REVISED DRAFT

GFATM tracking study

Macroeconomics and sector background paper

MOZAMBIQUE

Prepared for LSHTM
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Acronyms

AIDS	acquired immuno-deficiency syndrome
CCM	Country Coordinating Mechanism
CFMP	[Medium Term Fiscal Scenario]
NAC	[National Council for the Combat of HIV/AIDS]
CPI	Consumer Price Index
DAG	[MOH Directorate for Administration and Management]
DANIDA	Danish Agency for Development Assistance
DCI	Development Cooperation Ireland
DFID	Department for International Development (UK)
DGIS	Directorate-General for International Cooperation
DPC	[MOH Directorate for Planning and Co-operation]
EC	European Commission
FCG	[General Common Fund]
FCM	[Common Fund for Drugs]
FCP	[Common Fund for Provincial Administrations]
FY	financial year (1 January to 31 December)
GBS	general budget support
GDP	gross domestic product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIPC	Heavily Indebted Poor Countries
HIV	human immunodefiency virus
HSER	Health Sector Expenditure Review
IHSD	Institute for Health Sector Development
IMF	International Monetary Fund
IMR	infant mortality rate
JDP	Joint Donor Programme
MOH	[Ministry of Health]
MOU	Memorandum of Understanding
MPF	Ministry of Planning and Finance
Mt	Metical (pl. Meticaìs) (Mozambican currency)
MTEFF	Medium Term Expenditure and Financing Framework
PAF	Performance Assessment Framework
PARPA	[Action Plan for Reducing Absolute Poverty] – PRSP equivalent
PES	[Economic and Social Plan]
PESS	[Health Sector Strategic Plan 2001 – 2005 (- 2010)]
PNI-DT	[Integrated Health Programme – Communicable Diseases]
PRGF	Poverty Reduction Growth Facility (IMF)
ROM	Republic of Mozambique
SB	State Budget
SISTAFE	[Integrated financial management information system]
STI	sexually transmitted infection(s)
SWAp	Sector-Wide Approach to Programming
SWAP	Sector-Wide Approach to Policy-making
TB	tuberculosis
WB	World Bank
WHO	World Health Organisation

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Caveats

This document is the draft output of a desk-based study, and as such has been limited by the number and type of documents available to the consultant. Particular problems relating to the Mozambique case study arose from the number of relevant documents which are understandably prepared only in Portugese.

Summary of key issues and areas for Phase 2 tracking

Mozambique is considered a success story within the region both in terms of recent economic performance, and in terms of the degree of donor harmonisation achieved in past years.

Economic performance following initial post-Independence has been strong, averaging over 10% per annum in the late 1990s. The floods in 2000 severely disrupted the economy but there has been a good recovery since. Social spending is among the highest in the region, made possible both by debt relief and sustained high levels of external support to the country.

The fiscal position is relatively weak, and there are substantial problems with public expenditure management. The deficit before grants is very high, reaching 19% of GDP in 2002, and even after taking into account the substantial grants the deficit remained over 7% of GDP. A prudent fiscal policy is therefore in place, and has been given priority within the Plan to Reduce Absolute Poverty in Mozambique (the Poverty Reduction Strategy Paper equivalent).

General budget support is well-established in the country, with the “Group of 10” bilateral partners and the EC providing support under a common framework, the Joint Donor Programme, agreed in 2000. Other key bilateral partners support a more progressive move towards GBS through sector support, with an emerging Sector-Wide Approach in the health sector which builds on a number of common funds for particular items/levels within the sector, the most recent one of which, the General Common Fund, is expected to be relatively fully integrated in government financial systems.

External funding for the GFATM target diseases is currently provided through a combination of integrated programmes and vertical project support. The approved funding through GFATM totals US$155m over five years, and will be channelled through the common funds in the Ministry of Health and the National AIDS Council, thereby helping to consolidate efforts made in the sector to develop a comprehensive planning and budgeting system, and to reduce the inefficiencies fostered by multiple and parallel funding channels.

Macroeconomic issues for follow-up

Among the indicators to be monitored through the remainder of the study are:

- **Fiscal deficit, before and after grants, as a % of GDP**

The high fiscal deficit is a concern both in relation to broader economic growth, through its impact on the interest rate faced by private sector borrowers, and as interest payments on borrowing to fund such a deficit have first claim on available resources, thereby reducing the envelope available for poverty-reducing expenditures.

- **Real GDP growth**

The targets for reduced public expenditure as a share of GDP, required as part of fiscal policy, depend on Mozambique being able to maintain high levels of real GDP growth in order to ensure a steadily increasing resource envelope and therefore maintain the political feasibility of such a reduction.

- **Domestic revenue performance as a share of GDP**

The Mozambican government has an ambitious projection for domestic revenues as a proportion of GDP as part of the strict fiscal policy aimed at reducing the fiscal deficit. Given

the very high levels of public expenditure which have been enabled by an extraordinary level of external aid, this indicator will be an important determinant of the potential for maintaining activities which are initiated with GFATM funding.

- **General budget support as a % of total revenues within the budget**
    - Loans cf grants

The share of loan funding will determine future interest payments which have first call on budgetary resources.

