from the ground all the way to central level';
175. 'Ineffective country-level coordination', 'frequent deadlines and time stress', 'over-worked staff, communication challenges', 'out-of-touch with realities on the ground'
176. 'Reliance on external consultants to develop proposals', 'undefined roles and concerns about accountability', unused potential for agenda alignment and coordination with partners.'

justified cases where it serves training and the human resource qualifications required to improved service delivery[177].

As regards the GF's use of PBF, a study on HIV and maternal/child health services published in 2017 suggested a positive correlation between this, 'driving down the HIV epidemic and progress in MCH case service delivery as compared with input financing alone' (Rajkotia et al., 2017: abstract). However, other authors have suggested that the GF's current performance-based funding system does not adequately convey to recipients the incentives for performance (Fan et al. 2013). As one key informant suggested, the necessary monitoring and information system is fragile and does not easily permit the timely gauging of performance.

3.4.3. Perceptions

3.4.3.1. GFATM perspective

Today, seven years after the study was conducted, several of the issues that once plagued GF operations in Mozambique have been resolved, according to its manager in Mozambique. According to this key informant, GF's unfortunate experience of being part of PROSAÚDE II up to 2011, with its expenditure bias towards central government and salary subsidies for senior civil servants has been addressed through GF's own internal reform and its recognition as a vertical, fully aligned and integrated stand-alone programme. It is 'fully owned' by government (MISAU) to the extent that its programmatic priorities within the overall GF framework are set by MISAU, which takes the initiative to submit a proposal to the GF. Its specific areas of intervention as a vertical programme are thus 'perfectly aligned' with MISAU's PESS. Planning, budgeting, disbursement and reporting processes are fully integrated into the national PFM system and e-sistafe. The same is true for implementation based on collaboration with national institutions and their rules (e.g. CMAM, national procurement rules and procurement units). In other words, the way GF is designed, managed and implemented reflects full ownership by government and MISAU, which recognizes that 'what is outside the agreed key features' of the GF and its core areas of intervention in public health 'remains outside' (e.g. support for medical assistance). This does not mean, however, that there is no possibility to negotiate exceptions. According to the KI, in order to maximise 'exceptional' benefits outside the core GF business, MISAU might want to be better able to demonstrate 'intelligent and informed initiatives and negotiate strategies for succeeding'.

The KI agrees that there has been little improvement in PBF: 'we want to see the results of our interventions, but they are difficult to gauge and deliver'. This affects the reporting and monitoring systems necessary for PBF. While technical solutions for establishing an efficient health information system may lead to some improvements, they are unable to address the core problem. What is the core problem?

In the KI's opinion, the main cause for this failing is the structural fragility of the SNS itself. Promotion in the civil service is not based on merit, and generally poorly paid doctors and health workers do not necessarily demonstrate professional motivation and work ethics and may be inclined to engage in corrupt practices in the workplace to increase their income. Inflated costs for training courses and travel are ways to generate additional income via per diems and exaggerated fuel bills. This is one of the reasons why GF has a 'no tolerance' approach to the misappropriation of funds. If such cases are detected and confirmed by an independent audit, the culprit must repay the loss. GF also retains the prerogative for paying subsidies to civil servants. These may be justified under certain conditions, such as qualitative human resource development and training that will have an impact on the quality of services.

In addition, the KI observed that the hierarchical superior of a health worker does not necessarily insist on correct quality control and accountability procedures. Plans sometimes lack quality and realism, a point shared by a MISAU consultant[178].

Curbing the effects of this structural frailty produces additional costs (e.g. for consultancies and external audits). But, worse, the perception of systemic misuse and lack of accountability may undermine confidence in the national partner institutions of externally financed programmes. As will be seen below, this was the case with PROSAÚDE, where important CF funders left the programme.

As regards coordination with other programmes, GF sees participation in PROSAÚDE as an episode in the past. The pool-funded programme is no longer of interest. As regards the GFF, the GF KI also stated that the logic for it is difficult to understand and it seems to lack a well-defined planning document for implementing the Primary Healthcare Strengthening Programme (PHCSP), for which an investment case document has been drafted, but not yet been approved (see section 3.6).

177. KI 7, 13/10/2021

178. KI 9, 26/10/2012

3.4.3.2. MISAU perspective

For KIs representing MISAU, the GF with the new funding mechanism is well established, pretty much aligned with national procedures and does not lack national ownership. As one KI put it: 'there is no problem, as long as the programme's priorities, areas of intervention and expected outcomes are well defined by government and well-negotiated with the programme management in Switzerland', and follow their procedures and hierarchical decision-making structures[179]. However, in cases of necessary adjustments and exceptions the negotiation process is considered cumbersome and costly. Proposals submitted by government may be returned for time-consuming adjustments and renegotiation.

One point highly appreciated by key informants, including those in MISAU, is the fact that the GF works with NGOs, in addition to the PR. This is considered necessary in order to deepen and broaden health interventions and include other voices in matters of health policy, programme and financing. However, the inclusion of secondary beneficiaries may not always be appreciated by government (MISAU) that, as the Principal Recipient, may want to claim exclusive decision-making and implementing power[180].

From a planning, programming and budgeting perspective, the main obstacle to alignment is the fact that MISAU and GF follow different planning cycles and fiscal years[181]. From the MISAU perspective, the different planning cycles produce a lack of predictability and an extra burden on human resource and transaction costs when plans must be adjusted to fit GF finance into the national PFM system which it uses. The complete change in the GF's 'rules of the game' i.e. introduction of the new funding mechanism between 2013 and 2016 and reflected in the spending pattern shown in Figure 9 meant considerable, unpaid extra work for MISAU staff on top of their routine work. The case of 'overworked staff' is also mentioned in the study cited above (Warren et al., 2018). Compared to other programmes (PROSAÚDE, GAVI) GF is said to have more frequent changes to its rules, resulting in not only extra work under stress, but also knock-on effects on routine work and for other programmes i.e. higher transaction costs[182].

Other senior MISAU officials also mentioned the frequents audits, which are considered 'policing' and reflect a lack of trust between the partners and the national PFM system[183].

179. KI 10, 26/10/2021.
180. KI 13, 01/11/2021
181. KI 9, 26/10/2021 and KI 12, 01/11/2021
182. KI 9, 26/10/2021
183. KI 13, 01/11/2021

According to another official, this is the main and general problem (not just restricted to GF) and could be considered an 'echo' of the above-mentioned leadership crises between MISAU and GF around 2011[184]. The discovery, in 2016, of the odious debts shattered confidence into the Mozambican government's effective and transparent financial management and accountability procedures even further. According to this KI, such lack of trust may have reenforced existing prejudice rather than a factual substance arising from health sector practises. In this opinion, 'confidence building measures' are called for e.g. improved familiarization with the current PFM system.

Finally, the GF's 'monopolization' of ownership of outcomes and achievements on its website and publications is a matter of concern. This position does not reflect Mozambique's contribution to the joint effort[185] and a change of attitude is called for. The victory in the fight against a given disease is not solely and exclusively the external financing mechanism but, rather, in the final instance the Mozambican citizen burdened with sickness.

3.4.4. Conclusions

Following the introduction of the NFM approach the GF is perceived to have gained a higher degree of national ownership, alignment with national priorities and integration into the national PFM system. Nevertheless, it is still considered 'one cause of our headaches' in the health sector[186], given the often-cumbersome planning, adjustment and (re)negotiation procedures, arising from the lack of alignment of between the programme's fiscal year and planning cycle and that of Mozambique. It is probably not impossible to resolve this matter as budget cycles resulting from specific historical circumstances and contexts are not defined or adjusted by health ministries and support programmes. The early, well documented fragility in management and accountability seem to have been overcomed, at least partially, although the cost of frequent external audits are high and regarded by MISAU staff as an expression of distrust that undermines the agreed principle of using national institutions for financial management and accountability. Overall, however, alignment with and integration into the national PFM system have moved forward. There continue to be major challenges to effective coordination, due primarily, the lack of a country representation.

184. KI 9, 26/10/2021
185. KI 9, 26/10/2021
186. KI 9, 26/10/2021

Looking forward, both MISAU staff and the GF coordinator agree that the improved mutual understanding of each other's particular partnership constraints and needs requires confidence building. There is also agreement on the mutual benefits of making better use of the tools available in the e-sistafe IT platform for programme budgeting (e.g. via the planning and budgeting subsystem and the use of programmatic classifiers). Further efforts are required to improve coordination with other programmes and a coordination office in Mozambique outside MISAU might be useful for this.

3.5. Global Alliance for Vaccination (GAVI)

3.5.1. Key Features

The Global Alliance for Vaccination (formerly the Global Alliance for Vaccines and Immunization) has been supporting MISAU since GAVI's inception in 2000 with an exclusive focus on immunization. GAVI was established in 2000 as an international organization covering 'public and private sectors with the goal of saving lives and protecting people's lives through increasingly equitable and sustainable immunizations'[187]. The Alliance partners include WHO, UNICEF, the WB and the Bill and Melinda Gates Foundation (BMGF), with industrialized countries the main donors[188]. Other members are governments in the global South, and above all, pharmaceutical companies and vaccine manufacturers.

GAVI differs from PROSAÚDE and the World Bank's 'classical' approach to development financing via International Bank for Reconstruction and Development (IBRD) loans and International Development Association (IDA) grants in two ways. The first is the private public partnership model said to 'capitalize on the sum of the partners' comparative advantages'. Secondly, GAVI's business model involves 'pooling demand for vaccines from the world's poorest countries', securing long-term funding and shaping viable vaccine markets, thus 'accelerating access to life-saving vaccines in the countries that need them the most'[189].

GAVI support has four strategic goals: a) the 'vaccine goal', reflecting its core business[190], b) the Health System Strengthening (HSS) goal ('equity goal') to increase equity in immunisation through support for well-managed, sustainable primary healthcare and c) the 'sustainability goal', to promote the mobilization of domestic support and financial resources for immunization. Finally, GAVI also pursues the 'healthy markets goal' i.e. shaping and developing 'healthy' markets and demand for vaccines for which a specific healthy markets framework was jointly developed by the GAVI Secretariat, UNICEF and the Gates Foundation.

Since the outbreak of the Covid 19 pandemic, GAVI is co-leading COVAX, the vaccines pillar of the Access to Covid 19 Tools (ACT) Accelerator. This involves coordinating the COVAX facility, a global risk-sharing mechanism for pooled procurement and equitable distribution of Covid 19 vaccines.

3.5.2. Relationship with MISAU

Its interventions are aligned with the national Comprehensive Multi-Year Plan (cMYP) 2020-2024 for vaccination that guides investments and the strategic directions for immunization programmes (MISAU, 2020a). The accumulated GAVI budget of approximately US$ 260 million spent between 2000 and 2019 on cash and non-cash support benefitted vaccinations (roughly 90%) with support for strengthening the sector having a minor but albeit recently increasing role over that period (approximately 10%). GAVI has been the largest donor to immunisation, providing an average US$ 29 million per year over the period 2014-2018. Government expenditure on vaccines as a percentage of total expenditure on vaccines has been around 20% while government expenditure as a percentage of total expenditure on routine immunization has equally been around that mark (MISAU, 2020a 58). As a vertical programme GAVI supports MISAU using the on-CUT modality. Between 2015 and 2020 GAVI contributed about 10% of the total external budget support to the Mozambican health sector, delivered on-CUT.

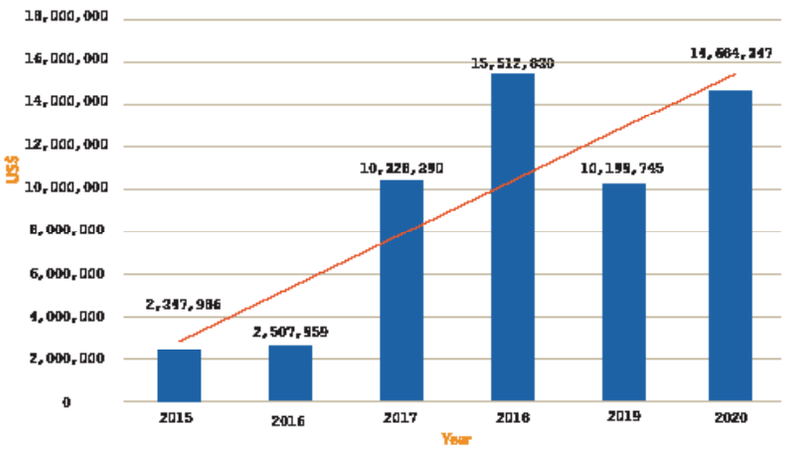
3.5.2.1. Funding

Figure 11 below gives the annual GAVI funding for the sector and its evolution. Total spending was US$ 55.6 million, with an annual average of US$ 9.2 million over this period.

187. https://www.gavi.org/our-alliance
188. For the 2021–2025 planning cycle, US$ 8.8 billion was raised for the funding cycle 2021 to 2025 with the UK, BMGF, the US and Norway the main donors.
189. https://www.gavi.org/our-alliance/operating-model/gavis-partnership-model

190. The immunization portfolio includes the following vaccines human papillomavirus (HPV); inactivated polio (IPV); Japanese encephalitis (JEV); meningococcal A; measles and measles-rubella (MRV); pneumococcal conjugate (PCV); pentavalent (PV); typhoid; oral cholera (OCV); rotavirus (RV); and yellow fever (YFV). Source: https://www.gavi.org/programmes-impact/types-support/vaccine-support

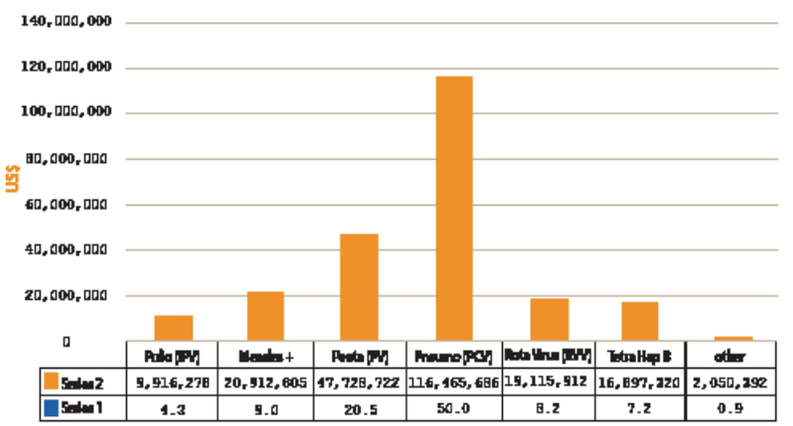
Figure 11: GAVI budgets - Updated allocation (dotação actualizada), 2015-2020 (in US$)



Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

Some US$ 233 million were made available for vaccinations between 2000 and 2019. Figure 12 shows that about 50% was spent on immunization against infections caused by bacteria Streptococcus pneumoniae, followed by pentavalent vaccine support[191]:

Figure 12: GAVI vaccine support (disbursed), 2000-2019, by type of immunization (in US$ and %)



Source: https://www.gavi.org/programmes-impact/country-hub/africa/mozambique

191. Also called 5-in-1 vaccine, it protects against diphtheria, tetanus, whooping cough, hepatitis B and haemophilus influenzae type B.

GAVI's financial support to the various sub-programmes (vaccination, health sector strengthening, campaigns, etc.) results from a matching funding arrangement, as it is supplementing the government's own contribution to GAVI financed programme of about 10% of its total cost. This is in addition to government's own contribution to routine vaccinations. This co-financing commitment is guaranteed annually through the inclusion of a specific line in the MISAU budget. Mozambique has never defaulted on this funding. This is in addition to the government's own financial resources for routine vaccinations. This co-financing contribution assures ownership and voice by government and the preparation of the Expanded Programme of Immunization (EPI) annual plan is led by MISAU and partners, observing certain agreed parameters (priority districts/activities).

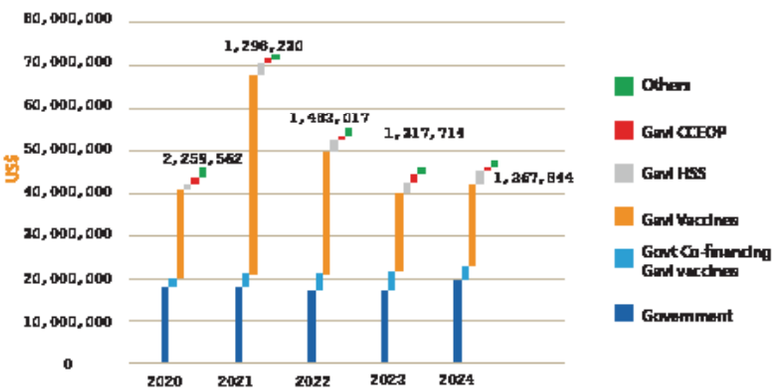
Like PROSAÚDE, GAVI also sees the need to decentralize vaccination. To give an example, GAVI funding, including for MRV (measles vaccinations), for 2020 was allocated at the ratio of 50:50 to MISAU and all of the Provincial Health Directorates (DPS)[192] in the country[193].

Figure 13 shows the projected secured funding for vaccinations over the 2020-2024 period. The projected average annual funding gap between secured and needed funds is estimated at 7.6%.

In addition, GAVI's Targeted Country Assistance (TCA) finances smaller individual projects, such as support for MISAU's Health Information System implemented by organisations contracted individually by GAVI. The amount available for TCA is determined by GAVI and, based on a Joint Appraisal (GAVI, MISAU, partners), technical assistance requirements for the coming year are agreed. TCA partners then submit proposed activities to GAVI and EPI, with the latter responsible for the final negotiations and selection of successful TA providers. Such additional projects may be delivered off-budget[194].

192. Direcção Provincial de Saúde (DPS)
193. Source: own calculations on the basis of e-sistafe data. The DPS share also includes a small budget for CMAM.
194. KI 8, 15 /10/ 2021

Figure 13: Vaccinations: Projected secured funding, 2020-2024, by source (in US$)



Source: Author, based on MISAU (2020a), Annex 3.

3.5.2.2. Management

GAVI funds a small grant management team that is fully embedded in MISAU's administrative structure. All positions are remunerated on the government's salary scales with topping up, except for the HSS focal point. In addition to the latter, the team comprises a financial advisor and three other members serving as advisors for GAVI activities in the three regions of the country (Southern, Central and Northern Mozambique)[195]. GAVI's country representative (senior country manager) for Mozambique is based in Switzerland. Regular monitoring against performance criteria in the five-year country programme is assured. The Immunization Technical Working Group (with 4 sub-working groups) established by MISAU and its regular monitoring of immunization plans and partner progress against plans as well as decision-taking on technical and programmatic matters and corrective action, based on analysis by sub-working groups, is an important asset. In addition, there is a regular external monitoring agent (at present a Germany-based consulting company) as well as regular reporting through quarterly and annual reports.

195. A local company for financial management contracted by GAVI has been replaced by an individual advisor in the ministry. Sometimes UNICEF or WHO's competence and services are used for procurement and making specific and urgent payments (KI 8, 15/10/2021)

3.5.3. Perceptions

3.5.3.1. MISAU perspective

From MISAU's perspective[196], as a vertical programme with its clearly defined, specific focus GAVI is well embedded in the SNS, which keeps government in the driving seat. Proposals submitted to GAVI for support through its specific immunization programmes for HSS and for other associated activities depend entirely on MISAU's own initiative. They are well aligned with the EPI's cMYP. The full integration of GAVI financing into Mozambique's PFM system and e-sistafe is considered another asset197, together with an absence of 'policing' i.e. 'heavy control and external audit mechanisms imposed by the donor'[198], which is 'detrimental to confidence building among partners'. It could be further strengthened by including other international health financing partners199, and by improving its coordination mechanism, the Inter-Agency Coordinating Committee (ICC) that, according to MISAU (2020), 'has been less than optimal to fulfil its mandate and government has taken more interest in revamping'.