Sectoral issues for follow-up

- **Timing and level of GFATM funds**

In the context of a concerted effort to improve the comprehensiveness of sectoral planning and budgeting, and in linking the planning and budgeting process with overall sectoral priorities and objectives, monitoring the timing and level of GFATM funding will be important to determine the extent to which this particular funding source aids or hampers this effort.

- **Share of GFATM funding in the sectoral budget**

Although existing levels of spending in the Mozambican health sector are high relative to other countries, the share of GFATM funding is projected to be significant, at up to 39% of the total[1]. This could distort sectoral priorities and activity, particularly in a situation where human resources are already stretched, capacity is constrained, and future disbursements depend on performance. How this might be monitored in the context of the current weak financial management systems is not clear, but ideally the various proposals for strengthened internal MOH systems will be implemented.

- **Disbursement as % of budget**

The channelling of the GFATM monies through the General Common Fund should hopefully minimise distortions by enabling other resources to be more flexibly programmed in relation to a comprehensive plan and budget. However, this will depend on the programmed resources actually flowing as planned, and actual disbursement should therefore be compared with budget.

- **Proportion of resources flowing to districts (or at least sub-national level)**

In the context of decentralisation, an analysis of the extent to which the new funding is channelled, directly or indirectly, to the operational level, the district, should be monitored, as should absorption capacity at that level. This might require more detailed tracking studies than currently envisaged under the study.

- **Additionality**

Mozambique does not yet appear to have explicit ceilings for individual sectors even for domestic resources, and the value of external funds fluctuates, so it is likely to be difficult to determine the extent to which the GFATM funds are "additional". However, monitoring the health sector share of the total budget, and any real increase in absolute value (ideally compared with other priority sectors) would help determine this. ***<<This needs to be checked – I could be wrong but haven't seen anything referring to hard (medium-term) budget ceilings as exist, for example in Uganda>>***

- **Share of tradeables in the GFATM proposals**

[1] Excluding sources such as Clinton Foundation, World Bank MAP etc (according to Sjolander figures, see later footnote)

More information is required on the share of the different component budgets which is tradeable and therefore exchange-rate neutral.

1 Introduction

1.1 Background to the study

This paper forms part of a series of four country background papers undertaken as a desk study in order to support an 18-month Tracking Study which aims to report recipients' (governments and other country stakeholders) perspectives on the operationalisation of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) at the country level; and to make recommendations that will contribute to successful future GFATM implementation. The study is jointly funded by the UK Department for International Development (DFID), the Danish Agency for Development Assistance (DANIDA), Development Cooperation Ireland (DCI), and the Netherlands Directorate-General for International Cooperation (DGIS). The study is being undertaken by the London School of Hygiene and Tropical Medicine.

The objectives of the tracking study are as follows:

1. to synthesise government and other country stakeholders' perspectives on CCP (proposal) preparation, functioning of CCMs and implementation processes at the country level;
2. to identify lessons learned and make recommendations on the coordination of the Global Fund and other global health initiatives with existing country-level processes (Sector-Wide Approaches and Poverty Reduction Strategy Papers).

The study will be undertaken through a combination of methods, notably document review, in-country fieldwork, and separately commissioned desk studies on specific areas.

1.2 The country macroeconomic and sectoral financing desk study

The purpose of this background paper is to provide an overview of the macroeconomic and sectoral financing context for the second phase of the more detailed fieldwork, to review the planned inflows through GFATM in relation to aid levels and their potential macroeconomic impact, if any, and to propose areas related to economics and financing which might be tracked during Phase 2 of the main study. Terms of reference are attached at Annex A.

The need for a separate background paper on these issues has arisen in response to growing debate regarding potential trade-offs between the substantial and acknowledged increase in investment in priority sectors such as health if the Millennium Development Goals and others are to be achieved, and the need for sound policies for macroeconomic stability and growth as a basis for long-term development. This debate has been most strongly articulated in Uganda to date, but is of increasing concern more generally among low income countries. In addition, there is some political concern within countries regarding the wisdom of an increasing share of the government budget and Gross Domestic Product (GDP) coming from external resources, both in terms of predictability of revenue flows but also regarding national sovereignty with respect to the policy-making process.

In late 2002, DFID issued a policy paper summarising the macroeconomic effects of aid[2]. This was based in part on a paper commissioned on aid and monetary policy in Uganda in order to help clarify the position in which Uganda finds itself, ie of needing to trade off the availability and potentially productive use of additional external assistance to the country, with the adverse macroeconomic effects which such an inflow could produce[3]. These

[2] DFID (2002). *The macroeconomic effects of aid*. Policy paper. London: December 2002
[3] Adam C, *Uganda: Exchange rate management, monetary policy, and aid*. Paper prepared for the Bank of Uganda with DFID support. Revised version. Oxford: September 2001

primarily involve an appreciation of the exchange rate, resulting in a fall in the demand for exports and increase in imports. Other things being equal, this results in a contraction of the tradable sector of the economy in which it is generally assumed that there is greater long-term scope for productivity gains, and hence a lower long term average growth rate for the economy as a whole. This phenomenon is generally known as “Dutch disease”, after the macroeconomic effects seen following the discovery of natural gas of the Dutch coast.

There is a question mark, however, over this general assumption, with an alternative view suggesting that long term productivity can be enhanced by increased investment in the social sectors. Two key assumptions are necessary for the long term benefits of such investment to be delivered:

- that the increase in public spending on education and health should result in improved health and education outcomes;
- that these improved health and education outcomes should result in increased productivity.

The evidence from the WHO Commission on Macroeconomics and Health (CMH) supports this position, arguing that use of increased aid inflows to purchase non-tradable goods such as health care and education can and should translate into a healthier and more productive workforce, thereby mitigating, at least in part, the effect of such a contraction of the tradable sector of the economy. For example, the impact of girls’ education on future infant mortality rates (IMR) is well known, and lower IMR translates in term to higher life expectancy and a longer productive life. Higher contraceptive prevalence rates result in smaller, healthier families. Nutritional interventions enhance learning capacity and thus productive potential in later life. In addition, a substantial proportion of aid flows to the health sector is used to purchase imported inputs (eg pharmaceuticals, vehicles) and is therefore exchange rate neutral. GFATM funded interventions could be expected to contribute to such productivity increases through extending life and reducing morbidity.

Unfortunately, the two impacts have different timeframes, with improved health outcomes being a longer term effect, while real exchange rate appreciation has an immediate effect. It is therefore generally recommended that some aid be focussed on measures aimed at improving private sector competitiveness through addressing supply side constraints. In addition, intervention in the financial markets is likely to be necessary in order to prevent domestic inflation due to sudden and excessive increases in the money supply. Such intervention might involve “sterilisation” of excess money through selling Government stocks, which in turn results in increased debt and higher interest rates, again crowding out the private sector. Success in this area therefore depends on the strength of individual country fiscal and monetary policy.

One key indicator of sound macroeconomic policy relates to the size of the fiscal deficit in relation to national income, or GDP, ie the gap between public expenditure and revenues. A distinction is sometimes made between the government deficit which excludes external grant funding, and the overall deficit which includes such grants. This document generally refers to the overall deficit. Any such gap between government incomes and expenditure clearly needs to be financed, with options including the printing of money, issuing of domestic debt, or borrowing from abroad.

There is general acceptance that reducing the fiscal deficit of a country is in itself a good thing, not least as it results in an increased proportion of the overall government resource envelope potentially available for priority poverty-reducing expenditures. Debt service, whether domestic or international, generally has first claim on public resources, and can often lead to a substantial reduction in the pool of funds for “discretionary expenditures”. There is generally less consensus regarding the relative, immediate priority to do so in low

income country governments with both a heavy burden of disease and substantial economic loss arising from HIV/AIDS, tuberculosis and malaria among other conditions.

The potentially large and supposedly additional inflows of funding through GFATM to low income countries has resulting in increased interest both in the broad macroeconomic debate outlined above, but also with respect to the relative advantages or disadvantages, and the potential impacts, within the health sector of different aid mechanisms. In a climate of increased moves towards either general or sectoral budget support, often through a health Sector-Wide Approach (SWAp) to the planning and financing of an agreed sectoral plan and more-or-less integrated package of health services at the operational level, GFATM funding threatens to re-introduce parallel systems and a vertical approach, with subsequent reversals in the efficiency of external support. These background papers therefore aim to explore these issues in the four study countries.

1.3 Structure of the document

The paper is structured as follows. Section 2 provides a snapshot of the current macroeconomic situation, describing the structure of the economy, recent economic developments, and the Poverty Reduction Strategy which currently govern overall macroeconomic policy and inter-sectoral allocation decisions. It goes on to outline agreed arrangements for managing external assistance in Mozambique, focusing particularly on recent moves towards general budget support.

Section 3 describes the government budgetary framework, covering the planning and budgeting cycle, the Medium Term Fiscal Scenario, and current administrative and financial management arrangements.

Section 4 goes into more detail on health sector planning and financing, and the relationship with HIV/AIDS-related activities. To the extent permitted by the data, overall trends in sector financing are reviewed, and the changing nature of external support is examined. Specific details of financing for activities relating to HIV/AIDS, tuberculosis and malaria are presented where available.

Section 5 pulls out issues specifically related to the GFATM proposal in the country.

2 The macroeconomic context

2.1 Overview and past performance

2.1.1 Structure of the economy

At Independence, the Mozambican economy was largely agricultural, with little industry, and an infrastructure in disarray after years of conflict. In 1987, the government adopted a comprehensive economic reform programme in order to stabilise and liberalise the economy. Substantial progress with these policies over the past 15 years mean that the country is generally seen as a success story within sub-Saharan Africa.

Tables 1 and 2 below show the recent composition of the Mozambican economy, and changes therein.