3.5.3.2. Partner perspective[200]

As for all other health programmes, one of the key challenges is a structural one: the relatively low salaries of civil servants that may affect their motivation, productivity and may feed into corrupt practices of embezzlement and misappropriation of funds destined for non-salary recurrent expenditure[201]. This is particularly true under the present work stress created by the Covid 19 pandemic, which demands dedication and overtime work by health staff, who complain about lack of equipment and inadequate remuneration. Furthermore, the bureaucracy and top-heavy procedures plus the strong centralization of the health sector not only reduces the efficiency of GAVI-supported interventions (particularly at subnational level), but also results in high transaction costs and slower reporting and monitoring feedbacks. Other matters of concern are the occasional delays in the transfer of funds disbursed by GAVI to government, from the DNT to MISAU as well as the weak effectiveness of the ICC, the high-level coordination forum for dialogue and decisions on all matters related to immunization programme governance, strategic direction, planning and policy[202]. These points are also recognized by one of the

196. KI 9, 26/10/2021
197. KI 12, 01/11/2021
198. KI13, 01/11/2021
199. KI 9, 26/10/2021
200. The views expressed here are not those of any GAVI representative, but of consultants familiar with the programme, as it was impossible to conduct an interview with a GAVI official in Switzerland, for reasons of agendas and time constraints.
201. KI 9, 26/10/2021.
202. KI 8, 15/10/2021

MISAU collaborators203. An evaluation of GAVI for the period 2013-2016 showed that, within a solid overall framework, further improvements are possible e.g. in the management of medicine procurement by the CMAM and the roll-out of vaccines (e.g. training health staff). It is also felt that the GAVI Secretariat should better align with government's fiscal rules when disbursing cash grants or ensuring timely supplies of inactivated polio vaccines (IPV) where these have been introduced (GAVI, 2016).

3.5.4. Challenges

GAVI's intention to decentralize vaccinations via funding for the DPS might be challenged by the introduction of the new decentralization paradigm[204], where the DSP under the Decentralised Provincial Government (OGDP)[205] shares responsibility with the Provincial Health Service (SPS)[206]) that falls under the Representative of the State in the Province (REP)[207]. This may not only affect GAVI support, but the health sector and its funders in general. The risk, also perceived by senior MISAU officials[208], is that the sector could suffer institutional fragmentation that, in a worst case scenario, could lead to cuts and or the retention of funds destined for provincial health activities e.g. supported by USAID (Weimer, 2021).

Another challenge that GAVI and its support for Mozambique may face, is general and not necessarily specific to Mozambique. Firstly, international NGOs have criticized the programme for not having a strategy for reaching the poorest children, particularly in fragile states such as Mozambique, and because there is an unresolved intrinsic conflict of interest of the pharmaceutical companies represented on GAVI's Board, which could lead to the unsustainable sale of vaccines to poor countries that cannot afford them[209]. This poses the further question of the extent to which GAVI's strategic goal of 'healthy markets' is realistic in poor and fragile countries such as Mozambique. A 'healthy market' for vaccines in Mozambique with paying clients and patients on the demand side may, for the time being, be a supplier rather than a demand-driven market, with its offer largely financed by external stakeholders in partnership with government as a junior, albeit consistent, funding partner. A strategic co-option of additional funders into the established GAVI mode of cooperation's would reduce the risk of a partial collapse of the EPI, should the current main funders reduce their contributions, for whatever reasons.

This is particularly true in the case of Covid 19 vaccinations, the second major challenge. A particularly demanding test case for GAVI in Mozambique is the supply of Covid 19 vaccines, where GAVI is part of the COVAX initiative and has self-assumed responsibility for mobilization and distribution of vaccines. So far, according to 2020 budget data210, GAVI has only registered some MZN 70 million (equivalent to about US$ 1 million) to the health sector for operational costs related to anti-Covid 19 measures, although additional funding has been mobilized through the Clinical Decision Support (CDS) funding streams and for COVAX-related TA211. It remains to be seen to what extent GAVI and its stakeholders will be able to reconcile the needs of Mozambique and other poor countries in the global South with the fact that 'progress towards vaccination goals remains slow because competition — not cooperation — continues to drive the global pandemic response', with 200 million doses allocated to African nations through COVAX, but only 88 million received as of October 2021212. The UN Secretary-General is quoted as saying that 'the richest countries and regions are getting vaccinated more than 30 times faster than those with the lowest incomes. This vaccination gap is not just unfair, it threatens everyone'. The Director-General of the WHO, has described the ongoing vaccine crisis as a scandalous inequity 'where just 10 countries have received 75% of all vaccines administered so far, while 0.3% have gone to lower-income nations, with the African continent receiving just 1%'213. Estimates cited by the ONE AFRICA Covid 19 tracker suggest that there could be twice as many deaths from Covid 19 in the global South if rich countries continue to monopolize vaccine doses instead of distributing them globally, with the unequal vaccine distribution costing millions of lives and the global economy a total of US$ 5.3 trillion over the next five years.

It remains to be seen to what extent GAVI and its COVAX allies will be able to break the monopolization of global supplies by the world's richest counties, including some GAVI partners, and become part of a solution in the sense of accelerated access to vaccines and rapid facilitation of distribution and application everywhere in Mozambique.

203. KI 9, 26/10/2021
204. For a critical analysis, see Weimer (2021) (OGDP)
205. Órgão de Governação Descentralizada Provincial
206. Serviços Provincial de Saúde (SPS)
207. Representação do Estado na Provincia (REP)
208. KI 13, 01/11/2021
209. Sarah Broseley, Vaccines and Immunization: Analysis: Vaccine programmes come under the microscope. The Guardian, 06/06 2006. https://www.theguardian.com/society/2011/jun/06/analysis-vaccination-programmes.
210. Source: CEDSIF, e-sistafe data for 2020 (dotação actualizada)
211. KI 8, 15/10/2021
212. https://www.one.org/africa/issues/COVID-19-tracker/explore-vaccines/
213. https://timesofindia.indiatimes.com/blogs/The-underage-optimist/global-vaccine-apartheid-it-is-a-blot-on-the-human-race-and-COVAX-is-too-feeble-a-remedy/

3.5.5. Conclusions

From a Mozambican perspective, it is concluded that MISAU staff, in particular, see GAVI as an essential and much appreciated specialized programme supporting the SNS, well embedded in MISAU and its financing architecture, aligned to a high degree with national procedures and with national ownership. GAVI's special focus on immunization and its strong integration into MISAU and the national PFM system, together with its cost-efficient implementation, make for a good and trusted partnership, the aforementioned structural challenges notwithstanding. The GAVI 'rules of the game' with an emphasis on the use of domestic planning and budgeting systems are considered 'strict but flexible'[214]. The senior GAVI management, said to have a cooperative approach to managing its relations with MISAU, appears open to requests for mobilizing additional resources, e.g. by promoting cooperation and financing possibilities with foreign non-state actors (NSA) such as the Clinton Health Access Initiative (CHAI)[215] or Oslo University in Norway (in the area of health information systems).

The overall positive assessment by both local stakeholders and evaluators largely corresponds to a global evaluation of GAVI commissioned by the UK government in 2010. It showed that the strong points were multi-year commitments, flexible financing options, a transparent allocation system and strong financial oversight. These together produced a highly cost-effective health intervention (UK Government, 2011).

3.6. Global Finance Facility (GFF)

3.6.1. Key features

Established in July 2015 in the Third International Financing for Development Conference in Addis Ababa, Ethiopia, the Global Financing Facility (GFF) can be considered as what we termed a 'diagonal programme'[216] with its own funding mechanism to support healthcare for women, children and adolescents. supported by the World Bank, its focus is on 'prioritizing and scaling up evidence-driven investments to improve reproductive, maternal, newborn, child and adolescent health and nutrition in the world's most vulnerable countries through targeted strengthening of service delivery systems' seen as necessary steps 'toward achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs)' (GFF, 2020: 8).

In its strategy for 2021-2025 GFF departs from the premise that during its first five years phase (2016-2020) GFF has 'pioneered a country-driven, collaborative model for global health linked to sustainable financing and results', has enabled 'other global health partners to achieve more by working better together and by empowering countries to lead' and 'has demonstrated how its approach is working to improve the health of women, children and adolescents in its partner countries and help close equity gaps' (GFF,2020: 9), while acknowledging, that these gains, however, have been threatened by the effects of the COVID 19 pandemic on health and nutritional services and poverty.

The GFF strategy 2021-2025 is based on five strategic directions, namely

1. Bolstering country leadership and partner alignment behind prioritized investments in health for women, children and adolescents;
2. Prioritizing efforts to advance equity, voice and gender equality.
3. Protecting and promoting high-quality, essential health services by reimagining service delivery.
4. Building more resilient, equitable and sustainable health financing system.
5. Sustaining a relentless focus on results.

The GFF innovative approach includes collaboration and co-financing with the WB, GF and GAVI. Cooperation with Civil Society Organizations (CSOs) is an integral part of the collaboration mechanisms, as it is felt that these play an important role in advancing Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition (RMNCAH-N) through technical expertise, engagement with decision makers, their links to communities, and holding governments, donors and other key actors to account. A GFF-promoted Civil Society (CS) Coordinating Group, which represents global, regional and nationally focused civil society organizations that come together to share information, coordinate, and engage in GFF. A manual has been developed to guide their interaction with it (Dennis, 2016).

214. KI 8, 15/10/2021
215. CHAI collaborates with MISAU in the area of treatment and diagnosis of HIV for children, cold chain systems for the supply of vaccines and the prevention of malaria (https://www.clintonhealthaccess.org/mozambique/)
216. see FN 20

Regarding health financing , the GFF approach includes the promotion of private investment in health service provision, and of global innovative financing opportunities, such as Sustainable Development Bonds and blended finance. Results-based financing (RBF) or performance-based financing (PBF) is also part of its approach, which includes the promotion of the necessary databases and information systems. RBF is considered crucial for of an effectiveness-driven investment. It requires 'evidence' to gauge the performance level that determines further funding, implying that the healthcare services , particularly at the level of health facilities / hospitals are being rewarded for the delivery of quality services as measured against predetermined indicators. It is felt that this innovation rectifies the 'problems with traditional, input-oriented public financial management systems that were unable to incentivize efficiency or utilization in the delivery of quality health services' (Piatti-Fünfkirchen et al., 2021).

The overall financing goal is to provide public and private funding together with Technical Assistance for the implementation of prioritized national health plans in order to scale up access to affordable, quality healthcare for RMNCAH-N. GFF's funding comes from various funding sources: governments[217], foundations[218],WHO and the private sector, including the pharmaceutical industry[219].

However, as a 'financing facility' GFF is 'not an entirely new source of funding that provides development assistance to deliver goods and services, but a mechanism that uses modest amounts of grant resources catalytically, bringing programmes to scale by leveraging far greater sums of domestic government resources'[220]. The basic idea is that this type of 'smart financing' and sharing and pooling funding should enhance the possibility of achieving more sustainability moving towards the SDGs for mother and child health (MCH), through improved efficiency and added value for money. The aim behind this approach, with its expected efficiency gains through PBF, is also to reduce the recipient country's dependence on foreign aid finance for its primary healthcare systems, particularly MCH, and increase the generation of domestic resources for this purpose.

The GFF funding mechanism can be perceived as a funding platform with three components outlined in Figure 15.

Figure 14: GFF Funding platform

Source: Author, adapted from https://www.fpfinancingroadmap.org/learning/specific-topics/global-financing-facility, Figure 1

Like GAVI's 'innovative' financing modality, GFF regards the funding of a country's health sector as an investment, 'fully owned' by the recipient country[221]. Among the expected returns on investment are the effectiveness gains generated by PBF. Consequently, an 'Investors Group' (IG) is part of the GFF's governance structure. Each country seeking to receive GFF support for its primary healthcare system and the improvement of reproductive, maternal, newborn and children's health is requested to submit an investment proposal, the 'investment case'(IC).

According to Seidelman et al. (2020), GFF was successfully replenished with more than US$ 1 billion in 2018. After nine new countries joined in 2019, GFF currently benefits 36 countries worldwide, one third of which considered 'fragile and conflict-affected states'. As of June 2019, US$ 629 million had been committed in 27 countries with an additional US$ 4.8 billion from IDA/IBRD funds. However, only US$ 120 million from GFF and US$ 901.5 million from IDA/IBRD have been disbursed so far, according to the above cited source.

3.6.2. GFF in Mozambique

Key to the understanding of GFF's support to the Mozambican health sector is a five-year Investment Case (IC), the proposal of which was elaborated between June 2016 and April 2017 in what has been deemed a wide consultative approach led by MISAU[222]. The initiation of the IC coincided with the moment in which 'Mozambique began to benefit from GFF for every woman and every child' (WB, 2017: FN 6) and in which the WB, began to design its Primary Healthcare Strengthening Programme (PHCSP) for which the IC also serves as reference (see below). The IC has been published in 2017 (GFF, 2017[223]). Focussing on Reproductive, Maternal, Neonatal, Child and

217. Including Burkina Faso, Canada, Côte d'Ivoire, Denmark, the European Commission, Germany, Japan, the Netherlands, Norway, Qatar, the United Kingdom and the USA;
218. Including the Gates Foundation, the Susan T. Buffett Foundation and Rockefeller Foundation;
219. E.g., Merck through their 'Merck for Mothers' programme, Laerdal through their non-profit branch 'Laerdal Global Health'.
220. https://www.globalfinancingfacility.org/financing-model

221. KI 11, 28/10/2021
222 For details of the methodology, see GFF (2017, Annex 1).
223 The IC Proposal exists in both Portuguese and English language. The English version available on the internet and accessed in March 2022 (https://www.globalfinancingfacility.org/investment-case-republic-mozambique) appears to still be lacking final review and editing.

Adolescent Health and Nutrition (RMNCAH-N) and oriented by the PESS 2014-19, it was developed under the leadership of the Government of Mozambique and in collaboration with GFF and a range of HPs. The IC prioritizes 'high-burden' districts[224] in 10 provinces with a combination of health system strengthening activities that are needed to overcome bottlenecks in providing services in RMNCAH-N.

According to GFF[225], the investment case defines three priorities for strengthening the SNS:

- Improvements in coverage, quality, and access to essential primary healthcare services through a combination of supply- and demand-side investments that extend to sparsely and high-burden districts, for example through the use of community health workers;
- Systems-strengthening interventions, such as efforts to improve data collection and monitoring in the civil registration and vital statistics (CRVS) system; and
- Increases in the volume, efficiency, and equity of domestic and external health financing.

In a press release of 20 December 2017[226], the World Bank announced the agency's approval of US$ 105 million equivalent in non-reimbursable grants for the Government of Mozambique's Primary Healthcare Strengthening Program-for-Results. Of this amount, US$25 million equivalent is provided by the GFF, and US$80 million comes from the International Development Association (IDA). It states that the programme 'will use a financing instrument called Program-for-Results (PforR), which allows for disbursements to happen only in a phased manner and based on achievement of pre-agreed targets'. The program comprises a set of 11 indicators established jointly with the Ministry of Health and its Health Partners. The PforR tool is deemed appropriate given its combination of robust elements of technical assistance, capacity development, coordination, and monitoring to support enhanced service delivery. It draws on recent experience with RBF in Mozambique, particularly the WB-supported Public Financial Management for Results Program (PFMRP) (P124615) that, according to the Programme Appraisal Document (PAD), has effectively contributed to strengthening the medicine supply chains. The other relevant experience with PBF was gained in the education sector i.e. the Educating Sector Support Fund (FASE)[227], through which the WB 'has channelled financing through disbursement-linked indicators (DLIs), while providing fiduciary oversight and coordination support for a wide range of other partners' (WB, 2017: 12).

In addition, this operation draws on recent experience with results-based financing in Mozambique and is fully aligned with the World Bank Group's Country Partnership Framework with Mozambique (2017-21).

3.6.3. Collaboration with the World Bank

Thus GFF thus is not only aligned with the government's IC proposal with its focus on RMNCAH-N, but is also embedded in the WB's programmatic operations the Mozambique's health sector, notably the PHCSP. In fact GFF co-finances the PHCSP and its underlying rationale, the IC. GFF's embeddedness takes the form of 'a multi-stakeholder partnership' housed at the World Bank supporting country-led efforts to improve RMNCAH-N through 'smart, scaled and sustainable financing' (WB, 2016: 12). The joint effort is based on the IC's identification of the most critical health system bottlenecks and challenges to sustained financing of the health sector, and proposes evidence-based interventions to overcome them. The bottlenecks identified cover the following areas (WB, 2016: 13, Box 1):

- Health service availability and readiness, particularly regarding obstetric and neonatal care, essential RMNCAH-N medicines/supplies, and facility access to water and electricity;
- Lack of capacity to retain and increase health human resources (HRH);
- Quality of care at different levels, particularly at rural health centres and district hospitals . The quality assessment methods include a balanced scorecard (BSC) to hold facilities accountable for results, incentivized through performance-based payments.
- Health financing and PFM. This includes promotion of more equitable resource allocation, the increase of health funding for lagging and under-resourced districts, as well as reforms that strengthen fiduciary oversight and fiscal decentralization to facilitate service delivery;
- Information for decision-making and accountability aimed at improving birth and death data in the Health

224. These are districts with below average health coverage and deficient capacity as measured by services provided on a per capita basis.
225. https://www.globalfinancingfacility.org/sites/gff_new/GFF-annual-report-2019/mozambique/
226. https://reliefweb.int/report/mozambique/world-bank-injects-105-million-improve-primary-health-care-underserved-areas

227 Fundo de Apoio do Sector de Educação (FASE)

Information System for Monitoring and Evaluation[228] health information system and a strengthen of the interface with Civil Registration and Vital Statistics (CRVS); and

- Change Management Support through capacity building for frontline workers and managers, including via technical assistance.

In a nutshell, according to the WB/GFF programme appraisal document (PAD), Mozambique's five-year IC aims to address these challenges by channelling financing to what is referred to as 'high impact investments'. It states:

> 'While focusing on RMNCAH-N, the Investment Case (IC) defines priorities for strengthening the National Health Service (NHS). The IC focuses on coverage, quality and access to essential primary healthcare services (delivered through APEs/mobile teams, health centres, and first line referral hospitals), as well as systems strengthening interventions such as improving data collection and monitoring through Civil Registration and Vital Statistics (CRVS). The IC also promotes increases in the volume, efficiency, and equity of domestic and external health financing. It addresses demand-side constraints as well as gender norms (e.g., family practices, cultural norms, and related inequalities) through a multi-sectoral approach, emphasizing community-based engagement and interventions' (WB, 2016:11).

GFF is seen to add value to the PHCSP with specific emphasis on results, quality, and access to essential primary healthcare services, as well as data collection, improving data quality and monitoring (GFF, 2018).

Based on an identification of the obstacles to improved primary healthcare, a theory of change and an analysis and classification of 'result potential', by district (MISAU/GFF, 2017), the proposed IC priorities were defined as:

1. Equity and expansion of coverage, which include the analyse of regional inequalities (the investment case prioritizes 42 'lagging districts' in 10 provinces) and the development of strategies to reach rural populations by expanding the community health worker network and mobile teams.