Table 1 Composition of Gross Domestic Product, 1998 – 2002 (Meticais billion and %)

	1998		1999		2000		2001		2002	
	Mt bn	%	Mt bn	%	Mt bn	%	Mt bn	%	Mt bn	%
Agriculture	12,756	27.2%	13,231	25.5%	12,346	21.7%	15,555	21.9%	16,645	19.5%
Fishing	1,418	3.0%	1,310	2.5%	1,378	2.4%	1,601	2.3%	1,366	1.6%
Industry	10,090	21.5%	11,534	22.2%	13,623	23.9%	17,742	24.9%	26,096	30.6%
o/w Mining	*143*	*0.3%*	*73*	*0.1%*	*206*	*0.4%*	*254*	*0.4%*	*227*	*0.3%*
Manufacturing	*5,113*	*10.9%*	*5,993*	*11.5%*	*6,830*	*12.0%*	*9,852*	*13.8%*	*9,676*	*11.4%*
Electricity and water	*938*	*2.0%*	*1,447*	*2.8%*	*1,281*	*2.3%*	*1,466*	*2.1%*	*2,640*	*3.1%*
Construction	*3,896*	*8.3%*	*4,021*	*7.7%*	*5,307*	*9.3%*	*6,170*	*8.7%*	*13,553*	*15.9%*
Services	22,648	48.3%	25,838	49.8%	29,570	52.0%	36,237	50.9%	41,099	48.2%
o/w Commerce	*10,078*	*21.5%*	*10,997*	*21.2%*	*11,859*	*20.8%*	*14,960*	*21.0%*	*15,304*	*18.0%*
Repair services	*369*	*0.8%*	*404*	*0.8%*	*494*	*0.9%*	*120*	*0.2%*	*563*	*0.7%*
Restaurants and hotels	*534*	*1.1%*	*626*	*1.2%*	*797*	*1.4%*	*838*	*1.2%*	*836*	*1.0%*
Transport and communications	*4,299*	*9.2%*	*4,924*	*9.5%*	*5,297*	*9.3%*	*6,811*	*9.6%*	*9,468*	*11.1%*
Financial services	*1,264*	*2.7%*	*1,045*	*2.0%*	*2,240*	*3.9%*	*2,785*	*3.9%*	*2,990*	*3.5%*
Real estate services	*1,093*	*2.3%*	*1,146*	*2.2%*	*1,089*	*1.9%*	*1,719*	*2.4%*	*1,257*	*1.5%*
Corporate services	*600*	*1.3%*	*451*	*0.9%*	*444*	*0.8%*	*-*	*0.0%*	*-*	*0.0%*
Government services	*2,383*	*5.1%*	*3,584*	*6.9%*	*4,220*	*7.4%*	*5,510*	*7.7%*	*5,394*	*6.3%*
Other services	*2,029*	*4.3%*	*2,660*	*5.1%*	*3,130*	*5.5%*	*3,494*	*4.9%*	*5,287*	*6.2%*
Gross domestic product	**46,912**		**51,913**		**56,917**		**71,135**		**85,206**	

Source: IMF (2004), Table 2

Note: Source does not indicate whether GDP measured at factor cost. Figures assumed to be at current prices.

Table 1 shows the shift away from agriculture since the late 1990s, its share of GDP having fallen by almost 8% over the four year period. The share contribution of fishing has also declined over the period. This is due to a change in structure of the economy in favour of industry, whose share has grown by over 9% in the same period, largely driven by a near doubling in the importance of the construction sub-sector, up from 8% 1998 to almost 16% in 2002.

The share of the service sector was broadly similar in 2002 to 1998, although this masks an increase of almost 4% between 1998 and 2000, and subsequent fall. Within the service sector, gains have been made in the share of Transport and communications, Financial services, and other services. Government services also rose in importance over the period, increasing from 5.1% in 1998 to 7.7% in 2001, but then dropping back somewhat in 2002 to 6.3%.

2.1.2 Recent economic performance and prospects

Economic growth has been impressive in Mozambique, averaging more than 10% per annum in the late 1990s. GDP growth fell sharply in 2000, but this is largely attributed to the floods which devastated the country, and there has been a strong recovery since then, with growth of over 13% in 2001 and over 8% in 2002. Table 2 shows the real rates of change by sector between 1998 and 2002.

The data show that the fastest growing areas in the economy in recent years have been within the manufacturing sector, namely construction (with spurts in 1998 and 2002), the utilities, and mining. The table also shows how variable growth rates have been in a number of areas, with both positive and negative growth rates recorded during the period. Examples include restaurants and hotels, transport and communications, and the financial services sub-sector. The effect of the 2001 floods on the agricultural sector is also clear.

Table 2 Annual percentage change by sector, 1998 - 2002

	1998	1999	2000	2001	2002
Agriculture	9.5	6.5	-10.8	13.0	8.5
Fishing	-11.0	-1.9	-9.5	9.0	-5.9
Mining	20.6	-6.5	52.8	12.4	39.8
Manufacturing	14.4	14.7	20.3	27.2	5.2
Electricity and water	279.0	78.3	-6.1	13.9	2.5
Construction	26.2	3.4	4.7	9.7	32.8
Commerce	11.9	2.5	2.4	5.7	5.4
Repair services	16.6	3.2	3.5	1.2	4.3
Restaurants and hotels	-2.1	5.4	6.4	19.1	-1.6
Transport and communications	4.8	9.0	1.2	21.6	-7.3
Financial services	-17.4	-26.9	41.9	9.2	2.2
Real estate services	3.8	2.2	-2.8	7.9	2.4
Corporate services	20.9	4.4	-0.1		
Government services	5.0	15.1	6.7	15.8	0.4
Other services	-20.0	-44.8	12.0	9.8	11.0
Gross domestic product	**12.6**	**7.5**	**1.5**	**13.0**	**8.3**

Source: IMF (2004), Table 3

One additional point of interest in Table 2 is the very low growth in the government services sub-sector between 2001 and 2002, following substantial growth in previous years. ***<<any explanation for this?>>***

Table 3 below shows some key macroeconomic indicators for recent years, demonstrating the broadly positive performance of the Mozambican economy, together with the clear impact of the HIPC and other debt relief on debt service due after 1999.