2. Reduction of barriers to both demand and supply to implement high-impact interventions in RMNCAH-N, including childhood and adolescent malnutrition, as well as family planning

3. Comprehensive Emergency Obstetric and Newborn Care(CEmONC) in district health centres through improved human resources[229], commodity management[230]– health information systems and civil registration and vital statistics – and health financing (commitment to increase the share of the government budget allocated to the health sector in the next five years).

In a log frame approach, the planned inputs (resources, TA) are linked to expected (quantifiable) outputs ('service production') and intermediate results, ('outcomes by problem') that, taken together, are assumed to produce the expected impact (MISAU/GFF, 2017: 72, Matrix 2). Indicators and targets are defined for each expected result per level of the hierarchy of objectives covered by the log frame. A distinction is made between the programme development objectives (PDO) indicators and disbursement-linked indicators (DLI) typical of the RBF approach. Disbursements will be based on achieving pre-agreed targets for a set of 11 DLIs jointly established with MISAU and the HPs which are expected to be committed to their use. Key activities to meet the DLIs are incorporated in national, provincial, and district plans. The joint DLIs are given in Annex 6.4.

3.6.4. Financing Arrangements and Risks

The initial financing arrangements for the PHCSP of which GFF is part are reflected in the WB's PAD and are given in Table 2 below.

Table 2: World Bank PHCSP: Total Initial Cost and Funding by Source (US$ million)

Source	Amount	Total
Government / Borrower		963.00
WB IDA (grant)		80.00
PROSAÚDE (Common Fund)	16.00	
GFF	25.00	
Embassy of Kingdom of the Netherlands	35.50	
USAID	22.50	99.00
TOTAL		1,142.00

Source: Author, based on WB (2017): 4

228. Sistema de Informação de Saúde para Monitoria e Avaliação (SISMA)

229. Availability, skills and distribution of MCH nurses, specialized professionals for ONC and surgical teams; professional motivation and satisfaction;

230. CMAM, national chain of warehouses, stock, transportation and allocation.

Since 2017, additional donors, Canada and the United Kingdom (UK) have joined the multi-stakeholder global partnership for PHCSP led by the WB and GFF. The emerging picture in 2018 is given in Table 3, which also groups the financing sources by the type of trust funds held and managed by the WB.

Table 3: Financing of WB led PHCSP support, by type of trust funds (2018), in US$ million

Source	Total	TOTAL	
IBRD/IDA			80.00
GFF			25.00
Multi Donor Trust Fund			
The Netherlands		35.50	
Canada		57.06	
DFID (Agreement not yet finalized)		33.10	125.66
Single Donor Trust Fund - USAID		22.50	22.50
TOTAL		253.16	

Source: Author, based on MISAU, (2020): 163

The WB's PAD is clear that only that portion of the IC based PHCSP inscribed in the annual PES and OE will be financed via its Programme for Result (PforR) component via on-budget and on single treasury health expenditure operations. The PfoR with its Trust Fund (TF) arrangements provides an entry point for HPs, which may no longer wish to continue their commitments to PROSAÚDE. Consequently, only this portion, together with government's own tax-financed health spending and the PROSAÚDE funds will be reflected in the e-sistafe operations and reports (WB, 2018: 15). According to PAD, 'the main difference between the PROSAÚDE common fund and the PHCSP PforR is that PROSAÚDE provides sector budget support to the entire PES, while the PforR will finance, through DLIs, only the majority of the PES that is directed to implement the IC' (WB, 2018: 21). The WB fiduciary oversight of the Programme will apply only to those health expenditures reflected in the PES (WB, 2018).

The PfoR insistence on PES and e-sistafe , however, does not mean, that other, non-PES and non-e-sistafe bonded financing modalities are excluded. In fact, PAD recognizes, that vertical financing by HPs, notably the vast majority of vertical financing is channelled outside of the on-treasury modality, i.e. with execution not managed or decided by the Government, with a large portion also channelled off the Government's budget and thus not reported via e-sistafe.

PforR is thus considered to represent a mechanism for maximizing the volume of resources, which is aligned with both IC and e-sistafe . The establishing a new sub-account of the Treasury to enable HPs co-financing of the IC through the GFF TF, MDTF and/or SDTF is foreseen. The PAD states that funding will be accessed the same way that state budget funding is accessed, but mechanisms will be put in place to ensure a more efficient, regular flow of funds to decentralized levels (WB, 2018). Regarding the GFF funding component, the day-to -day management operations are connected to IDA or IBRD financing mechanisms and the Management Unit in MISAU. Seeking to mobilize additional resources, including domestic ones is part of the business. According to the GFF website, 'each dollar invested in the GFF TF brings together four sources of funding: domestic government resources, IDA and IBRD, aligned external financing, and private sector resources'. Thus GFF is not designed as a financing gap filler but rather for crowding-in and bundling 'additional resources from the broader set of partners that are part of the facility and to ensure that the available resources are aligned and working smoothly together'. In other words, GFF claims to produce an increasing degree of control over other bi- and multilateral resources, as well as, via IC, indirectly over domestic budget resources.

The innovative PBF element serves to encourage achievement of the predetermined targets by conditioning funding for local health authorities and units to improved PBF based on two principles:

- 'The variation in the volume of services, depending on the population and intensity of use of capitation financing; and
- 'Compliance with outcome indicators and/or quality in the IC M&E framework, allowing the negotiation of incentives/penalties that encourage good management and motivate professionals' (MISAU/GFF, 2017: 67).

The 'parallel use' of the two principles is said to facilitate the application of 'conditionality' in disbursement linked to result-indicators, without jeopardizing the continuity of the provision of services.

In a wider perspective, also in Mozambique, the WB 'has become one of the largest and most influential health funders

worldwide' (Sridhar et al., 2017). This is particularly true for the health support programmes under WB trusteeship. This financing model implies that donors may want to rally behind and use the WB as the manager of trust funds, as well as a valid interlocutor with national governments. One reason why bi- and multilateral donors wish to associate with the WB is to minimize fiduciary risks considered high when funding is channelled to the national treasury (on-CUT) and managed directly by the host country, as the historical case of PROSAÚDE demonstrates (see section 3.3). Bilateral donors may believe that WB trusteeship and its management capacities minimize the risk of misuse of the funds managed by the host country, either in bilateral or pool financing arrangements.

The WB TF model is attractive to donors for several reasons (Winters & Sridhar, 2017). Unlike IBRD/IDA funded health programmes financed by governments only, Trust Funds have the added advantage of also drawing on private sector funding e.g. by big companies, including those in the pharmaceutical industry, and philanthropic organizations such as the Gates Foundation. Consequently, these gain a voice and power in decision and policy making bodies. Compared to WB core business lending operations (via IDA/IBRD) this may allow more flexibility in disbursing funds while maintaining the WB's trusted fund management .

As we have seen the trust fund model often involves a results-based approach (as in the case of GFF and GF), with 'narrowly defined goals' and measurable outcomes gauged 'by simple metrics' (Winters & Sridhar, 2017). A gradual shift has been observed, also in Mozambique, from a CF model such as PROSAÚDE to the Trust Fund financing model. Another advantage of working with the WB is its longstanding relationship with the Ministry of Finance in the country supported by the WB, an agency which is often more powerful than a health ministry. This is a not a negligible aspect for leverage over and shaping, promoting or limiting health reforms under aspects of fiscal and macroeconomic stability, especially when it comes to the number of civil servants and salaries in the public sector.

According to academic literature, the WB's powerful position in TF health financing entails risks , for both recipient countries and donors partnering with the WB. These include 'its potential for misaligned aid allocation, reduced Bank accountability and inadequate transparency' (Winters & Sridhar, 2017: 1). These authors have raised three main concerns:

- Small groups of stakeholders and donors may gain increasing influence over the WB's priorities by bypassing existing allocation systems, which could 'tilt health funding towards vertical interventions and away from health priorities in the recipient country'. In particular, the attractiveness of innovative health financing mechanisms such as GFF, 'places health decision-making authority in the hands of a small group of donors' (ibid: 1);
- The risk 'that trust funds erode capacity of core health, nutrition, and population staff and weaken accountability mechanisms at the bank' which 'might increase transaction costs for the bank and recipient countries'; and
- the 'especially high risk' of TF financing global health programmes is that of lacking oversight and accountability. The cited authors suggest that 'the bank does not have a central unit to oversee its participation in global partnerships ...and the financial intermediary funds that typically fund these partnerships are not covered under the bank's standard fiduciary, operational, or administrative policies' (ibid: 4).

For these and other reasons, including a better alignment with specific country contexts, there has been a call for a thorough evaluation and review of GFF (Seidelmann et al., 2020) and for a more coherent understanding of what is meant by 'country systems' where GFF funding is supposed to be using PFM management (Piatti-Fünfkirchen et al., 2021).

It should also be mentioned that private sector interest in health financing has been particularly, and not surprisingly, on the agenda of the WB, the GFF and the World Economic Forum. They have argued in favour of private business engagement in the African health sector (IFC, 2008) . The argument is that there is a widening health financing gap, given that Sub-Saharan Africa accounts for 11% of the world's population and bears 24% of the global disease burden, but commands less than 1% of global health expenditure. This gap and, in particular, the investment needed for clinics, warehouses, training of medical staff, etc., provides an opportunity for private business to enter the scene, on the assumption that the public sector and aid are unable to generate the much-needed resources for meeting the growing demand for health services. Outside the scope of this study, it is recommended that this topic be further explored in a more systematic way.

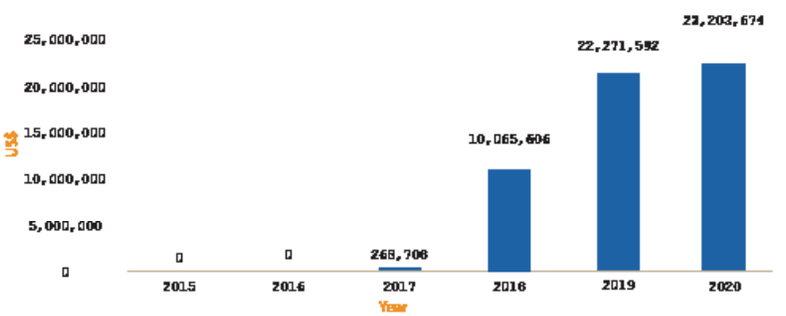
3.6.5. Relationship with MISAU

3.6.5.1. Funding

The agreement between Government and the WB on the IDA and GFF grants stipulates and details the funding rules in Section C (chapters 43-45), taking the specificities of results-based financing into consideration. In principle, the loans are said to follow the on-CUT modality and the e-sistafe system, 'but mechanisms will be put in place to ensure a more efficient, regular flow of funds to decentralized levels' (WB, 2017: 30). For several interviewees, it is not clear what these mechanisms are.

The projected annual WB IDA funding for the health sector for the PHCSP is shown in Figure 16. The total spent to date is US$ 55.8 million with an annual average of US$ 13.9 million.

Figure 15: WB IDA PHCSP, annual budget (updated allocation) 2015-2020, in US$



Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

Except for the programme's first two years, annual spending in 2019 and 2020 has oscillated modestly around the projected amounts defined in the PAD (WB, 2017: 16, Table 1).

In the case of the GFF Trust Fund, the MDTF and the SDTF in the PAD (and depicted in Figure 13), which are also supposed to be channelled on-CUT, neither the e-sistafe data seen by the author nor the budget execution report show any entries under the corresponding classifications. It is not clear whether or not the MDTF and SDTF are included in the funding allocations via the WB IDA programme in the Figure above. Nevertheless, taken together these funding sources are considerably higher than the WB/ IDA funding, as Tables 3 and 4 above show. The answer to a written request by the author to GFF to provide information on matters of planning, budgeting , execution and accounting for its funding contribution to PforR unfortunately did not help much in clarifying the doubts raised above.

Consequently, for the purpose of this study, it was difficult to establish with confidence the extent to which the GFF, MDTF and SDTF funding contribution to PHCSP via the PforR mechanism is aligned with the national system' i.e., e-sistafe, and how spending by these three sources can be tracked. One reason for this difficulty may lie in the fact that, according to PAD, the IC has two parts: (i) activities that are in the PES i.e. on-budget and on-CUT health expenditures financed by the government's own revenues, and external funds such as PROSAÚDE; and (ii) vertical financing by health partners, most of which may be channelled off-budget and thus not captured by e-sistafe. Another reason may be that because PBF being part of the GFF approach, funding is disbursed after the annual planning and budget cycle, i.e. after the level of performance, in relation to the DLI has been validated by a monitoring mission. The Aide Memoire for the monitoring and validation mission suggests that disbursement for 2018 to 2020 may not yet have been made at all (WB-GFF, 2021: 2).Thus, the budget execution report might not yet reflect disbursements. Furthermore, the absence of MDTF and GFF financial data in this report might suggest that the funding is channelled off-budget, a common practice and a not infrequent preference by MISAU and MEF, for reasons explained in section 2.4. In any case, the reconcilability between PBF and established PPB approaches embodied in e-sistafe remains a challenge – and a risk for GFF (see section 4.4.3).

3.6.5.2. Management

GFF's governance is exercised collectively by three bodies: the Trust Fund Committee (TFC), a set of donor representatives contributing over US$ 30 million each annually and World Bank representatives. This is where the main decision-making power lies. In terms of strategic planning, it is advised by the Investors Group (IG) in the GFF Secretariat in Washington, which also provides analytical and technical support to recipient countries (via the country platforms) and the GFF focal point in a specific country hosted in the World Bank's offices. The secretariat's team is composed of international

experts in matters such as health systems, health financing, maternal and child health, nutrition, family planning, private sector engagement, communications, knowledge and learning, and monitoring and evaluation. The Country Platform (CPF), led by the national health ministry, represents the GFF's domestic governance structure responsible for the elaboration of documents such as the IC, resource mobilisation plans, and the coordination of technical assistance and monitoring.

In Mozambique, at the central level, MISAU's Directorate of Planning and Cooperation(DPC), in MISAU will provide the overall coordination of the programme. This includes ensuring that the programme's key activities meet the DLIs are incorporated in national, provincial, and district plans. although the 'new decentralization paradigm', has affected the structure of health administration and at provincial level, at the time of the design of the IC the provincial and district governments were foreseen to be part of the implementation mechanisms of the programme, particularly the Provincial Directorate for Health (DPS) and the District Services for Health, Women and Social Affairs of the District Governments (SDSMAS) to which the subnational health facilities are administratively and financially attached. MISAU, at central level, is also responsible for coordinating with other ministries which must be strengthened through the IC. These include the MEF for financial planning, execution and domestic resource mobilization, as well as the Ministries of Gender, Children and Social Action (MGCSA), of Youth and Sports (MINJUD), and the Ministry of Education and Human Development (MINEDH) with regard to activities aimed at enhancing access to information on nutrition and comprehensive sex education.

A Programme Management Unit (PMU) in MISAU reporting to DPC, which manages several WB funded programmes, is responsible for the day-to-day management and logistic and administrative support of the programme. It will cooperate with the MISAU's DAF and UGEA. Further, the National Directorate of Medical Services (DNAM) is responsible for ensuring service delivery in health facilities, in the district/rural and general hospitals targeted by the programme, whereas the National Directorate of Public Health (DNSP) will provide the key strategic and technical guidance to the implementers of the programme, and will ensure implementation oversight at all levels.

The above sketched complexity of the Programme's governance and management structure requires a systematic and high degree of coordination, sharing of information and communication within, between and across institutions. This might be a major challenge in a situation in which institutional cultures sometimes reflect a 'silo mentality', i.e. barriers to communication between members of a team and within and across institutions.

Given the PBF approach introduced in PfoR and thus GFF, monitoring performance based on an established and agreed framework is another one of the management challenges. GFF's use of performance indicators seems to lack a clear distinction between levels or layers of performance, where progress is measured. According to this source, it would be useful to distinguish explicitly between three indicator levels. These are: i) the macro level, where nation-wide indicators are used, as in the case of general budget support (see section 4.2.1) or, in the case of GFF, 'domestic financing' (Disbursement Linked Indicator 5); ii) health facility-based performance indicators used to reward collective achievements with more resources for the facility (which seems to be the case with GFF funding) and iii) individual performance indicators for health workers. Managing the performance-based component is further complicated by the fact that the performance assessment is a task assigned to different independent evaluation agencies, which include the Supreme Audit institute / Administrative Court (TA/3a) and also MEF, which do not necessarily have a good methodological rapport with MISAU. Misunderstandings between the verification agency and the ministry may therefore be frequent and time-consuming. For example, DLI 5 on domestic health financing represents an indicator that does not appear in MEF's annual budget execution report.

However, according to the GFF Annual Report 2018/2019, the results of the IC case, only introduced in late 2017, suggest that most of the defined targets at the programme development objective (PDO) level have been exceeded (IBRD / GFF, 2019: 32 f).

With these intended innovations, new to Mozambique, GFF finds itself on a steep curve of learning and producing its first results. These are particularly visible at provincial level, lass so at national level. Before assessing the relationship with MISAU and perceptions of GFF, there are comments on the role of the WB that, as the host of GFF and trustee, plays a major role in implementing this funding mechanism.

3.6.6. Perceptions

3.6.6.1. GFF perspective

From a GFF perspective, and according to two Annual Reports (IBRD/GFF, 2018; 2019), the mechanism is on track. GFF's 'invitation to MISAU to present an investment case' and 'design', 'drive' and 'own' the resulting programme, as well as to contribute to its financing, are pointed out as indicators of progress . A KI interviewed concedes that the programme, while 'fully owned' by government, is managed by the WB, which may lead to misunderstandings about the nature of the programme. Some observers may also not clearly see the difference of focus between the RMNCH-N (GFF) on the one hand, and PHCSP on the other.

Given the main difference between, on the one hand, a 'conventional' programme such as PROSAÚDE and, on the other hand, GFF with its focus on women, children and adolescents and its innovative results-based approach, there are several challenges. The context and the nature of the programme is said to require new and different working methods and, institutional and individual capacities. One of the required innovations is the existence of an IC owned by government.

This is particularly the case for setting up and managing the PfoR and RBF framework, improving the necessary data systems and their quality, as well as familiarity with log frame methods and results-based evaluations. From a GFF perspective, much remains to be done in these areas. It also requires more frequent meetings at central and provincial levels compared to other programmes. In particular, the concern about data and their quality are echoed by the Annual Report 2018-2019 when its states that 'data quality also remains a challenge; it needs to be strengthened further as it is a key input to the country platform's functioning and data monitoring role' (IBRD/GFF, 2019: 34).

These challenges notwithstanding, and although the GFF approach has its own challenges, the first results produced by GFF 'tangible and encouraging'. The monitoring and validation of progress in implementation for 2018, 2019 and 2020, done remotely, have concluded that many of the targets as measured by the DLI were fully or partially met, with verification of the 2020 data still pending (WB-GFF, 2021). The Aide Memoire concludes that, after completion of the validation exercise, this achievement may trigger the disbursement of 48% of the total programme amount, if the advance is included. Areas of concern about the DLI were: (i) delays in transfers from the province to districts to implement activities critical to the DLIs, (ii) delays in the schedule of validation of DLIs in 2020, which will affect cash flow. Other concerns include the lack of clarity on decentralization policies, and the community sub-systems, and the quality of APE service delivery, the need for better routines, accountability, and training in monitoring and evaluation as well as the issue of more equitable financing (WB-GFF, 2021).

From this perspective, the programme is also seen to be contributing to the necessary decentralization of the sector, as it gives far more responsibility to the sector's subnational entities, notably DPS in planning, and district governments (SDSMAS), hospitals and health units in service delivery. It is there where some of the predetermined targets, on which further funding depends, need to be met. Together with the PBF, this is a contribution to what is referred to as 'a transformation of the health sector' at subnational level towards improved service delivery in primary healthcare.

GFF emphasis on a proactive and complementary role for national health NGOs that, in the case of Mozambique, are to have their own 'platform' within the GFF framework, is also noteworthy. A representative of national NGOs should be an additional player together with the partners' representative at the coordination level of the 'troika' (see section 4.2.3).

From a GFF perspective, coordination with government and donors remains a major challenge. The heterogeneity of the donor landscape, the lack of a detailed understanding of each other's programmes, little progress on a common MoU with Government to replace the existing one (with PROSAÚDE) and delays in updating the 2003 Kaya Kwanga Code of Conduct have hampered coordinating efforts. As the GFF Annual Report 2018/2019 concludes, 'it is critical for Mozambique to further strengthen existing coordination structures and establish a well-functioning country platform'. Areas of focus for the country platform should include 'monitoring the implementation of the investment case on a regular (quarterly) basis to facilitate timely and relevant course-correction' (IBRD/GFF, 2019: 34). For some observers in the health partners group, it is unclear how the Investment Case is coordinated amongst its many partners (including MISAU and non-GFF ones like UNICEF), and how it is embedded in MISAU's routine MCH coordination structure.

Given that GFF sees itself as a catalyst for innovative funding arrangements, the development of a health sector financing strategy (HSFS) is one of GFF's priorities, including the mapping of resources ('fiscal space'). The HSFS elaboration process, started in 2015, has 'taken too long' and may lack the necessary quality, including due to 'lacking substantive inputs from MEF' . It is a major concern that GFF funders, government included, do not allocate and disburse the promised funding in a timely manner. Moreover, the (lack) of government commitment to financing the community health workers was also mentioned . For the reasons addressed in section 2.4, MEF is not necessarily a proactive partner in supporting the health sector. However, the other side of the coin is the substantial increase in the 2019 and 2020 national health budgets, a strong indicator of government's commitment to mobilizing resources for the sector, towards achieving the target set by the Abuja Declaration.

As regards effective financial management, some hope is placed in the reformed e-sistafe, notably the planning and budgeting subsystem and the annual budgeted plan (PESO). To make use of these, MISAU needs to improve technical competence in both DAF and DPC (MISAU, 2020).

3.6.6.2. Trust Fund Partners' perspective

From the perspective of agencies such as British High Commission / FCDO and the Canadian High Commission / Canadian International Development Agency (CIDA), both former donors of PROSAÚDE - their decision to support GFF via the MDTF was triggered by the fiduciary challenges facing the health sector and the Mozambican government as alluded to above , and their desire to see improved results and efficiency, or value for money spent on the sector. In the case of Canada this the joining of GFF reflects also a principled decision, since the country is a major supporter of GFF globally .Other features of GFF and the WB's PHCSP which attracted co financiers were its focus on RMNCAH-N, particularly at subnational levels of SNS, particularly the high-burden' districts', its stated endeavours to boost sector coordination and align HSF , the combination of targeted interventions with its focus on PHC and MCH with HSS at national level, the proactive engagement with and involvement of INGOs and national NGOs, as well as, to some extent, the introduction of PBF. The underlying IC was seen as a document of high-quality and an excellent point of departure.

Today, more than 3 years into the GFF's first five-year implementation period, the perception of the programme and its specific financing approach is somewhat less enthusiastic. There is a general perception that GFF, excellent by design, did not sufficiently reflect the concrete institutional realities of the sector and the country. This led to a gap between the initial aspirations on the one hand, and the complex mechanisms, management challenges and constraints retarding implementation on the other, because 'basic preconditions were not in place'. In the words of KIs representing GFF financiers the programme is 'very ambitions' or ' overambitious', lacks a 'sense of realism', with GFF and the WB 'overpromising' of what is doable .

Specifically, four critical issues regarding GFF performance were highlighted, namely:

- insufficient progress regarding coordination and alignment with other programmes, particularly at sub national level;
- insufficient sense of leadership / ownership by MISAU at central level – contrary to provincial level institutions such as SPS and DPS;
- the initially claimed production of value for money is difficult to gauge since it is not clear what has been spent on what, with little information provided;
- the envisaged alignment of both planning and of HSF has not seen little progress, probably because of delays in the production and approval of a national HSFS.

while the representatives of the two MDTF members whose opinions are reflected above argue in favour of a wait and see attitude regarding continuation of financing GFF beyond the present implementation phase , the USAID with its SDTF already withdrew its financial support to the GFF in Mozambique. Having initially committed to disburse US$ 22.5 million to GFF over the current five-year financing period, the agency decided to terminate the financing agreement after two years, with only approximately US$ 8.3 million having been spent. The reasons given were issues such as lack of clarity about the purpose of funding (of what exactly is being funded), weak ownership by MISAU, poor performance, and lack of transparency.

A decision by both Canada and the UK on continued support to GFF for its subsequent phase from 2024 onwards is likely to be influenced by several factors. One is the outcome of the substantially delayed GFF Mid Term Evaluation .Other factors are whether GFF can construct, together with other programmes, notably PROSAÚDE, a kind of common platform, which enables programmes to cooperate, coordinate and finance in a planned way, particularly at sub national level, despite differing approaches and philosophies of the programmes. A hybrid form of support to SNS at particularly at decentralized level is clearly being called for , · a form which draws on and maximizes the strengths of both GFF and PROSAÚDE and enhances leadership by MISAU. This also is to include an improved PBF approach. The Pro-Accountability Initiatives (PAI) presently being tested in health sector in Nampula, is part of the emerging FCDO's Potenciar programme. It might provide an opportunity to reinforce participatory monitoring and thus supporting of the PBF approach at the level of the health unit.

3.6.6.3. MISAU perspective

The perspectives on GFF by key MISAU informants and health consultants / advisors contrasts with that presented above. Of all the funding modalities, including vertical programmes, GFF seems to merit major criticism. 'GFF is where we have the most problems with'is a statement heard from several KIs. The programme is considered 'well-intentioned' but 'technically too complex to be well understood by key stakeholders' and 'lacks a concrete implementation plan aimed at strengthening primary healthcare services'. In this context, the above-mentioned complexity of inter-institutional relations and particularly between the independent evaluation agency establishing the extent of programme performance and MISAU has been emphasized.

Although the programme claims to be fully owned by government, a critical view expressed by two KIs holds that MISAU never took formal ownership of the Investment Case (IC), which was elaborated by a consultant and not formally validated by government. In fact, the IC version published on the GFF is labelled 'proposal' and lacks final editing. One source maintains that it is the Secretariat in Washington that frequently, unilaterally and urgently requests changes to details of the IC (planned actions, indicators, etc.) and in documents, as well as disregarding decisions that have already been agreed upon. The evidence for this assertion is the various versions of the IC, each representing an incremental update of the previous one, driven by the Secretariat. According to a senior MISAU official, 'GFF does not want to negotiate, but only wants to decide, often without the necessary consultations'. The IC is seen to have been, to some extent, the result of pushing for a more innovative, result-based approach to strategic planning – even as a potential substitute to PESS – but has been lacking not only dedicated ownership by government, but also clear ideas on implementation and on translating the approach into the national PFM system.

Several KI are of the opinion that GFF's use of PBF implies the risk of 'creating a parallel system' at the cost of the established PFM system. The current GFF practice of encouraging health facilities to open separate accounts at private banks for performance related payments clearly is not in line with the principles of channelling financing through CUT and is regarded as introducing such a 'parallel system' i.e. that does not inspire confidence in accountability procedures and transparency.

Consequently, performance-based payments to accounts of health facilities in the private banking sector run the risk of being considered legally questionable, as the PFM system does not foresee such payments. Indeed, one MISAU interviewee in charge of financial management referred to a letter that the MISAU Permanent Secretary sent to the GFF management requesting clarification about GFF's financial management procedures. Of particular concern is the GFF managers' apparent 'lack of understanding of how the e-sistafe works in practice at district government and at hospital level, among the main foci of interventions'.

In this context, reference was made to the need to make use of the 'budget windows' (janelas orçamentais) currently being introduced at SDSMAS level. These windows permit viewing and monitoring budget allocations and execution of health facilities at primary and secondary level (CSP, CSS). The data generated would serve as indicators for performance and for earmarking funding within the district budget. The GFF assumption that, as in other African countries, Mozambican hospitals and health units are 'budget holders' and have a degree of autonomy, is clearly flawed. As suggested by a recent study, such autonomy is not just around the corner, as funding is allocated to health units indirectly via SDSMAS and not directly to a hospital (N'weti, 2021).

Some of the MISAU staff concerns are also shared by KIs representing other health financing programmes analysed here. According to these sources, there is a clear mismatch

between GFF ambitions and the way MISAU is structured and operates, as well the SNS on the ground. These KIs also point out that the SNS health units and hospitals, do not yet have the GFF-required capacity to monitor and report on performance, the necessary precondition for GFF's functioning as an RBF mechanism. Nor is it clear how the GFF planning cycle is aligned with that of MISAU, given that the funds are hardly predictable as they are dependent on performance.

One KI suggested that, as GFF is perceived to seriously lack transparency and accountability, it can be compared to a 'slush fund', a description that once sullied the reputation of PROSAÚDE. Even beyond Mozambique, some authors stress the need to improve governance. They insist that 'GFF and World Bank representatives, as well as recipient government officials, have been found to fail to align with GFF-stated core values such as transparency and inclusiveness for all stakeholders and specifically for civil society' (Seidelmann, et al.,2020).

From a conceptual and technical point of view, and taking into considerations the perceptions reflected above, there are three key issue which GFF might want to address to ensure making a difference trough innovation:

- The issue of full ownership of the IC by government;
- The way forward, or a roadmap, for implementing the programme in line with priorities and aligned with established procedures' and
- Seeking a way to make the introduction of PBF commensurate with the established planning and budgeting procedures. This includes addressing issues of a degree of autonomy of local health units, the reflection of ex post performance financing in ex ante planning and budgeting, and the issue of data systems required to monitor performance.

Without addressing these concerns GFF's viability and sustainability might continue to be questioned, particularly by senior MISAU staff. Particularly the introduction of PBF reforms clearly needs to be analysed further in the Mozambican PFM context. A recent WB discussion paper recognises the need to address this issue, and not only in Mozambique. The paper identifies a set of steps required to make good use of the PBF approach and requests feedback from the health finance and PFM community in order to guide further work in this field (Piatti-Fuenfkirchen et al., 2021).

Another critical issue, to be addressed in more detail in section 4.4 is the urgency of continued responsiveness by government and donors to the need for additional funding, particularly for subnational health units and community health. This priority with a focus on MCH is clearly reflected in the GFF/WB approach. On the other hand, GFF sees itself not as a financial gap filler. A test case for GFF's viability is therefore its capacity to help engineer a strategic shift to increased domestic and international HP resources. If GFF's aim is to be a catalyst that unlocks more domestic and international resources for RMNCAH-N, the mapping of the fiscal space and promoting public revenue generation and more efficient spending on health are imperative for its future path and success (see section 4.4.3).This implies that 'realistic perspectives' and 'feasible avenues' for government to increase public domestic resources and to mobilise additional external funds via different pathways for RMNCAH-N 'need to be placed high on the agenda' (Seidelmann et al., 2020). For reasons addressed above, it may be far from certain that GFF can count on mobilizing the resources needed, particularly for the Multi Donor Trust Fund. In other words, scenarios where donors such as the UK substantially reduce their funding contribution and/or where the Netherlands leaves, are not entirely unlikely . As we have seen above, USAID has already halted its planned contribution via the SDTF.

The stock-taking exercise of the GFF experience in all countries where it operates, after its first five years of operation, announced for 2021, will be an opportunity to evaluate the Mozambican experience and identify the system's strengths and weakness and suggest changes. Given the critical perceptions of the programme by national stakeholders, this exercise must, from a Mozambican perspective, be most welcome.

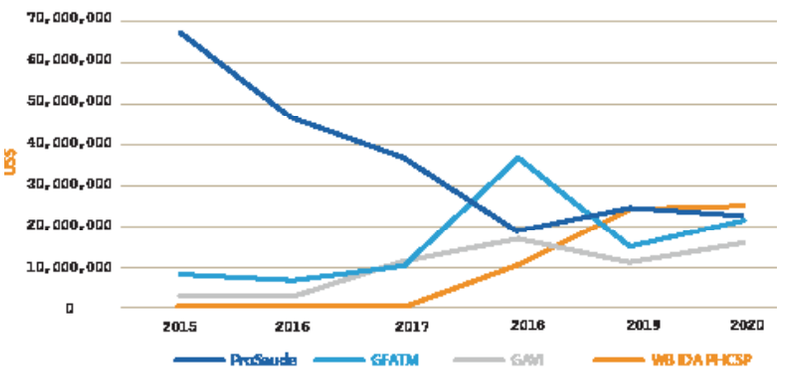
3.7. Conclusions – Case Studies

This final section of the case studies chapter begins with an overview of the external resources that programmes allocate to the health sector. This is followed by an attempt to portray, from a Mozambican perspective, the perceived opportunities and challenges for each of the funding modalities analysed in the case studies followed by, in conclusion, a summary of key findings.

3.7.1. Funding trends

An overview of SNS funding via the programmes examined in the case studies is given below in Figure 18.

Figure 16: Overview: Budget - Updated allocation (dotação actualizada) by programme (case studies) (2015-2020), in US$

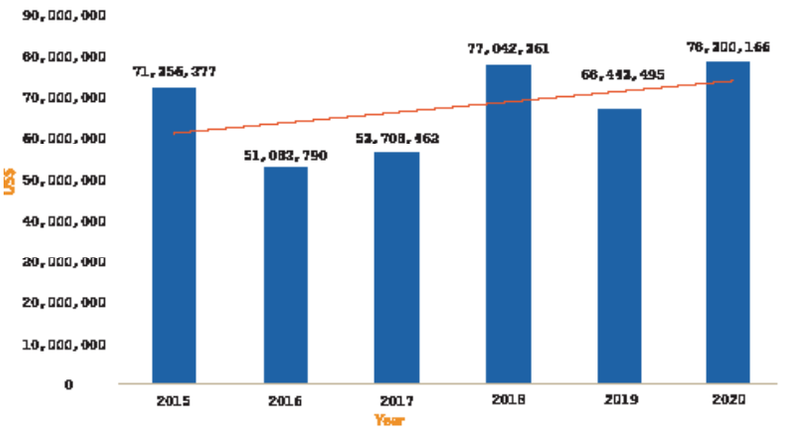


Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

For the reasons discussed in section 3.3, PROSAÚDE funding fell dramatically by more than two thirds between 2015 and 2018. Since then, it has stabilized at around US$ 20 million per year. GF funding rose steadily from low levels in 2015 and 2016, when the new funding mechanism was introduced and peaked in 2018, but has since fluctuated: falling to US$ 15 million, then picking up to a level equal to PROSAÚDE funds in 2020. GAVI funds rose from low levels up to 2017, but remain modest, fluctuating around US$ 15 million per year between 2018 and 2020. The WB PHCSP which includes a GFF contribution only started in 2017 and grew to approximately US$ 22 million in 2020. As already pointed out above, neither the GFF nor the MDTF and SDTF funding components are explicitly reflected.

The annual cumulative amounts for the four programmes between 2015 and 2020 are given in Figure 19. On average, it ranges between US$ 60 million (in 2015) and US$ 70 million in 2020, with a tendency to grow, essentially due to the entry of WB PHCSP in 2017.

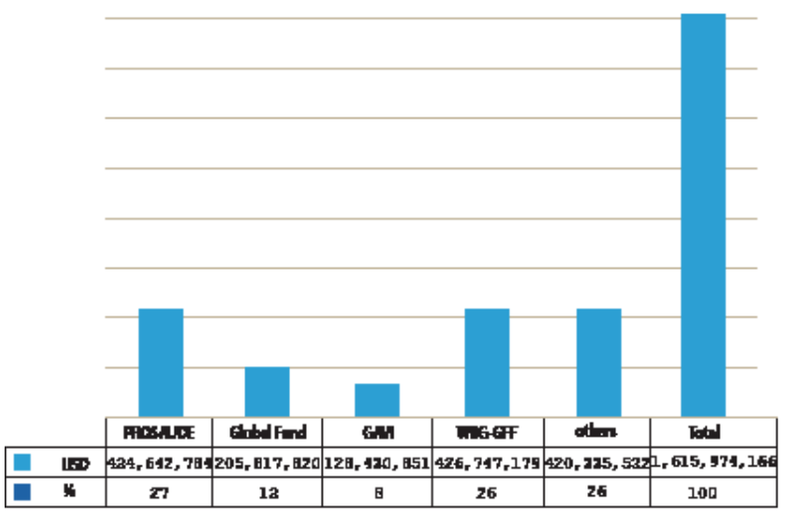
Figure 17: Total Annual Budgets, all case studies, 2015-2020, in US$



Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

The relative weight of each programme's cumulative contribution to health sector financing in Mozambique between 2015 and 2020 is given in the Figure 20.

Figure 18: Aggregate Budgets (2015-2020), by case study programme and 'other' external support, in US$ and %



Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

Over the six-year period, PROSAÚDE has maintained its solid position as an important pillar of health financing, despite the declining amount and number of partners contributing 27% of the overall budget, on a par with the WB and other programmes . The percentages for GF and for GAVI are 13% and 8%, respectively.

3.7.2. Dynamics

Beyond the analysis of perceptions presented in the four case studies the study further draws the following conclusions:

- PROSAÚDE, which arose out of a SWAp in 2003 and introduced common fund (CF) concept, continues to be seen as a firm pillar of support for the SNS, despite its declining volume and membership over the past nine years. This is particularly true for KIs representing MISAU and the group of consultants. The reasons for this are its embeddedness in the SNS, strong ownership by national stakeholders, its full alignment with the national planning, programming, budgeting and reporting process in the country's public financial management system and its potential for decentralization (under PROSAÚDE III);

- In the opinion of most of the KIs, PROSAÚDE, is also open to address its deficiencies, notably in procurement and innovation, such as introducing performance-based financing (PBF) for which there is a window of opportunity in the planning and budgeting subsystem following the review of Mozambican PFM legislation. Contrary to the opinion of some observers, PROSAÚDE is not to be written off. It could receive new 'life blood' in the form of increased funding by international partners or even the return of funders who left.

- The GF – once a PROSAÚDE contributor/partner – has been supporting the SNS since 2004. The US government is the single largest donor for this disease focused vertical funding mechanism. Its financial contribution to the SNS is considerable and rising. Its cumbersome approach to management and partnership, based on a three-year 'replenishment' fund-raising and pledging mechanism was replaced by a New Funding Mechanism (NFM) between 2012 and 2014. It now has a Programme Management Unit (PMU) within MISAU and channels funds through the on-CUT approach. These changes are said to have improved local ownership, alignment, the management of programme implementation and the predictability of funding. Unlike PROSAÚDE, GF, together with GFF also emphasizes the role of NGOs in achieving its specific objectives.

- From the perspective of MISAU KIs, the big disadvantages of GF are the need to follow the US budget cycle and administrative procedures, its top-heavy management by a Secretariat in Geneva and its strong dependence on external consultants. Mainly for these reasons, it has high transaction costs for MISAU staff. Its use of a performance-based funding approach involving an incentive funding stream is considered less controversial than in the GFF case. The programme's total funding between 2015 and 2020 has been rising. There is potential access to additional funds through well-prepared and well-justified applications.