Table 3 Key macroeconomic indicators, 1998-2002

	1998	1999	2000	2001	2002
GDP growth	12.6%	7.5%	1.5%	13.0%	8.3%
Inflation (annual % CPI)	-1.0%	6.2%	11.4%	21.9%	9.1%
Exchange rate (official, US$, annual average)	11,853	12,673	15,141	20,456	23,180
Domestic revenue (% GDP)	11.3%	12.0%	13.2%	13.3%	14.2%
Public expenditure (% GDP)	21.6%	24.7%	27.3%	34.6%	34.1%
Current account deficit, excl grants (% GDP)	18.9%	28.2%	28.7%	28.1%	23.3%
Gross international reserves (months of imports)	7.8	5.5	6.3	5.8	5.9
Debt service ratio (debt/exports)		15.3%	2.5%	3.5%	4.3%

Source: IMF (2004), various tables

The data in Table 3 show that although the recent picture in terms of overall growth has been positive, macroeconomic stability has not yet been achieved, with inflation rates still relatively high at 9.1% in 2002. However, this represented a significant improvement on the previous year.

In addition, Mozambique has been quite successful in boosting international trade over the last few years, with the indices of export volume and value reaching 236.5 and 240.5 in 2002 respectively (1999 = 100). Key exports include aluminium, prawns, and electricity. Imports have similarly grown, but by less, with the respective indices reaching 107.1 and 105.3. Both prior to and since the flotation of the Meticais, the currency has steadily depreciated, with the value in US dollars almost halving over the four year period shown in the Table.

2.1.3 Fiscal performance

The high growth rates and low inflation experienced during the late 1990s are attributed in part to prudent fiscal policies combined with necessary structural reforms and controlled monetary policy. The availability of substantial external assistance enabled the country to maintain a relatively low deficit after grants until 2000, despite rapid expansion in public expenditure. However, deficits before grants are currently very high, having risen from 11%

of GDP in 1998 to 19% by 2002, resulting in an unsustainable fiscal position which, if uncorrected, will *"threaten macroeconomic stability and growth"* (WB 2003).

This situation has been largely driven by very rapid growth in public expenditure, particularly during the period 1999-2002 when two banks were bailed out, the civil service wage bill rose by 46% in real terms, and higher spending on the social sectors was facilitated by HIPC debt relief. Made possible by the exceptional volume of external assistance available to the country, it is expected that this will eventually reduce to the sub-Saharan African average of around 4% of GDP compared with its 2002 value of 11% in Mozambique. Fiscal discipline is therefore required in the short to medium term in order to reduce the deficit. The domestic financing which is also helping to cover the deficit has already had an impact on interest rates, with prime rates over 35% by the end of 2002, leaving the small and medium-sized firm sector in recession.

In recognition that this position cannot be maintained, strengthening the country's fiscal position has therefore become a priority of the Mozambican government, with limiting public expenditure explicitly identified as a measure to be undertaken under the PARPA. The 2003 Public Expenditure Review indicates a macroeconomic framework that aims to reduce total public expenditures from an estimated high of 32% of GDP in 2002 to just under 26% by 2005. In the context of strong economic growth, this is deemed politically feasible as it still enables real increases in expenditure of around 4% per annum.

Domestic revenues have gradually been improving as a percentage of GDP, from 11.3% in 1998 to 13.5% in 2002, and are programmed to rise further to 15.2% by 2005. This positive performance is largely due to improved tax performance, both in income tax and on goods and services. Continued good performance in 2003 is attributed to implementation of a new code for personal and corporate income taxes, together with more transparent fiscal incentives, and to a significant rise in taxes on domestic petroleum products.

This projected fiscal scenario is expected to reduce the deficit before grants from its 2002 estimate of 19% of GDP back to 11% by 2005, while the projected position of the deficit after grants is reduced by more than half to 3.4% of GDP by 2005.

2.2 Poverty and the PRSP

2.2.1 Poverty in Mozambique: an overview

Poverty in Mozambique is defined as the *"inability of individuals to ensure for themselves and their dependents a set of basic minimum conditions necessary for their subsistence and well-being in accordance with the norms of society"* (PARP, p11). The PARPA also give three other definitions as follows:

- Absolute or extreme poverty: insufficient income to satisfy basic food needs of minimum calorie requirements;
- Relative poverty: insufficient income to satisfy basic food/non-food requirements given the average income of the country;
- Human poverty: *"lack of basic human capacities, such as illiteracy, malnutrition, low life expectancy, poor maternal health, prevalence of preventable diseases, together with indirect measures such as access to the necessary goods, services and infrastructures necessary to achieve basic human capacities – sanitation, clean water, education, communication, energy etc"* (ROM 2001, p11)

Table 4 shows a variety of poverty estimates for different areas of the country. The Headcount index measures the proportion of the population defined as poor (using

consumption data), the Poverty gap index measures …., while the distribution of the poor is a straightforward breakdown between geographical areas.

Table 4 Average consumption and poverty estimates by zone and region

	Portion of the population (%)	Average value of real consumption Total (Mt)	Head count index (%)	Poverty gap index (%)	Distribution of the poor (%)
Rural	79.7	150,740	71.3	29.9	81.8
Urban	20.3	202,685	62.0	26.7	18.2
North	32.5	167,834	66.3	26.6	31.0
Centre	42.6	141,990	73.8	32.7	45.3
South (incl Maputo)	24.9	183,718	65.8	26.8	23.6
South (excl Maputo)	18.8	161,036	71.7	30.2	19.4
National	100.0	160,780	69.4	29.3	100.0

Source: PARPA, Table 2.1, p 22

Among the determinants of poverty in the country, the following have been identified: slow economic growth until the early 1990s; high dependency rate; limited employment opportunities; poor infrastructural development in rural areas; and low education levels among the economically active, particularly women. A poor rural road network has also contributed to hurdles in the sale of agricultural surpluses.

2.2.2 Poverty reduction policies and strategies

The Mozambican Poverty Reduction Strategy Paper equivalent, known as PARPA (the acronym for the Portugese title Action Plan for Reduction of Absolute Poverty) builds on earlier government efforts to eradicate poverty in the country. These can be said to have begun following Independence, when a focus on health and education was adopted in order to improve human development in the country, together with investments in basic infrastructure rehabilitation following the years of conflict.

The PARPA was approved by the Council of Ministers in April 2001, and the Joint Staff Assessment of the same year concluded that *"government ownership was strong, the policy agenda was appropriate, and the macroeconomic framework was broadly sound. For the most part the PARPA integrated and consolidated existing sectoral strategies and put them in a consistent institutional and macroeconomic framework"* (IDA/IMF 2003 – JSA).

The central objective of government through the PARPA is stated as *"a substantial reduction in the levels of absolute poverty in Mozambique through the adoption of measures to improve the capacities of, and the opportunities available to all Mozambicans, especially the poor"* (p1). The incidence of absolute poverty is targeted to reduce from 70% in 19097 to under 60% by 2005 and to under 50% by the end of the decade[4]. The document identifies two categories of areas for action: six 'fundamental' areas and a further eleven secondary areas, as shown in Table 5.

[4] Preliminary information from a recent National Household Survey indicates that the 2005 target has already been exceeded, with the proportion of the population living below the poverty line falling below 60 percent in 2002 (IMF 2003 – PIN).

Table 5 Action areas in the Mozambican PARPA

Fundamental areas	Other areas
• Education • Health • Infrastructure (roads, energy and water) • Agriculture and rural development • Good governance, legality and justice • Macroeconomic and financial policy	• Employment and business development • Social action • Housing • Mines • Fisheries • Tourism • Processing industry • Transport and communications • Technology • Environment • Reduction of vulnerability to natural disasters

Source: ROM (2001)

Given the country's history, a major assumption for the attainment of poverty reduction objectives is the maintenance of peace and socio-political stability. However, rapid economic growth is seen as the key strategy for poverty reduction in the medium and long-term, in order to increase the resource base and thereby expand opportunities for the poor. Through the fundamental area of macroeconomic and financial policy, the PARPA therefore includes policies aimed at the achievement of an average annual GDP growth rate of 8%, through the creation of a favourable climate for investment expansion and productivity enhancement. Such policies include fiscal, monetary and exchange rate policy to maintain low inflation and increase competitiveness, the efficient and equitable mobilisation of additional budgetary resources, improved public expenditure management, expansion of financial markets, promotion of international trade, and strengthening of debt management.

Key strategies articulated under other fundamental areas of action include:
- the achievement of universal primary education, together with rapid expansion of secondary and informal education, and technical and vocational training;
- improvements in access to agricultural markets, together with the extension of particular crops and technologies, and improvements in the financial system for farmers;
- improvements in the road network, and expansion of provision of water and energy, together with rehabilitation and construction of basic infrastructure in areas of the country with high populations and poverty levels;
- improved governance through decentralisation and devolution to bring government closer to the people, strengthening the capacity of the judicial system, and a reduction of corruption at all levels.

Table 6 shows the original proposed allocations to these fundamental areas of action during the period of the PARPA, while Table 7 shows the actual pattern of expenditures between 1999 and 2002. Unfortunately, it has not been possible to locate information using the same values (ie 2001 Meticais), and calculations are therefore subject to some query due to differing data sources, but the information still demonstrates some points of interest.