- GAVI, a vertical programme focusing exclusively on immunity and vaccination, is well embedded in the SNS, despite being managed from Switzerland, i.e. no PMU in MISAU. It is fully aligned with the government's comprehensive multi-year vaccination plan. With its clear focus (complemented by HSS), its long-term, market-oriented perspective and the pooling of various resources (including from private companies and the pharmaceutical industry) GAVI is appreciated by its Mozambican and international partners. Its response capacity to the Covid 19 challenges has yet to be fully tested.

- As shown above, GFF, the youngest programme is perceived to not have yet managed to fully demonstrate its worth and the difference it makes compared to the other programmes. Issues of the quality of ownership and transparency have been flagged. Particularly controversially perceived is also its understanding and implementation of the performance-based financing approach, seen by some observers to be maladjusted to the Mozambican primary healthcare reality and the way subnational budgets are managed. However, this is not to suggest that the principle of PBF as such is questioned. On the contrary, PROSAÚDE stakeholders have expressed interest in learning from the GFF experience in this regard. And GFF Trust Fund members have expressed their interest in a common platform to develop a ' hybrid system' between PROSAÚDE and GFF focussing on PHC and coordinated interventions at subnational levels of the SNS.

- Related to the previous point, GFF, despite all critical perceptions of the programme alluded to above, clearly represents conceptually an innovative, cross cutting approach with a clear focus and the recognition of action in favour of healthcare facilities and their users at subnational level with well-defined fragilities. As a 'diagonal programme' it may be able to inspire the transition from vertical approach to a more integrated approach, potentially epitomizing the 'convergence' (Glassmann et al. 2020) between vertical and horizontal programmes which so far have been characterizing health financing modalities in Mozambique.

Finally, the opinions expressed by KIs in the case studies have contributed to a better understanding of the history and complexity of Mozambique's health sector financing architecture, where MISAU and the SNS are trying to respond to the varied interests, focus topics, ways of doing business and even the financial cycles, of highly diverse external partners. They thus add weight to the PESS MTE argument of the fragmentation of the sector. Securing funds for the sector via the different modalities, managing and supervising their implementation, accounting for the results, is clearly testing MISAU's institutional capacity to the maximum, indeed, possibly wearing it out when a large part of this capacity is needed in maintaining routine business and for addressing the domestic reform issues such as decentralization. Maintaining this architecture also has high opportunity costs if and when funding modalities cannot be better aligned with the health sector reform agenda. Under these conditions, speaking of MISAU's ability to better 'control' and channel external financial support to SNS clearly would be an euphemism. Under these conditions, and keeping everything else the same, MISAU may at best be able to influence, encourage or discourage, accelerate, or delay certain aspects and practices preferred by the diverse funding modalities, unless it reviews and strengthens its own capacity for strategic leadership and management, coordination and designing, leading and implementing a health financing strategy (HFS).

These are the topics to be considered in the next as well as the final section of this report.

4. EFFECTIVENESS AND HSF – SELECTED ISSUES

4.1. Introduction

The effectiveness of an external health financing programme/modality in achieving its desired or planned results requires measurable programmatic targets, against which the recipients' performance can be assessed. This is the 'primary criterion for decisions about funding allocation' (Oomman et al., 2010) but, in a complex, multi-actor setting such as Mozambique's health sector, effectiveness will vary according to the extent of ownership by the recipient country, whether a programme is well planned and coordinated, has realistic, achievable targets and whether the instruments and tools for managing programme implementation and measuring its outcomes are in place. The basic assumption is that the more effective the HSF programmes, the more the gains from all available resources can be used to financing investments, without additional recurring domestic or external sources.

This chapter assesses three aspects of the effectiveness of external funding for Mozambique's health sector. Section 4.2, starting from the 2005 Paris Agenda on Aid Effectiveness looks at issues of ownership and the importance of a sector-wide approach (SWAp) as a shared framework. Section 4.3 focuses on the planning framework (strategic, mid- and short-term planning), and also raises the question of to what extent the building blocks for a solid health system with a primary healthcare focus are considered in planning. Section 4.4 analyses the extent to which the emerging health sector financing strategy impacts on the effectiveness of external support. This includes throwing some light on the fiscal space and its potential, which is enhanced or constrained, and political and economic dynamics.

Before drawing the conclusions, section 4.5 revisits the issue of performance-based finance that, particularly in the case of GFF, has been controversially assessed (see section 3.6). Other determinants of aid effectiveness in the health sector, such as accountability, are not addressed.

Related to the concept of effectiveness is that of efficiency, performing activities with the minimum wastage of resources. This aspect is neglected in the analysis, although it merits attention. The 2010 World Health Report on 'Health Systems Financing: the Path to Universal Coverage', has identified several common causes of inefficiency in health systems, 'which together might mean that between 20% and 40% of all health resources are being wasted' (WHO, 2011:4).

4.2. Effectiveness, SWAp and Coordination

4.2.1. The Paris Agenda of Aid Effectiveness – still relevant?

The issue of aid effectiveness is neither new nor only related to the health sector. Since the gradual demise, in the 1980s, of a development approach motivated by solidarity, justice and humanitarian considerations, perceived to be in the interest of wealthy countries in the North as an expression of 'world domestic policy', donor countries and institutions have become increasingly attentive to 'value for money', or the 'return on the investment' they make through aid. One expression of this concern, shared by the recipient countries, is the 2005 Paris Declaration on Aid Effectiveness subscribed to by more than 100 governments and international organizations (OECD, 2005). Driven by the Organization for Economic Cooperation and Development (OECD)'s Development Assistance Committee (DAC), it had five pillars: Ownership, Alignment, Harmonisation, Managing for Results and Mutual Accountability. These themes have found their way into cooperation and development assistance programmes, including in the health sector.

In Mozambique, for example, the Paris Declaration's principles were mirrored in the various phases of the government's poverty reduction strategy programme, the Poverty Reduction Action Plan (PARPA I and II) in the years 2006 to 2013, tied to debt relief through the Heavily Indebted Poor Countries (HIPC) initiative.

The framework was provided by a Memorandum of Understanding (MoU) between the Government of Mozambique and the so-called Programme Aid Partners (PAPs) whose members reached 19 in 2014. It established, among others, general budget support (GBS) delivered on-CUT as the preferred financing modality, as well as a Performance Assessment Framework (PAF) for annually assessing progress in implementation of the programme. The latter was negotiated between the government and its programme aid partners (PAP). Progress in implementing the programme was measured against more than 60 indicators divided across the main PARPA thematic groups (including macroeconomy,

good governance, social sectors such as health and education, agriculture and rural development, etc.). This assessment was carried out by joint government-PAP working groups. Its results determined the – often unpredictable – financial envelope to be provided by PAP donors and increasingly delivered as on-budget and on-CUT general budget support. The mechanism also included a facultative evaluation of PAP performance on behalf of the Mozambican Government, where criteria such as ownership, alignment with national systems and predictability of funding were applied.

Separate SWAPs such as that in health with PROSAÚDE's Common Fund, with finance delivered as sector budget support (SBS), were dovetailed with and integrated into the PARPA-PAF framework (Visser-Valfrey & Umarji, 2010). The health sector had its own specific PAF that had 37 indicators. The results of the Joint Annual Review (ACA)of the health sector decided on the next funding envelope.

As was to be expected, the PFB approach to poverty reduction was controversial. While the IMF lauded the successes of the 'Mozambican Model' for increasing aid effectiveness and providing lessons for African countries (Peiris & Clément, 2008), other authors such as Castel Branco (2008), questioned the assumption of national ownership in an aid-dependent context or stressed the highly intrusive neo liberal character of the coordination-cum-PBF approach (Green & Burns, 2006). Not surprisingly, 2010 and 2011 saw strained relations, indeed even 'confrontation' between government and PAP donors. These arose out of the latter's concerns about lack of progress on governance issues (economic accountability and irregularities in the 2009 elections) and the former's dissatisfaction with lower-than-expected outcomes in poverty reduction via PARPA. While the PAP's overall level of aid commitment was maintained in 2011, the 'donor strike' (Hanlon, 2016) affected in particular the social sectors, including the health, through a substantial reduction in funding. Writing on a government-commissioned evaluation of PAP performance Hanlon quoted officials as saying that discussions among the PARPA partners did not follow the agenda established in the MoU, and often degenerated into mutual accusations, suggesting that at some point the relationship between GoM and the PAPs ceased to be a partnership.

Moreover, the performance-based financing approach and its performance assessment framework instrument, had other limitations and produced unwanted side effects. The annual reviews and adjustments to PAF were not only time-consuming work for the joint teams, who spent more time in their offices and in meetings than becoming familiar with the challenges to and outcomes of funding through field visits. In order to work effectively, PBF also required considerable investment in baselines and information systems that, some sectors, required additional effort to be set up and regularly updated. An evaluation study of the effectiveness-based budget support for Mozambique under PARPA found that, like all indicator-based performance assessments, the PAF had several disadvantages. These included its exclusive focus on what was measurable ('that is not always what is important'), and the risk of 'generating perverse incentives by converting performance indicators into policy targets, to which money and prestige are attached' (ADE/ITAD/COWI, 2014: 195). Corroded by lack of confidence between PAP and government and given its high transaction costs and fiduciary risks, PARPA ended in 2013 and direct budget support after 2016, when the odious debts were made public. The common practise of joint measurement based on a common framework fell into disuse with the dissolution of the PAF mechanism although, to some extent, sectors such as health were more resilient to the decline of performance-based financing.

With hindsight it could be argued that, that in addition to the above-mentioned factors, the phasing out of the Paris Declaration also had to do with a shift in international cooperation from an 'aid for development' to a 'private sector investment for growth' paradigm (Vollmer, 2013). One of the Paris Declaration's underlying assumptions, that political elites in recipient countries are development-oriented, may have been flawed, as argued by Booth (2011). This may have been another reason for the decline of the Paris Declaration's relevance for improving aid effectiveness.

Nevertheless, the principle of looking at aid effectiveness by measuring performance in producing outcomes has, to some extent, been maintained, particularly in the health sector, although a recent study on the Paris Agenda concludes that 'its role in framing donor action has declined', arguing that

> 'a review of the current development strategies of ten donor countries... reveals that effectiveness principles are scarcely mentioned, though some donors, such as the EU and Sweden, still emphasize core elements of the agenda. Many donors engage selectively with the prescriptions of the Paris Declaration. For example, the Declaration's focus on managing for results has evolved, increasingly reflecting donor concerns over accountability, rather than strengthening country-based reporting frameworks as originally intended (Lundsgaarde & Engberg, 2019: 2).

4.2.2. Sector Wide Approach (SWAp)

According to the WHO a SWAp is,

> 'a method of working that brings together governments, donors and other stakeholders within any sector. It is characterized by a set of operating principles rather than a specific package of policies or activities...in contexts where external financing plays a significant role, SWAps have to date in several countries proved to be a good way to support government leadership and implementation and to make health financing more predictable and flexible'.

A SWAp provides a formal framework for health partners' coordination and for policy dialogue between them and government. It is also important for collecting aid data, particularly in the education and health sectors (World Bank, 2017). SWAps are therefore considered a necessary condition for coherent and effective management and for articulating government-led health policies and the associated expenditure frameworks, in order to build institutional capacity in health ministries and provide the instruments for more effective relationships between governments and donor agencies (Peters et al., 2013).

In Mozambique the first health SWAp was piloted in the preparation of PROSAÚDE and agreed in 2000 (Visser-Valfrey & Umarji,2010). Later, its formal expression was set in a MoU between the Mozambican government and the PROSAÚDE partners signed in July 2008. At that time, a growing number of donors supported the sector – 26 in 2008, 15 of which were providing sector budget support through the PROSAÚDE Common Fund. One condition for participating in the SWAp was the partners' adherence to the 2003 Kaya Kwanga Code of Conduct.

According to Visser-Valfrey and Umarji (2010) the combination of the SWAp, MISAU's adherence to the Code of Conduct, its PESS and the introduction of a health financing strategy through the PROSAÚDE CF providing sector budget support and delivered on-CUT, increased aid effectiveness. The official data cited by the authors show, that

> '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' (Visser-Valfrey & Umarji, 2010: 6).

However, ten years later, in 2020, the PESS MTE revealed that the gains in the maternal mortality rate could not be sustained and the rate had increased as measured against targets. The infant mortality rate was not measured given the lack of data (MISAU, 2020).

Boosting MCH thus continues to represent a major challenge, exacerbated by growing state fragility and the adverse political economic factors addressed in Chapter 2. Under today's adverse socio-economic conditions – quite different from those at the time of the first health SWAp – the need for a SWAp and increased effectiveness in funding the strengthening of primary healthcare is more obvious than ever. However, over the years a certain 'SWAp fatigue' had been observed, because of the sector's increasing fragmentation. An urgent revitalization of the SWAp approach and improved coordination was called for.

In 2017, the Rapid Donor Data Collection and Donor Coordination Mechanisms Report (WB, 2017) concluded that the preparation of a coherent SWAp involving all 26 DPs at that time, 14 of which also originally joined PROSAÚDE, had progressed (WB, 2017). The SWAp objective was to support coordination among government, development partners and NGOs to 'implement' the PESS with a view to a gradual transition to universal health coverage. It aimed to reduce donor fragmentation through PROSAÚDE and vertical programmes, and on- and off-budget spending. The report acknowledged the External Funding Survey (IFE) as 'the best way' to capture the on- and off-CUT financial commitments and disbursements and, annually track and report on commitments, investments and projects as part of a Joint Annual Review (ACA), despite the IFE' shortcomings alluded to in section 2.5. Nevertheless, it also concluded that coordinating and eventually harmonizing donor plans, activities and particularly financing mechanisms continued to be a major challenge.

As of today, there has been further progress towards a comprehensive SWAp, even though harmonizing donor financing mechanisms still has a long way to go to overcome fragmentation, as shown in Chapter 3. Support measures to fight Covid 19 and contain its spread was a major driving force behind the HPs attempts at improving coordination on a SWAp basis. According to several KIs, both in MISAU and the among health partners, a current priority is to harmonize the PROSAÚDE MoU with partners who are outside PROSAÚDE,

or to replace it with a more comprehensive one. According to one senior KI in MISAU, both options also imply a review of the Procedural Manual used by PROSAÚDE partners, and approving the Kaya Kwanga Code of Conduct.

In the meantime, there has been progress on a partnership agreement that is both part of SWAp and updates the Kaya Kwanga agreement, although no final document has been produced and adopted. A draft document focusing on health sector governance and fostering health sector dialogue in Mozambique sets out the principles for both, which somewhat echo those of the Paris Declaration. These are:

- Mutual commitment between MISAU and the health partners;
- Alignment with sector planning and implementation tools;
- Use of national systems;
- National leadership and commitment;
- Transparency and mutual accountability;
- Building the capacity of Mozambican institutions.

The six objectives formulated in the draft agreement aim to reinforce MISAU ownership and control of externally funded programmes. These are:

a. Strengthening MISAU in its role of coordinating the health sector and facilitating the management of MISAU commitments with partners.

b. Supporting MISAU in the development and implementation of national priorities, as defined in the PESS and its annual operational plan (which includes all the sub-strategies for operationalization of the PESS).

c. Using research results, monitoring and evaluation to feed into strategic discussions on health priorities and coordinating new research and M&E to improve and understanding of the health system's challenges and potential solutions.

d. Improving mobilization and the alignment of donor and government funding (including the alignment of technical assistance) with national priorities: establish consensus on health spending targets, ensure harmonization of internal and external funding around those targets and ensure results monitoring using a common set of indicators (Single Framework) for the implementation of health programmatic strategies.

e. Improving the sustainability of health sector interventions with a focus on MISAU systems strengthening and capacity-building, and

f. Ensuring the strengthening of multi-sectoral health interventions.

It remains to be seen whether these objectives, claiming to achieve stronger MISAU control over the sector's policies and funding, are negotiable with health partners, especially those like GFF that are pushing their own agenda and ways of doing things, and even attempting to control domestic health financing sources. In the words of a senior MISAU official it is 'the donors, particularly those in vertical programmes, who want to dictate the rules at the cost of MISAU ownership. For them, coordination is important as long as it serves their interests' . For this KI there is clearly a need for a 'negotiated settlement' and finding 'a way to bring both sides together'.

From this point of view, it can be argued that the SWAp and Code of Conduct should include a provision or mechanism for mitigating different claims of control over health sector resources. As regards use of the national PFM system, it would be worthwhile considering including in a SWAp the need for partners to 'familiarize' themselves with e-sistafe before they take a final decision on the use of their own systems.

Before drawing conclusions on the SWAp's contribution to aid effectiveness, the issue of dialogue and coordination, which is also addressed in the draft agreement cited above, is briefly discussed.

4.2.3. Coordination

If SWAp is regarded as a mutually agreed instrument, for implementing strategies and managing aid and domestic resources in a rational and optimal manner to achieve universal healthcare through more effective delivery of strong primary healthcare, then effective coordination among key stakeholders is an imperative for success.

Mozambique has several 'theatres' for coordination, mostly at national level.

Firstly, there is a coordination mechanism among donors.

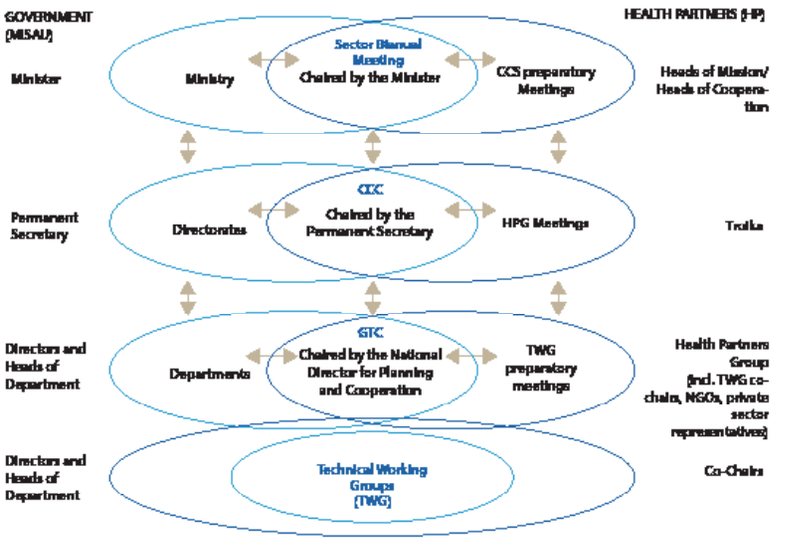
The current framework is the Health Partners Group (HPG), a mechanism with a two-year rotating leadership by a member. Over the years, NGOs such as N'weti have increasingly participated in this mechanism, given its growing importance in analysing and monitoring the execution of health policies, plans and budgets and its role in advocacy and heath governance. Given the challenges of fighting the Covid 19 pandemic, the HPG has established a complementary coordination mechanism specifically for the pandemic response. The group is currently chaired by the WB and has a management team comprising four HPG members. The group provides guidance to the senior level of MISAU level and coordinates resource mobilization efforts .

The second 'theatre' is coordination between MISAU and donors. A Health Partners Coordination Framework provides the basic reference structures formal coordination in the health sector. According to a 2017 WB assessment (WB, 2017), meetings are held at three levels:

- Working groups and ad hoc task groups, chaired by MISAU Directors and Department Heads on matters of policy and specific topics (human resources, medicines, administration and financing, planning, infrastructure and M&E);
- Joint Coordination Committee meetings every 1-2 months, chaired by MISAU's Permanent Secretary; and
- The Sector Coordination Committee, which meets biannually, chaired by the Minister of Health, and co-chaired by a representative from the Development Partners Working Group.

The structure of and leadership in this coordination mechanism is given in Figure 22, extracted from the above cited draft partnership agreement for the health sector.

Figure 19: Coordination Mechanism MISAU – Health Partners



Source: MISAU (draft)

A third 'theatre' of coordination and dialogue serves MISAU's interaction with vertical programmes that are largely driven by decision-making actors outside Mozambique with headquarters in Geneva or Washington DC. One example is PEPFAR which requires specific consultation and coordinating mechanism for the annual preparation of the Country Operational Plan and the associated work plans, as well as their implementation by contractors and monitoring. GF and GAVI also have specific requirements and fora, such as the former's Country Coordination Mechanisms (CCM) and the latter's Inter-Agency Coordinating Committee (ICC). Other separate coordination platforms exist on matters such as AIDS, nutrition and for NGOs working in the health sector.

Fourthly, the annual MISAU Coordination Council (Conselho Coordenador) is the ministry's main internal coordination instrument and is attended by all national directorates and departments, health institutes, provincial health directors and health services, etc., and to which donor representatives may be invited as guests.

It should also be noted that MISAU also has coordination requirements arising from decentralization reform under the 'new paradigm'. According to Article 24 of Law 4/2019 and Article 6 of Law 7/2019, both of 31 May, articulation between

the Decentralised Provincial Government and the State Representative in the Province takes place through Provincial Coordination Councils, in which the provincial and district health authorities participate. Specific regulations have been approved of the functioning of these councils. . In addition, the new legislation also foresees annual coordination between central government and subnational government institutions. The importance of these mechanisms was stressed by the Minister of Health in his opening address to MISAU's annual Coordination Council meeting in Maputo in December 2020.

Box 2: PBF – A municipal experience

The pool-funded Programa de Desenvolvimento Municipal (PRODEM), 2015-2018, experimented with providing Municipal Councils (by law, all have administrative, fiscal and patrimonial autonomy) with three funding options. The first, Window 1, served to allocate an equal amount to all municipalities. This was introduced following pressure by central government, i.e. the Ministry of State Administration and Public Service (MAEFP). The second option (Window 2), the competitive fund, represented the PBF approach, with disbursement based on the submission of a realistic project and the evaluation of its execution. Through Window 3 PRODEM allocated funds to each of the municipalities using government criteria (area, population, poverty indicators, vulnerability to effects of climate change). Projects were only financed if they were reflected in the municipal plan and budget and approved by the Provincial Assembly, i.e., on-plan, on-budget etc.

Three lessons learned are relevant in to health financing. Firstly, central government preferred Window 1, followed by Window 3. Window 2 was clearly preferred by smaller and medium-sized municipalities with dynamic leadership, irrespective of the governing party. And, thirdly, central government was not interested in continuing with or promoting the PBF approach after PRODEM's premature closure. Source: PRODEM (2018).

Yet, while coordination at central level is well structured and function , little is known about systematic coordination at provincial and sub provincial level , both between programmes with a focus on decentralization such as GFF and PROSAÚDE, and between institutions responsible for delivering health services such as SPS and DPS. KIs representing HPs who have participated in field visits believe, that coordination and exchange of information at those levels of the SNS appear to need substantial improvement and dovetailing with coordination efforts at central level.

The effectiveness gains in coordination in a results-based financing setting have been encouraging, as in the case of PROSAÚDE with its SWAp under the overall PAP framework. In their early assessment of PROSAÚDE, Pavignani and Durão (1999) concluded that effective coordination among donors, and between them and MISAU represented one of its achievements and one of the reasons why PROSAÚDE and its institutionally challenging innovations such as the Common Fund could start off relatively well. They cited several causal factors:

- Solid and widely accessible information;
- Credible, long-term plans;
- Internal coordination within MISAU;
- MISAU leadership, the key role of people and institutional memory.

Taking 'increased coverage' of primary healthcare services as an indicator of effectiveness, it could be argued that Mozambique's early experience with its SWAp-based PROSAÚDE was exceptional. Walt et al. (1999: 281) concluded that 'health sector coverage in Mozambique expanded dramatically during the period 1993–96, in a situation of instable or even faltering external finance. During the same period, several coordination mechanisms were put in place, and the findings suggest, all conditions kept constant, a link between increased coordination and greater efficiency'. However, it is also likely that the increased coverage arose from the needs and opportunities provided by the post-war peace situation following the signing of the Rome Peace Accord of 1992. This ended a 16-year long war where targeting and destroying health and administrative institutions was a common military tactic by one of the belligerents. Thus there was a great need for reconstruction of health units, a decisive factor in the increased coverage.

The plethora of coordination mechanisms and fora in the health sector may not necessarily add value to aid effectiveness. Much will depend on the productivity of these coordination meetings

and the demonstration of their capacity to align stakeholders with common objectives and bind resources to achieving them. However, the transaction costs of coordination increase exponentially with the number of participants in such events: the costs involved in preparing, monitoring, controlling, and managing the actions and transactions leading to and resulting from the event. According to transaction cost theory (Young, 2013) an optimal organizational coordination structure that increases the effectiveness of an organization in meeting targets is achieved by gains in productivity and efficiency, in the latter case by minimizing the cost of the transaction. It might be worthwhile for MISAU and its partners to consider studying the established coordination mechanisms not only from the effectiveness angle, but also from that of productivity and efficiency wastage.

Finally, coordination may increase effectiveness in certain areas (e.g. health coverage, reducing MMR), but not in others. The findings of the PESS MTR (MISAU 2019) suggest that, while the overall quality of coordination had significantly improved since the start of PROSAÚDE, the coordination of financing did not improve much. The reasons, among others were (i) the absence of an integrated HSFS (as planned by the PESS), (ii) the diversity of health sector funding mechanisms, and absence of 'harmonizing procedures' and (iii) shortcomings in reporting via REO and IFE, as shown in section 2.5. A more sceptical view expressed by one of the HPs supporting the PHCSP via GFF suggests that 'not much has happened' regarding coordination, which ' has been falling behind the partners' expectations' towards inviting stakeholders such as UN agencies and the private sector to the 'SWAp table' .

4.2.4. Conclusions

It is concluded that the virtues of the Paris Agenda, a SWAp approach, coupled with improved coordinating mechanisms are only some variables that could explain a rise or fall in effectiveness. It is felt that the political and economic context is as an equally important determinant. In other words, aid effectiveness in is not just determined by the complexity of the health support architecture shown in Chapter 3, and the construction of a SWAp with adequate coordination mechanisms, but also the development stage or condition i.e. the consolidation or fragilization of the SNS as such. The author subscribes to the conclusion drawn by Walt et al. (1999), which argues that effectiveness-oriented i.e. results-based coordination and management of external resources

> 'is inherently unstable, involving a changing group of actors, many of whom enjoy considerable autonomy, but who need each other to materialize their often somewhat different goals. Managing aid is not a linear process, but is subject to setbacks and crises, although it can also produce positive spin-offs unexpectedly. It is highly dependent on institutional and systemic issues within both donor and recipient environments' (Walt et al, 1999: 281).

Other studies have also demonstrated that a SWAp and improved coordination are not a panacea for achieving effectiveness gains. They are a necessary, but not a sufficient condition for such gains. Results of a recent comparative study by Woode et al. (2021) suggest that in the global South 'SWAp implementation facilitated a 5.8% to 8.1% reduction in the infant mortality rate compared to non-implementing countries. This effect likely operates by releasing domestic resources and/or increasing the efficiency with which domestic resources are converted into health gains'(Woode et al. 2021: 1) . However, other authors are more sceptical about the linkage and their insights are still relevant today. While not discarding the high potential of SWAps for increasing aid effectiveness, a paper by McGee (2012) presented a more nuanced picture, arguing that there is a discrepancy between the underlying theory of change of health SWAps, and their implementation. This author also showed that, although the theory of change underlying SWAps is highly consistent with effective aid, the practice is not. The reasons given are: a cumbersome coordination architecture that is only partially implemented and used to drive changes towards higher effectiveness, and which does not necessarily facilitate government ownership and commitment to institutional development of the health sector. In Mozambique, the Paris Declaration and its application to poverty reduction programmes, particularly results-based finance mechanisms, may generate 'perverse incentives by converting performance indicators into policy targets, to which money and prestige is attached' (see section 4.2.1).

Furthermore, Peters et al. (2013) have shown that, although SWAps with efficient coordination play a crucial role in contributing to the development of robust national health policies, transparent expenditure frameworks and stronger institutional capacity, nevertheless, many problems in national health systems still persist. Success varies widely among countries using a health SWAp. These authors observed that global health initiatives and vertical programmes, in particular, have a tendency to by-pass SWAp arrangements.

Minimizing these risks depends to a large extent on their integration into national health systems and the quality of the strategic leadership by health ministries. Seen from this angle, the emphasis on a predominant SWAp role for MISAU and its leadership and in sector coordination is a step into the right direction.

Given the disputed leadership and resource control between MISAU and particularly the vertical programmes, SWAp and coordination structures need to reflect an agreed way to mitigate potential conflicts for the benefit of primary healthcare. Every effort must be made to ensure that the merits and benefits of health sector support 'are not claimed as a victory by one party or the other' but as the outcome of a joint struggle to improve such care in Mozambique.

In conclusion,

- The principles enshrined in the Paris Declaration on Aid Effectiveness (ownership, alignment, harmonization, mutual accountability, etc.) have gradually lost importance in shaping cooperation and development assistance, including in health sector financing. To a certain degree the one exception is 'managing for results', an expression which is results-based financing in vertical programmes. It was also found that the application of these principles in poverty reduction programmes and the health sector in Mozambique has produced mixed results.
- In line with the conclusions of several studies it is found that SWAp has great potential for increasing aid effectiveness, but the realisation of this potential varies with the context and the domestic and international environment, i.e., with the country's political economy factors. At best, a new SWAp is a necessary, but not sufficient, condition to increase aid effectiveness.
- In Mozambique, the early experience with a health SWAp was positive, and at present MISAU and the HP are making a major effort to conclude one. This includes the updating the Kaya Kwanga Code of Conduct. Reflecting the opinion of KIs, there is some risk that the SWAp may serve implicitly, if not by design, to wrestle control over policies and resources to either the government or the health partner side. It is, therefore, suggested that the SWAp should also address the issue of mitigation of potential conflict.
- Improving coordination is part of the SWAp agenda. There are several coordination mechanisms and 'coordination theatres' relevant to the health sector, particularly at central level. little is known about inter institutional coordination at the provincial level and below. Under these circumstances coordination, one among various instruments for increasing aid effectiveness must consider aspects of efficiency, productivity and hence the resulting transaction costs at all levels of the SNS hierarchy.

4.3. Effectiveness and Planning for Primary Healthcare

It has been generally recognized that strengthening primary healthcare is key to universal healthcare and achieving the SDGs in health. This implies that among other factors – such as quality of care and a dedicated, professional health workforce – the importance of (rural) hospitals and heath units must be recognized, in both health sector policies and in national PPB processes. As WHO & UNICEF (2018) have argued, hospitals 'must be an essential part of the solution rather than being considered as part of the problem. A substantial proportion of a country's health workforce, technology and financial resources is concentrated in hospitals; they are responsible for training many health service professionals and have the political, economic and social power to facilitate or hinder transformation of the system' (WHO & UNICEF, 2018: 16).

The following sections examine the extent to which this focus is reflected in both the Mozambican approach to health sector planning and the construction of a solid primary healthcare system that uses and monitors the building blocks proposed by WHO, including financing of infrastructure, equipment and the health work force

4.3.1. Health Sector Planning and the Mozambican Planning Instruments

The government's planning cycle has four key moments and comprises the following:

- Five-year government programme, (PQG), corresponding to the period of an electoral mandate;

- The Medium-Term Fiscal Scenario (CFMP) that, annually updated, forecasts the resources needed to finance the annual plan and budget;
- The Annual Economic and Social Plan (PES) that operationalizes the PQG;
- The Annual State Budget (Orçamento de Estado - OE), approved by Parliament (Assembleia da República - AR).

The 2018/2019 decentralization reform of also introduced the Decentralized Governance Bodies Provincial Plan and Budget for the 11 provinces. For the time being, the resource framework is set by central government (MEF) and is aligned with its priorities as established in PQG and PES, although the PO-OGDP is approved by the elected Provincial Assemblies. Following changes to legislation on the public finance management (PFM) system at the end of 2020 / beginning of 2021, the PES and OE have been merged into an annual, budgeted economic and social plan (PESO). This is approved and enacted into law by Parliament.

It is understood that the PESO will eventually require donors not only to channel funding to the health sector 'on-budget', but also 'on-CUT', given that planning and budgeting are no longer functionally separate processes, but combined and legislated as one annual PESO.

How does MISAU's approach to planning health investments fit into the government planning cycle?

The PESS provides the strategic orientation for health sector planning. As the name suggests, it is strategic in nature and, as such, its quality is generally recognized by donor agencies. For them, it serves as point of departure and 'compass' for all health sector programmes, also because of the joint evaluations of progress in achieving objectives and targets (JANS Team, 2013, MISAU, 2020). However, targets and interventions defined in the PESS are barely reflected in and dovetailed with the those in the annual PES, which has a different, more general planning logic translating the five-year PQG into annual plans. According to one KI associated with MISAU, the PES does not necessarily reflect the strategic and technical priorities of the health sector, but is rather linked to the PQG, the annual political priorities of the government of the day. In addition, according to the same source, from a health perspective the annual PES, 'lacks quality' and is produced mainly through what is known as 'incremental planning and budgeting' i.e. based on the previous year's plans and budgets (Stella, 2017). These may be altered incrementally but not according to strategic considerations, except in cases of outbreaks of pandemics such as Covid 19.

Moreover, as the 2013 evaluation of PESS showed, its priorities and expected results are not properly reflected in the PQG (JANS Team, 2013). And the medium-term fiscal scenario planning that looks basically at the fiscal space for government funding priorities in all sectors, including health, does not necessary translate the PESS objectives and priorities into a medium-term perspective.

One reason for this mismatch between health sector priorities and plans and those of the wider government plans lies in the fact that MEF's interests and priorities are not congruent with those of MISAU (see section 2.4). In the author's opinion, another reason is that PESS as a long-term plan is not being broken down into medium-term or even short-term action plans so, in other words, it lacks operationalization.

4.3.2. The Case for a Mid-term Planning Perspective in the Health Sector

By its very nature, any long-term strategic plan such as PESS needs to be ambitious and thus, runs the risk of being based on unrealistic assumptions about financial resources and other parameters. It is not surprising that the financial envelope to finance it is insufficient, as the PESS MTE report stated (MISAU, 2019: 14). It is thus a fallacy to believe that long term plans can be 'implemented' and financed, possibly with the exception of wealthy countries with, for example, ambitious strategic and military objectives or in space programmes. Engaging in the production of long-term planning documents such as PESS can be described as an exercise of 'fishing in a pond without water' . In other words, this type of planning helps to orient the mind on what should happen in the future under certain assumptions. In the concrete case of long-term planning for health financing, one such assumption in several planning documents is a major medium-term inflow of tax revenue from gas extraction in Cabo Delgado, which is questionable for the time being. Consequently, even in the case of strategic space projects, strategic plans need to be concretized and broken down into medium and short term, 'operationalized' partial plans, with a more realistic understanding of the domestic and external environment and with more concrete and realistic fiscal horizons.

For these reasons, the case can be made for considering introducing in MISAU a midterm planning cycle that translates the strategic PESS objectives into a medium-term health action plan (MTHAP). This would certainly enhance the ongoing practise of ex post reviewing the execution of health projects covered by PES in what was termed a 'rolling planning approach'. However, the MTHAP idea goes much further in that it is of a strategic, ex ante nature and reviews PESS as a point of departure. This idea was put to a number of interlocutors. On the whole, it was well received by both by MISAU, MEF and HPG KIs.

To varying degrees, the KIs see the following advantages of such a MTHAP:

- It helps to concretize and operationalize the strategic targets and interventions defined in the PESS, giving them a more realistic, 'doable' and concrete perspective;
- A MTHAP could be seen as a bridge between PQG and PES and help to align health sector priorities with these instruments;
- It would also help to promote alignment between MISAU's sector planning and that of externally-financed programmes, which usually also have a medium-term framework.

It would help to better associate medium-term health sector planning with a revised CFMP, which in turn would enable the health sector to include forecasting in planning, to date neglected, and provide a more realistic view of the availability of domestic and external resources.

In the view of several MISAU and HPG KIs, the introduction of a MTHAP could and should go hand in hand with the introduction of an e-sistafe instrument for merging planning and budgeting. Up to now, these are separate documents with different legal statuses.

The overall advantages of MTHAP could well lie in improved resource mobilization capacity and the predictability of resources. It would also improve the embeddedness of MISAU's plans in the national planning cycles and possibly trigger the improved alignment of donor-funded programmes with the national budget and planning cycles. Under these circumstances, the overall winner would be the effectives of health financing for primary healthcare.

However, such a step would require a substantial strengthening of the human resource capacity in the MISAU DPC, which is said to have suffered from high staff turnover in the past few years.

4.3.3. Planning and Effectiveness Gains: A Look at WHO Building Blocks for HSS

The introduction to this section mentioned the WHO building blocks for health finance with a view to effective primary healthcare that focuses on hospitals as an essential component. These blocks are (WHO, 2007):

- Service delivery;
- Health workforce;
- Information and information systems;
- Medical products, vaccines and technologies;
- Financing; and
- Leadership and governance (stewardship);

Using and monitoring these criteria systematically over a period of time makes it possible to assess not only improvements in performance, for example at hospital level, but also to detect any (im)balance in resource allocation per building block. This permits better and more systematic planning of the allocation/distribution of resources required to transform hospitals into effective, viable pivots of for strengthening primary healthcare.

Two examples illustrate the argument. The first is from Ethiopia, where the building block approach was used to determine the performance of public healthcare facilities through a quantitative, cross-sectional study conducted in five public hospitals by surveying healthcare professionals (Manyazewal, 2017). The study shows:

> 'that the overall performance of the public hospitals was 60% when weighed against the WHO building blocks which, in this procedure, needed a minimum of 80% score. For each building block, performance scores were: information 53%, health workforce 55%, medical products and technologies 58%, leadership and governance 61%, healthcare financing 62%, and service delivery 69%. There existed a significant difference in performance among the hospitals (Manyazewal, 2017: Abstract).

The author concludes that this method was useful for understanding the status of efforts to strengthen the health sector in Ethiopia and, in particular, made it possible to detect and use opportunities for improving the service delivery capacity of public hospitals.

The second example is the assessment of a vertical programme, the GF, and health sector strengthening. The study by Warren et al. (2013) found that around 82% of GF total funding for this purpose was allocated to service delivery, human resources, medicines and technology, while the building blocks of stewardship/governance, financing and information received a relatively small share of funds. By revealing this skewed distribution of resources among the building blocks, the study helped to identify areas and opportunities for improvements, with more balanced investments. According to the authors, with the building block-based assessment method it is possible to identify the strategic interventions that have the greatest system-level impact for the cost-effective use of funding.

In the case of Mozambique's health system, neither the experimental nor the systematic use of the 'building block method' was identified during the research for this study, neither through interviews nor desk research. However, the draft 2019 joint review report does provide some scant hints as to the distribution of resources by building blocks. According to this report, resource allocation is particularly high for drugs and medical products, followed by human resources (health work force), and the delivery of healthcare services. Funding for health infrastructure i.e. hospitals, is low and the lowest is equipment, including health information systems (MISAU, 2019a: 41). The review concludes that weak investment in the development of health network infrastructure has not helped to improve access to and use of health services. Strategic interventions for the expansion of the health network, including the adequate provision of water and energy, were not implemented as planned. As a result, the health network stagnated, limited coverage persisted and the inequalities between provinces were not reduced (MISAU, 2019: 47f).