Table 6 Proposed allocations to priority poverty areas, 2001 - 2005 (in billion 2001 Meticais)

	2001	2002	2003	2004	2005
Resource envelope projection	20,173.3	22,385.3	22,924.7	24,123.6	26,507.7
Priority sectors/areas	13,598.8	14,553.2	15,336.2	16,085.4	17,102.8
Education	*4,948.1*	*4,357.2*	*4,640.4*	*4,871.2*	*5,230.0*
Health	*2,302.8*	*2,889.2*	*2,962.4*	*3,210.5*	*3,528.3*
Infrastructure	*3,760.1*	*4,481.0*	*4,634.1*	*4,729.9*	*4,872.6*
Agriculture and rural devt	*714.1*	*862.6*	*949.7*	*977.0*	*1,025.7*
Good governance	*1,643.6*	*1,703.4*	*1,850.5*	*1,958.1*	*2,053.6*
Other priority areas	*230.1*	*259.8*	*299.0*	*338.7*	*392.6*
Other sectors	3,028.9	3,105.8	3,138.1	3,199.2	3,249.9
Other budget expenditures	2,883.5	2,760.0	2,885.6	2,765.0	2,651.3
Total programmed expenditure (TPE)	**19,511.3**	**20,419.0**	**21,359.8**	**22,049.6**	**23,004.0**
Contingency reserve	662.0	1,966.3	1,564.8	2,074.0	3,503.6

Source: ROM 2001 (PARPA), Table 7.5, p

Table 6 indicates that the allocation to the health sector was originally programmed to rise both in real Meticais terms, by 53% over the four year period, and as a share of TPE, from 11.8% to 15.3% (see Figure 1 below). The data in Table 7 show that during the first two years of PARPA implementation, the absolute level of TPE had exceeded projections, while that of Health spending was close to the estimate. This resulted in a slower than envisaged increase in the sectoral share, reaching 12.6% rather than 14.1% of TPE in 2002.

Table 7 Actual expenditure on PARPA priorities, 1999 – 2002 (in billion 2001 Metacais)

	1999	2000	2001	2002
Health	2,045	2,500	2,063	2,813
HIV/AIDS	-	-	142	156
Total expenditure on PARPA priorities	9,380	13,197	13,800	14,380
Total Programmed Expenditure	15,128	19,379	20,973	22,294
Health as % TPE	13.4%	12.9%	9.9%	12.6%
PARPA priorities as % TPE	62.0%	68.1%	65.8%	64.5%

Source: IMF (2004) Table 14[5]

Notes: TPE calculated from IMF data, and excludes bank restructuring costs and interest payments; 2001 prices obtained using Consumer Price Index as the deflator, and may therefore not be wholly consistent with Table 6.

Table 7 also shows that the share of spending allocated to PARPA priorities fell in both 2001 and 2002 following publication, and that the health sector share, having fallen initially, picked up in 2002 but still remained lower than its share in 1999 (see also Table 9).

2.2.3 The PRSP, Health and HIV/AIDS

Health

The health sector is identified as one of the six fundamental areas for action, based on its dual role both directly improving well-being, particularly for the poor, and through its contribution to human capital development which benefits the broader economy. Actions included in the PARPA are based on existing sectoral programmes, notably the Strategic Plan for Health which was under development at the same time as the PARPA, and a long-standing commitment to strengthening Primary Health Care (PHC).

[5] IMF data for 2002 differ slightly form those presented in the PARPA progress report (ROM 2003) as the latter was prepared using data up to September 2002. Actual performance appears therefore to have been worse than projected at the time of writing the progress report.

Six components are identified under Health in the PARPA:

- Primary Health Care;
- Combating epidemics;
- The fights against HIV/AIDS;
- The health network;
- The development of human resources; and
- Planning and management of the health sector.

More details of the strategies outlined in each of the six components is given in Table 8 below.

Table 8 Health sector components in the PARPA

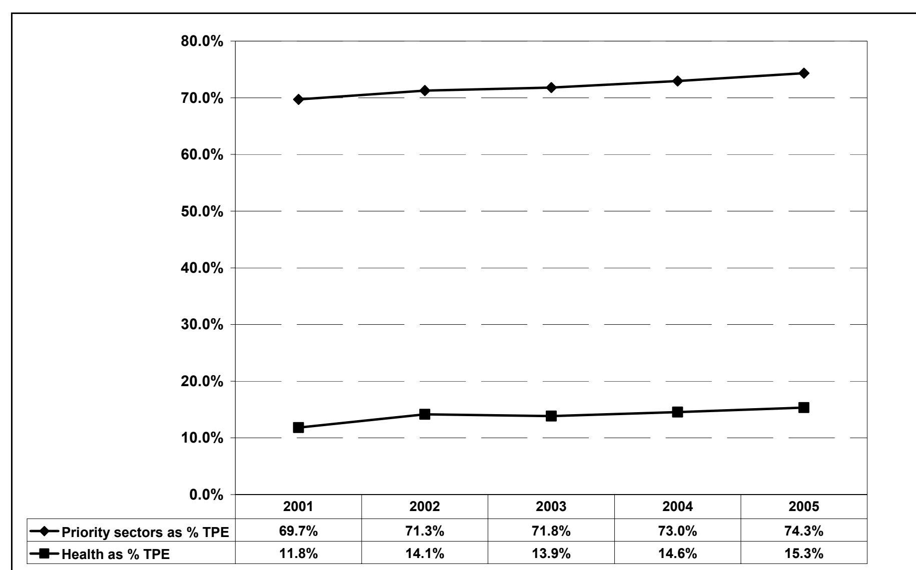
Component	Sub-component	Objectives
Primary Health Care	Women's health	• Improve access and quality of health care for women
	Child health care	• To improve child health care and prevent the main epidemics which affect children through vaccination
	Health care for youth and adolescents	• Improve health, and knowledge of health issues, amongst young people and adolescents, through school health activities
	Nutrition	• To contribute, in partnership with other agents, to an improvement and Food and Nutrition Security in the country • To reduce the prevalence of micronutrient deficiencies in children and women of childbearing age
Health care in the fight against serious epidemics	Diarrhoeal diseases	•
	Malaria	•
	Tuberculosis	•
	Leprosy	• To reduce the prevalence of leprosy to <1 case per 10,000 by the end of 2005
The fight against HIV/AIDS		• Prevent HIV infections • Assist people with HIV/AIDS • Reduce the impact of AIDS
The health network		• To improve access to health care services through an expansion of the network o Reduce the index for primary health units (PHU) to 10,000 inhabitants per unit o Reduce the direct and indirect zone of influence distances for PHU health units to 8kms and 100kms respectively o Improve quality of primary health service provision through equipping health units and making funds available to meet the following ▪ Increase hospital beds to 1/1000 inhabitants, and 1/1000 WCA in provinces where needs are greatest (Zambezia, Nampula, Cabo Delgado)
Development of human resources		• To ensure the training of essential personnel to meet the expected requirements for expanded and improved health care services • To create a balance between primary and secondary health teams • To pursue the targets of raising the ratio of health personnel per 1,000 inhabitants to 1/1000, with 100% of PHU staffed by qualified personnel
Planning and management of the health sector		• To improve planning and management methods with emphasis on the development of information, planning and financial management tools for primary level health services