It is not clear why the building block approach has not been tested and/or introduced more systematically, given its obvious advantages for identifying and directing resources to deficient areas and balancing the resource endowment of public healthcare providers in a more holistic way to increase their effectiveness.

According to the logic of the building block approach, investment in Mozambique would need to be redirected towards infrastructure i.e., building new and rehabilitating, maintaining and equipping (including with IT) existing hospitals and health centres, particularly in rural areas and in the central and northern parts of the country.

These priorities coincide with KI suggestions on the funding needs for sector strengthening with a focus on primary healthcare. Funding construction, maintenance and equipment for rural hospitals has a high priority for three MISAU-based KIs. One of them proposed investment focusing exclusively on construction and equipment for small rural hospitals. Other priority areas identified by the same KIs are the(re) qualification of the health work force, on the grounds that fewer specialist doctors (e.g. surgeons) are needed and more general practitioners and 'family doctors' immersed in local society. Their skill profile would include psychological skills in attending (female) patients and children in MCH wards and treating trauma. A third priority area is improving health services for patients with chronic, non-contagious diseases, such as diabetes and renal diseases (including dialysis facilities). Finally, more systemic support for community health needs to be given a higher priority.

In the author's view the GFF diagonal approach and experience with, health financing targeting MCH, and the experiences with PROSAÚDE at subnational level, could be a valuable point of departure for reviewing priorities for health financing. Their potential for 'convergence' (Glassmann et al., 2020) ought to be explored.

4.3.4. Conclusions

Adequate planning cycles and methods are crucial for increasing the effectiveness of investment in the primary healthcare services. The study found that the objectives and planned results expressed in the PESS, particularly for health financing, are neither adequately reflected in the five-year plan nor in the annual plan and budget. This means that the annual planning/budgeting process and thus external support via these instruments remains a challenge.

The study found that 'breaking down' or translating the long term planned PESS results into a medium-term health action plan was a way of operationalizing PESS. In the opinion of MISAU KIs, this would be a way to improve the alignment of health plans with the general government planning

instruments, including the CFMP, and would also help the forecasts of the resources required for strengthening the health sector. It could also help to align heath sector plans with those of externally funded programmes, which usually have short- to medium-term planning cycles.

It is also concluded that 'embracing' and piloting the potential of subsystem planning/budgeting in the health sector as soon as possible is a path to the combination of planning and budgeting for programme support. This would require, among others, reinforcing the technical capacity of staff in DPC and DAF.

Finally, it is suggested that experimenting with and eventually adopting the WHO building lock approach to the analysing and planning investment and resource needs at hospital level would provide an opportunity for significantly contributing to improving the primary care system. It would bring to light, in a systematic way and at hospital level, the existing resource imbalance in favour of medicines and work force.

4.4. Effectiveness and Health Sector Financing Strategy

This section discusses three themes. The first is the importance of MISAU and its partners having a financing strategy to guide aid and investment flows that improve quality, effectiveness and sustainability. After a brief analysis of the draft Health Sector Financing Strategy (HSFS) for the period 2020-2030 (currently awaiting approval), attention turns to the political and economic perspective or 'fiscal space'. This refers to the domestic resource potential that needs to be mobilized to finance health sector reform and improve primary healthcare. Finally, there is an assessment of PFM and PBF outlining a possible path towards mainstreaming into health the lessons learned from hitherto discrete and isolated experiences with performance-based financing.

Not covered are other relevant and necessary WHO-defined (WHO, 2019), elements of a health financing system for universal health coverage: 'pooling' resources, 'benefit design and rationing'and 'strategic purchasing for health services'.

4.4.1. Towards HSFS – Selected Key Elements and Controversies

The PESS MTE recognized the key strategic importance of a financing strategy for universal health coverage, but conceded that there had been no progress to this effect. According to the author, such a strategy would have to address not only securing diversified and sustainable mechanisms for mobilizing funds but also formally establish what they considered the four basic components of a health financing system, namely:

- The diversity of available resources and their mobilization;
- The aggregation of those resources;
- The allocation of resources via established planning programming and budgeting procedures (e-sistafe);
- Payment mechanisms for health services (MISAU).

Furthermore, the national health sector financing system would need to address and determine factors such as a) the administrative levels of health expenditure, b) the main contributors to health expenditure, present and future expenditure capacity (evaluation of fiscal space in health); c) an assessment and exploration of other sustainable (domestic) financing mechanisms (e.g. earmarked revenue and incentives for its collection), d) paid personal/private services, e) health insurance, f) family and out-of-pocket (OOP) contributions and special health taxes (tax-levy, health fund, etc.).

Work on designing the strategy started in 2015. A first draft (MISAU, 2021) was shared with health partners in October 2019. Senior MISAU and MEF staff, some HPs and NGOs, were involved, but not always continuously.

Departing from the government's commitment to universal care and the health SDGs the draft has three main strategic objectives: (i) contributing to universal access to quality healthcare, (ii) promoting efficiency in the allocation and use of resources in the NHS, and (iii) ensuring sufficient and sustainable public funding for the NHS.

The strategy focuses on universal access to primary healthcare in each of the Essential Healthcare Packages at all four levels of healthcare units. Ensuring the quality of PHC services is emphasized. A reform of the payment system at the point of use of services is foreseen, so that they are accessible and 'payments are simplified, standardized, regulated and managed with transparency'.

The document stresses that the state budget will continue to be the main source of health financing. Resources are to be generated through diversified general taxation that is aligned with the objective of offering financial protection to citizens through 'pro-active policies' aimed at reducing the financial burden when families need health services.

The Government of Mozambique will make efforts to progressively increase domestic funding for the SNS. A rise in of 'sin taxes' is proposed as a way to reduce the sector's financial burden and potentially obtain additional resources. It also proposes the gradual introduction of a social health insurance as a complementary funding mechanism for the SNS.

Finally, the financing strategy highlights the constant need to negotiate with partners to mobilize and align external funding with national priorities, especially strengthening the health sector as a whole. This support needs to be aligned with the country's planning/programming/budgeting system.

There are several explanations for the long time it took to produce the draft EFSS. Interruptions due to changes in ministers and in the planning team were mentioned, together with delays caused by the Covid 19 pandemic.

However, the main reasons for the delays, appear to have been political and partially technical controversies over three issues:

a) Is there a common vision among politicians, MISAU staff and users on what the SNS (NHS) should look like, in terms of service quality and access for all users? The answer is not uniform and even in MISAU there appears to be a disagreement. One senior MISAU official pointed out that Frelimo's 'socialization of medicine' policy promoted/introduced in 1979, four years after Independence, has never been formally revoked, even though today access to quality NHS services depends on the user's class and income. So access to health has gone from a rights-based matter of social justice to an issue of the ability to pay for it. In this context it was also mentioned that much of the political and economic elite (and a part of the middle class with private insurance) does not even seek the services of the public part of SNS, preferring instead private providers in Mozambique and abroad. An example given is that access to dialysis services is only affordable by the wealthy strata of Mozambican society.

b) There is general agreement that the symbolic user fee covered today (MZN 5 in rural and MZN 10 in urban areas) is totally inadequate and must increase. The controversial issue, however, is what a more adequate amount would look like, how it should be set, and whether the quality of service corresponds to higher out-of-pocket user fee. It is also important to note that user fees are not only considered the most regressive form of health financing i.e. they burden patients with low incomes relatively more than those with higher incomes (Onotai, 2008), but they could also lead to a significant fall in demand for health services (Lagarde & Palmer, 2011). As far as the author is aware, there has been no study on the effects of current user fee policies and scenarios.

c) Related to the previous point, the issue of fiscal space is controversial. Although there seems to be consensus on the need to increase 'sin taxes' there is disagreement about the dimensions and dynamics of the current health finance fiscal space. This includes the issue of the introduction of mandatory health insurance and its relation to the current system of medical and drug assistance (Assistência Medica and Medicamentosa - AMM) for civil servants, for which a certain amount is discounted monthly from their salaries. According to one KI, this part of the health finance strategy is weak and should have merited more substantial inputs from MISAU and MEF and a more profound debate.

A senior representative involved in drafting the strategy is of the opinion that the document should be approved and made public with some urgency, despite the possible ensuing controversy.

4.4.2. Fiscal Space

Heller (2005) defines 'fiscal space' as the 'availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position' (cited by Cheng & Pitterle, 2018: 3). This space is circumscribed by country-specific macroeconomic determinants such as domestic macroeconomic conditions, the fiscal situation, revenue and expenditure structure, debt structure and external economic environment.

A more dynamic understanding of the term would look at a country's potential to expand its own financing capacity. From this perspective, fiscal space would mean 'financing that is available to a government because of concrete policy actions for enhancing resource mobilization, and the reforms necessary to secure the enabling governance, institutional and economic environment for these policy actions to be effective, for a specified set of development objectives' such as universal health coverage (Roy, 2009, cited by Cheng & Pitterle, 2018: 3). Another determinant of fiscal space is a country's capacity to attract, mobilize and negotiate external financial support in its various forms: foreign direct investment, concessional and non-concessional grants, negotiating debt relief and specific sectoral partnerships with donors.

A World Bank study concludes that the major determinant of the fiscal space is the growth rate of a country's GDP (Tandon et al., 2018). Tax revenue is also a major determinant of progress towards universal health coverage (Reeves et al., 2015). These authors found that, in countries with low tax revenues, an additional US$ 100 tax revenue per year substantially increased the proportion of births with a skilled attendant, when direct taxes on capital gains, profits and income were preferred over indirect taxes such as value added tax (VAT) with their regressive effects. The authors conclude that increasing domestic tax revenues within a pro-poor framework is instrumental in achieving universal health coverage.

As far as the author is aware, there has been little work in Mozambique to assess the existing fiscal space, apparently except for two (unpublished) studies by UNICEF, which could not be retrieved for this study. However, according to one KI, there has been considerable work on resource mapping on the expenditure side (Anselmi, 2015), but little on the fiscal side, in part due to limited capacity in MISAU and a certain 'distancing' of MEF from this topic .

Given that the financing strategy is due for approval, there is surely a need if not some urgency, for a mapping exercise of the Mozambican fiscal space, an exercise that would combine a political economy analysis with a technical approach, inspired by insights garnered from research and discussions elsewhere (see, for example: WHO, 2016).

The previous section revealed that the political and economic dimension, and disagreement over domestic health financing, fiscal and nonfiscal revenue, will be decisive not only for the technical outcomes but also the social acceptability of health sector reform and financing.

Hence a political economic analysis of the fiscal space would not only take into consideration the trends, dilemmas and contradictions highlighted in section 2.2, but would also analyse the following issues:

- The impact on revenue potential and health finance of the continuing downward trend in business turnover, business confidence, employment and earned incomes, observed by INE's monthly bulletins in 2021 (INE, 2021, 2021a), as this could intensify the informalization of the economy and tax evasion;
- Associated with this, the general perception by industry and various business organizations is that the taxation level and cumulative tax incidence on business is extremely high and discourages investment and production.
- The discrepancy, brought to light by the recent household income survey (INE, 2021), between, on the one hand, a substantial increase in household expenditure on health services and, on the other hand, the low and falling levels of available household income in many parts of the country. This raises the issue of how this dynamic affects the health strategy proposal on raising user fees for the health service.
- Which social classes are the main beneficiaries and interested parties in health financing, and which are ignored? Or, framed in terms of fiscal sociology: which social classes and strata carry the major tax burden for this and which are the net beneficiaries? Are pro-poor health policies and tariffs supported by higher income groups? MISAU and government face here a policy dilemma, known as the 'Korpi and Palme paradox of redistribution' (Korpi and Palme, 1998). It implies that the more the poorer strata of health beneficiaries are targeted, the less likely wealthy income groups are willing to pay for such services via taxes and social insurance, thus jeopardizing redistributive justice. The delicate 'class coalition' of interests that has sustained the present system may be at risk of disintegrating.
- Do assumptions on fiscal space (on increasing user fees) correspond to poverty data and expected improvements in service quality?

There can be no doubt, that these issues are extremely controversial politically and touch on sensitive distributional issues. The most contested topics might include the established privileged access of certain social groups to health services, e.g. civil servants in the case of AMM or those who have access to personalized customer service and particularly the 'special clinics' in central hospitals, that are, in fact, subsidized by the general public through the health budget (McPake et al., 2011). Thus, any decision on additional domestic tax and non-tax resources for health financing should be based on an attempt to produce a broad societal consensus that involves not only the executive (MISAU, MEF) and health professionals but also Parliament, unions, the private sector and civil society.

Given these controversies, it can be argued that a possible way out of the dilemmas and the false sense of entitlement might be to opt for financing health services increasingly via taxes (progressive income tax, sin taxes) rather than by increasing user fees and introducing a compulsory national health insurance. This would be in line with WHO thinking on pooling resources to finance health systems with public and progressive taxes, focusing on general taxation, to advance towards universal health coverage. In this case, MEF would need to ensure the maximum resources for the sector.

4.4.3. Effectiveness Gains through Performance Based Financing (PBF)?

Oomman et al. (2010) define performance-based financing as an approach donors use to assess the performance of a health unit or other funding recipient against measurable programmatic targets. In this way, performance under the previous budget cycle or period is used to decide on funding for the subsequent period. This should help ensure that the best programmes or performers continue to receive resources (with the failing ones maybe receiving fewer resources) and programme managers have strong incentives to perform well. The previously agreed targets against which progress is measured could be outputs (e.g. the number of women attended and the number of babies delivered in a maternity ward), outcomes (such as the rate of hospital deliveries in a district), impact (such as MMR), or a combination of these.

As seen in sections 3.4 and 3.6, GF and GFF programmes using results-based financing or performance-based financing have been introduced in the Mozambican health sector, in line with a global strategy to increase the effectiveness and quality of primary care strengthening in numerous low- and middle-income countries.

These ideas and principles are not new to Mozambique, given the previous experience with sector budget support in the PARPA framework. However, as the conclusions of Chapter 3 show, it is difficult to assess to what extent GFF and GF are the result of coordinated joint efforts with government, guarantee government ownership and follow the 'government's playbook' for public finance management , and meet the results expected from this approach, i.e. greater aid effectiveness in the health sector.

A study comparing PBF AIDS health financing mechanisms in three countries, including Mozambique, shows some of the challenges. They include

- The proliferation of donor-specific performance targets can place a heavy burden on recipients;
- Donors have reporting systems that, to varying degrees, duplicate data. Such duplication increases the likelihood of two or more funding recipients taking credit for serving the same patients;
- GF 'clearly and systematically links funding decisions to performance' and publicly releases performance data' in a process where targets and indicators 'are proposed by the Main Recipient' and then finalized in discussions with the GF. 'Still, the Global Fund data is not always accurate or reliable, and there is room for improvement'.

Regarding GF's use of PBF, a 2017 study of a programme addressing HIV and maternal/child health services suggested a positive correlation between PBF and 'driving down the HIV epidemic and advances in MCH service delivery as compared to input financing alone' (Rajkotia et al., 2017: abstract). Another study conducted in Gaza and Nampula provinces shows that PBF had positive effects on maternal HIV knowledge and HIV testing at district level, but no effects on child and maternal care. Its effects on natal and infant mortality strongly varied with local heterogeneities in health care needs. Further, PBF is deemed to overcome inequality in health care access for outreach services (Ohrnberger et al., 2019).

- However, other authors have suggested that GF's PBF system does not adequately convey incentives for performance to recipients (Fan et al., 2013). As one KI suggests, the necessary databases and monitoring and information systems are fragile and do not easily permit gauging performance in a timely, accurate and reliable manner

- As outlined in section 3.4, KIs associated with GF are not entirely satisfied with the approach, which requires more investment in technical improvements in databases and is far from able to address issues related to the working culture, habits and instruments used in MISAU.

The main challenge, however, is how to overcome the incompatibility between the GF and GFF approach and the country's public financial management system, when their respective operational and sequential logics are opposed to each other. While the Mozambican PFM is an input-based budgeting system where resources are allocated to the health administration and health units before the beginning of the fiscal year, before a programme is implemented, the PBF approach is output-based. Payments are only made after an assessment validation of the degree to which results have been produced.

Pursuing the arguments advanced by Piatti-Fünfkirchen et al. (2021), the PFM system and legislation would have to consider the following changes to accommodate performance-based financing:

- The health units, particularly district hospitals, would need to have a degree of autonomy ('provider autonomy') in accessing and using funds from the Treasury via the PFM system. In technical terms, this means that the health unit has to be a Beneficiary Management Unit. Despite having been proposed by N'weti (2021), for the time being this is not the case in Mozambique (except for Nacala Hospital). At present, funding is made available, not to the hospital or health unit, but to the district health service department (SDSMAS).

- In contrast to input-based budgeting, where the sole purpose and category of expenditure is defined a priori ('eligibility of expenses'), RBF would increase the degree of flexibility ('spending flaccidity') of using the available funding for different purposes, including salary incentives. This would give the health unit more manoeuvrability in rewarding quality performance;

- The RBF approach, i.e. disbursement for services delivered, would also affect the planning/programming/budget process. The disbursement of the ex ante defined annual spending ceilings legislated in the state budget, during the fiscal year, would be conditional on meeting (e.g. quarterly) triggers, resulting from the de facto delivery of a performed and validated quality service, periodically verified against established and agreed indicators, by institutional level of performance.

As Piatti-Fünfkirchen et al. (2021) have suggested, the risk of introducing RBF elements into existing planning and budgeting procedures may be high because they 'create a sustainability challenge if government budget management systems do not adjust. As long as the PBF operates in parallel to PFM systems, it fragments the payment system and governments are likely to revert to the input-based system after the project closes, even if the PBF approach has shown results'.

This is precisely what has happened with the partial introduction of a PBF system in 26 Mozambican municipalities in central and northern Mozambique that received external budget support for the development of infrastructure, services and capacity building. This experience may hold some lessons for those seeking to promote PBF in the health sector (see Box 2).

There are voices, in MISAU and among partners, which argue in favour of mutual learning between PROSAÚDE and GFF and eventually integrating PBF into PROSAÚDE, MISAU's preferred funding modality. Indeed , the information provided by two KIs about the utility of e-sistafe providing a 'budgetary window' for tracking direct GFF spending at health unit level is a step in this direction[231].

There seems to be agreement, at least between PROSAÚDE partners and MISAU senior technical staff that the Tanzanian approach to RBF in primary healthcare may provide a 'compass' for guiding Mozambique's health sector reform[232].

A long-term study on the effects of the Tanzania model on the effectiveness of service provision shows that, after three years of RBF, although the effects were less than expected as measured against some of the outcome indicators RBF, nevertheless:

> 'accelerated the trend towards increased use of health facilities', 'has positively affected interaction and accountability in the health system, reduced interruption of services due to broken equipment and drug stock outs and reduced bureaucratic procedures among others' [and] 'health workers treated pregnant women kindlier' (Mayumana et al., 2017).

231. Mozambique considering an adapted Direct Facility Financing within PFM rule. https://p4h.world/en/news/mozambique-considering-adapted-direct-facility-financing-within-pfm-rules see also section 3.6.4.
232. KI 14, 15/11/2021; KI 13, 1/11/2021

Another study by Bezu et al. (2021) shows that the less frequent avoidance of health facilities by pregnant women is also is attributable to RBF[233]. On the effectiveness of the Tanzanian pay-for-performance approach, Binyaruka and Anselmi (2020) observed that most facilities were operating below their full capacity, a sign of potential for improving resource usage, concluding that 'effective reforms should improve inputs, outputs but also efficiency'.

In Mozambique, despite the view of a senior MEF official that 'finance follows function and performance' also in the health sector'[234], the political will to embrace the Tanzania model may not be widespread. For the time being this doubt is justified by the observation that the political leadership might prefer a completely different approach to building effective primary healthcare: the privatization of district hospitals (see section 2.2).

Despite these doubts, the author believes that there is presently a window of opportunity to at least pilot the integration of a GFF-inspired RBF element into public finance management and thus PROSAÚDE, with a focus on improving the quality and effectiveness of primary healthcare in a decentralized setting. Despite good will on the part of PROSAÚDE partners and concrete proposals e.g. by N'weti (2021) and others in favour of a more decentralized, health unit-based management and financing approach, there is still a long way to go to arrive at the 'Tanzania' destination. It would require rethinking not only of the current new decentralization paradigm, but also, as shown above, a review of the planning/programming/budget logic in the light of the opportunities that the reformed e-sistafe system offers. One step in the right direction is the above-mentioned 'budget window', which allows performance-based tracking of GFF resources spent at the lowest level of SNS, i.e. the health unit. And the newly created planning and budgeting system in e-sistafe, will certainly also 'look at the results produced by the allocated expenditure'[235]. At present it is only just beginning, with an on-going evaluation focusing, for the time being, on processes rather than results[236]. According to the same source, a programme budget using this system can only be expected from 2024 onwards.

4.4.4. Conclusions

This section has drawn attention to three issues considered crucial for increasing efficiency in primary healthcare. Firstly, there was a summary of the draft May 2021 health financing strategy that is awaiting political approval. It foresees continued government responsibility for increasingly financing the health sector through the budget, the main source of funding. Diversified general taxation observing pro-poor policies that minimize the fiscal burden on the poorer strata of society who seek health services are considered, as well higher 'sin taxes'. It also proposes the gradual introduction of social health insurance. It took a long time to prepare the strategy because of, inter alia, political and technical disagreement on three contentious issues: (i) the underlying vision of the SNS and the cost of accessing it for the different social strata, (ii) the issue of the proposed increase in user fees for health services, and (iii) the effects of the proposed introduction of a mandatory health insurance on access to, and the quality and cost of, health services.

These issues are related to the need to better understand the dimension and dynamics of the fiscal space. It is concluded that there is a need for an analysis of this matter that does not only take a technical approach, but also considers the political economy and sociological aspects of taxation for universal healthcare, such as the distribution of the tax burden.

Finally, the challenges of introducing PBF into the Mozambican health system were assessed e.g. via GFF, and its harmonization with the established public finance management approach. Certain incompatibilities, such as the lack of autonomy of health units and the difference in intervention logics in an input- and output-based funding approach were noted. Identifying the Tanzania approach as a 'compass' for the health finance reform that is acceptable to the different stakeholders, the benefits and challenges were presented. Finally, existing windows of opportunity for the gradual introduction of performance-based elements were identified.

233. See also: https://www.cmi.no/projects/1830-performance-based-financing-of-health-services
234. KI 15, 19/11/2021
235. KI 15, 19/11/2021
236. According to the KI cited in the above footnote, UNICEF has commissioned evaluation.

5. OVERALL CONCLUSIONS AND RECOMMENDATIONS

5.1. General Conclusions

Over and above the specific conclusions in each chapter – condensed in the executive summary – this chapter presents general conclusions on the management of change and the diversity of health financing modalities given the major changes that have taken place in health financing over the past twenty years. In the late 1990s and early 2000s the response of MISAU and its health partners to a proliferation of individual health support projects and thus the fragmentation of the sector was a SWAp and PROSAÚDE with a Common Fund, together with increasing use the government system for channelling and managing external support to the health sector. Today, PROSAÚDE is still an established, useful way to finance health, and is preferred by government. It co-exists with other financing modalities, notably vertical programmes such as GF, GFF and GAVI that, given the prominence of American and private sector interest and their planning, investing and budgeting methods and systems, health financing again faces the challenges of managing complexity and avoiding the fragmentation that creates extra costs and reduces the effectiveness of foreign aid to health (UNU-WIDER, 2013).

However, a new SWAp and an updated code of conduct for health partners, can only be a partial answer to these challenges, given the many other changes in Mozambique's health sector since the beginning of the century. Principles of the Paris Agenda such as harmonization, ownership and alignment have lost their relative importance, the only survivor being 'management for results' in the form of performance-based financing. And the role of the WB as the manager of trust funds in HSF has significantly increased over the years, driven by partners' desire to both reduce fiduciary risk and increase the effectiveness of their contributions to the sector. In common with Piatti-Fuenfkirchen et al. (2021a) it is argued that non-alignment of external health sector financing can lead to poor prioritization, increased fragmentation, duplication of activities and reduced government ownership.

One of the challenging issues is finding a common platform or a hybrid modality which allows for a focus on decentralized interventions in PHC and allows for maximizing the strengths, a reasonable division of labour and effective coordination of both PROSAÚDE and GFF while respecting their differences in philosophy and approach.

The context has also changed – politically, economically and socially – bringing major challenges for the SNS. Growing state fragility in the delivery of public services, the privatization dynamics and the prioritization of debt service and security spending in state budgets, have all impacted on the health sector. Given these circumstances, it is, however, noteworthy that the government's share in health financing has risen over the past few years, although there is still some way to go to reach the commitments of the Abuja Declaration.

Like any complex system the SNS is subject to forces of stability and instability that push it towards 'chaos', as seen from an organizational perspective (Thiétart & Forgues, 1995). As Keating (2000) has observed,

> 'healthcare organizations must operate in turbulent environments characterized by rapid change, high levels of uncertainty, and increasing levels of complexity. A fundamental issue for effective performance in these environments is the development and maintenance of organizational structures that simultaneously provide both operational stability and agile response to environmental turbulence' (Keating, 2000: abstract).

Under these conditions, the 'control approach' to management of the health sector and the resource inflow via diverse funding modalities and the use of instruments such as SWAp may not be the most promising and adequate way to manage change while maintaining operational stability and agile response capacity. As observed by Walt et al. (1999) when reviewing Mozambique's first experience with SWAp and Common Fund approach, the capacity required to manage complexity and diverse financing modalities, while securing the operational stability of the health sector, depends to a large extent on the robustness of the health administration, its detachment from politics, its competence in strategic analysis and management and its capacity to negotiate with health partners. This, in turn, is crucially dependent on MISAU's human resource endowment and the professional quality, remuneration scales of staff and their motivation. But above all, it requires strategic leadership.

From the case of China where, as in Mozambique, the health sector is undergoing tremendous transformations from a socialist approach to public health to market-based approaches with a major role for private providers, several lessons can be drawn on strengthening the resilience and adaptability of the health system. According to Zhang et al. (2014), these are:

- The Ministry of Health must view its role as both an advocate for the interests of health facilities and health workers and also the agency responsible for ensuring that the objectives of the government health system are being met;
- Its ability to adapt to rapid economic and institutional change was primarily a function of the ministry's capacity to provide strategic leadership and, for this purpose,
- There is a need for the health administration to increase its capacity to analyse the health sector as a complex system and to manage change processes.

MISAU KIs recognized its lack of capacity to do research, analysis and interpret changes in the sector strategically and in line with PESS, not just in the health finance field. Consequently, the need for establishment of a kind of strategic 'health think tank' unit in the ministry was proposed [237]. Its main functions would be to generate research-based analyses on changes and trends in the domestic and international environment that impact on the NHS, on PESS and health finance. Such analyses would inform the ministry's leadership, particularly when negotiating externally financed support for the SNS. In the author's opinion it could also serve to strengthen MISAU's position in the domestic political arena, e.g. by 'bridging the gap in relations with MEF on the flow of funding for SNS and securing and prioritizing domestic resources' (Kanthor & Erickson, 2013).

Increasing MISAU's analytical and strategic intervention capacity would also be in the donors' interest, as stressed by a KI representing a US-financed health support programme[238]. In this KI's view, such capacity would certainly benefit MISAU's ability to better understand the changes, pressures and limits of externally funded health programmes and their interdependence with government plans and other support programmes. And it would increase MISAU's 'smartness' in identifying opportunities to negotiate 'extra deals' for the SNS, the possibility for which exists, even in large and monolithic programmes such as PEPFAR.

237 KI9, KI 10, 26/11/2021; KI 13, 1/11/2021
238 KI 5, 24/09/2021

5.2. Recommendations

Several recommendations are offered. These are directed at three categories of stakeholders: (i) Government and MISAU, (ii) health partners, and (iii) the civil society organizations working in the health sector, although implementing the proposed recommendations would require interaction among them, particularly government and health partners.

I. Recommendations for MISAU and Government, in particular MEF on:

a. Make the PESS operational through a mid-term health action plan (MTHAP) to permit better dovetailing of planned PESS results with the annual plan and budget (the future PESO) and the CFMP, to improve forecasts of resources for the sector.

b. Promote the introduction, testing and monitoring of the planning/budgeting subsystem and the use of budget windows' a way of accommodating planning/programming/budgeting elements in the existing financial management system, associated with the development of data bases for monitoring performance.

c. Define clear and transparent criteria for exceptional choice of off CUT modality for external funding.

d. Consider giving selected health units Beneficiary Management Unit status and test and monitor decentralized financial management at hospital level;

e. Substantiate the health financing strategy with technical and political economic analysis of the Mozambican fiscal space;

f. Consider a study on private business engagement in the health sector;

g. Enrich the SWAp discussions by proposing a conflict mitigation formula and the need for donors to familiarize themselves with the capacity and opportunities offered by the national financial management system (e-sistafe)

h. Setup a health research and think tank unit in MISAU to support health finance strategic decision making and health reform.

II. Recommendations for Health Partners:

i. Support the implementation of the government efforts recommended and enumerated under (i) above;

j. Promote interaction between GFF and PROSAÚDE towards a common platform (e.g. in the form of a technical working group to address the integration of performance-based elements for PROSAÚDE (in collaboration with government (see Recommendation point b. above);

k. Share and discuss the results of the forthcoming GFF review;

l. Promote the introduction, in at least two programmes and as a case study, the WHO building block methodology for the analysis of resource distribution at hospital level to increase effectiveness and efficiency in primary healthcare service delivery, as an input to medium-term health sector investment planning.

III. Recommendations for CSOs:

m. Support MISAU through research and evidence-based policy papers with a focus on the sector financing strategy, performance-based finance and private business engagement in the health sector;

n. Conduct a study on the INGOs operating in the health sector, including on their thematic and regional focus and funding;

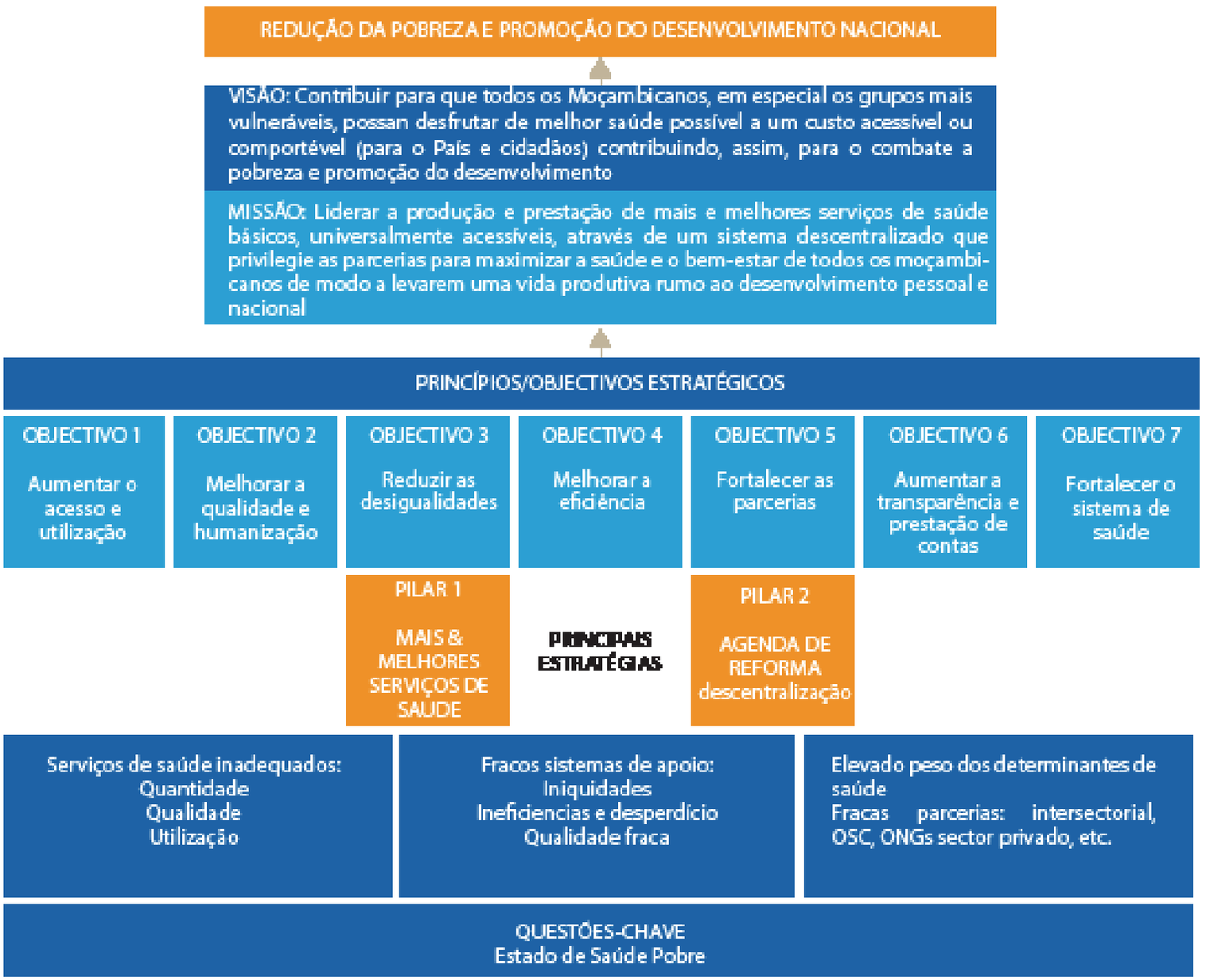
o. Promote debates and advocacy initiatives on social economic aspects of health finance and fiscal space;

p. Disseminate the results of this study among health stakeholders.

It is hoped that these commendations fall on fertile grounds for eventually producing a harvest in the sense of a more consolidated, less complex and MISAU-led approach to health sector finance for the benefit of the quality SNS and its (demographically) growing number of users and beneficiaries.

6. ANNEXES

6.1. PESS conceptual framework



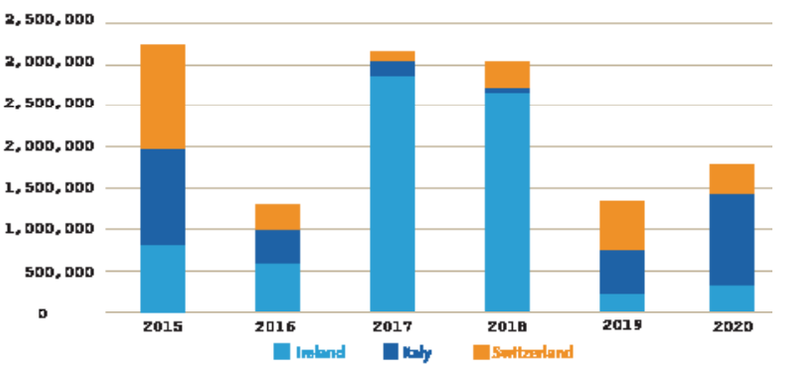
6.2. List of Persons Interviewed (Key Informants)

CODE	Date	Institution	Function
KI 1	17-Sep, 2021	MISAU /	Financial Advisor
KI 2	17-Sep, 2021	MISAU	Director
KI 3	17-Sep, 2021	MISAU / ENABEL	PFM Advisor
KI 4	24-Sep, 2021	Agência Italiana CD	Team Leader,Health
KI 5	24-Sep, 2021	USAID Maputo	Advisor, Health Policy
KI 6	30-Sep, 2021	World Bank	Team Leader, Health
KI 7	13-Oct, 2021	GFATM	PMU
KI 8	15-Oct, 2021	Consulting Company	Health Consultant
KI 9	26-Oct, 2021	Independent Consultant / MISAU	Health Financing and Management
KI 10	26-Oct, 2021	MISAU	Geral Inspectorate
KI 11	28-Oct, 2021	GFF	Focal Point
KI 12	1-Nov, 2021	MISAU	Director
KI 13	1-Nov, 2021	MISAU	Director
KI 14	15-Nov, 2021	Belgian Embassy,	Deputy Delegate, Focal Point
KI 15	19-Nov, 2021	MEF	Director
KI 16	12-Nov, 2021	Independent Consultant	Public Health and PFM
KI 17	26-Apr, 2022	MISAU	PROSAÚDE's Management
KI 18	26-Apr, 2022	Consulting Company / MISAU	Public Health and PFM consultant
K 19	26-Apr, 2022	British High Commission , FDCO	Advisor, Health programmes alignment
K 20	26-Apr, 2022	British High Commission , FDCO	Advisor, Demographic Transition
K 21	26-Apr, 2022	British High Commission , FDCO	Advisor, Health Programme
K 22	27-Ap, 2022	Independent Consultant / CIDA	Health sector consultant
K 23	27-Ap, 2022	Canadian High Commission, CIDA	Senior Development Officer, Health;

6.3. Example: Individual PROSAÚDE Donors Additional Support to SNS

Besides being part of the PROSAÚDE CF, individual donors support the health sector through additional funding outside the PROSAÚDE modality. This shows that these international partners have trust in the established government management system. This is the case, for example for Italy, Ireland and Switzerland. The latter two partners promote decentralization in the health sector, with Cabo Delgado and Niassa as focus (Switzerland), respectively Niassa and Inhambane (Ireland). The following figure gives an overview of additional funding to the sector, by these countries.

Figure 20: Individual PROSAÚDE donors contribution to health sector investment (outside CF), 2015-2020 (in US$)



Source: Author, based on e-sistafe data. The conversion MZN -to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

6.4. WB/GFF/PHCSP – Disbursement Linked Indicators (DLIs)

Table 4: -GFF / PHCSP: Joint Disbursement Linked Indicators

Number	DLI
1	Percentage of Institutional Deliveries in 42 lagging districts as defined in the IC
2	Percentage of secondary schools offering SRH* services (information and contraceptive methods),based on visits by health professionals, at least monthly.
3	Couple Years of Protection (CYPs)
4	Percentage of children between 0-4 months of age receiving the Nutrition Intervention Package (NIP) in the 6 provinces with the highest prevalence of chronic malnutrition (Cabo Delgado, Manica, Nampula, Niassa, Tete and Zambézia)
5	Domestic health expenditures as a percentage of total domestic government expenditures.
6	Health expenditures made in historically underserved areas (3 provinces and 28 districts identified)
7	Number of technical health personnel assigned to the primary healthcare network
8	Percentage of district/rural hospitals that received performance-based allocations (PBA) according to at least two scorecard assessments in the previous fiscal year
9	Percentage of rural health centres in priority districts that received performance-based allocations (PBA) according to at least two scorecard assessments with community consultations in the previous fiscal year
10	Number of APEs that are trained and active
11	Percentage of deaths certified in health facilities with data on cause coded per ICD 10 reported in SISMA and sent to the Civil Registry.

* Sexual and Reproductive Health

Source: WB (2016): Annex 3

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