Source: ROM 2001 (PARPA), pp51-56

In addition, reference is made to interventions in other sectors which influence health status, such as the supply of clean water and sanitation (included in water, under the fundamental area Infrastructure).

There is explicit recognition of the needs of under-privileged sections of the population, specifically children, women of child-bearing age, rural populations, and those in absolute poverty. The differential impact of war among geographical areas is also mentioned in the context of adopting a regional approach to the management of scarce resources in the sector.

Figure 1 Planned allocations to Health and to all priority areas, 2001 - 2005



Source: ROM 2001 (PARPA), Table 7.5, p 125.

Although it was not possible to obtain official comparable data on budgets and expenditures, calculations using recent IMF data suggest that although not living up to promises in terms of share of total public expenditure, the growth in the health budget was impressive between 2001 and 2002 as shown in Table 9 below.

Table 9 Health budget and expenditure as share of total public expenditure, 2001-02

	2001		2002	
	Budget	Actual	Budget	Actual
Priority sectors as % TPE	69.7%	65.8%	71.3%	64.5%
Health as % TPE	11.8%	9.9%	14.1%	12.6%
Annual real growth in Health budget		-17.5%	25.5%	36.4%

Source: IMF 2004

HIV/AIDS

The the HIV/AIDS epidemic is a serious threat to the overall economy and to the well-being of individuals and households in Mozambique. Life expectancy could fall from 50 years to as low as 36 years over the next decade, and the number of children either left as orphans or deprived of basic education due to caring for relatives or lack of funds is growing. Studies have indicated that the effect on the economy is negative and potentially substantial, with economic growth being as much as 25 per cent lower than it might otherwise have been over a 20-year period in high prevalence countries. In addition, the effect on scarce human resources throughout the economy is significant, with the labour force estimated to become 10 to 22 per cent smaller by the year 2020.

Tackling the HIV/AIDS epidemic does not feature as a specific area of action in the Mozambican PARPA, but actions are included under both Health and Education. Table 10 summarises the measures identified in the two sectors.

Table 10 Principal measures against HIV/AIDS in the PARPA

Sector	Principal measures
Education	• Include material on education and prevention of HIV/AIDS in school curricula; • Produce and disseminate informational material on HIV/AIDS for students and teachers; • Undertake an impact assessment of HIV/AIDS on the education sector and incorporate the results into educational planning
Health	• Carry out essential and high quality preventive measures, targeting the 2.31m people estimated to have sexual relations with irregular partners. To include: treatment of STDs, counselling and voluntary testing (VCT), controlling blood transfusions, testing for syphilis • To set up and operate confidential VCT centres in Maputo, Chimoio, Beira, Nampula, Tete, Quelimane • Establish and operate day care units in Maputo, Chimoio, Beira, Nampula, Tete and Quelimane • Carry out education and information campaigns on STDs/HIV/AIDS, to include theatre shows for 3.9m people • Distribute condoms to 4.5m HIV positive persons

Source: ROM (2001), pp49-50, 54

A number of other measures are listed under Health, including: provision of partner education; clinical treatment and home care; ensuring access to essential health care; and the provision of psychological, medical and social care in all health centres in district headquarters. Most activities are specified in terms of either geographical coverage or in terms of numbers to be covered, implying that they are not all indicated for scale-up nationally.

2.3 Current economic programme

Economic policies in Mozambique at present continue to reflect the objectives of the PARPA, and the need to consolidate recent successes in order to further improve macroeconomic stability and growth in the country as a prerequisite to further poverty reduction. According to IMF data, real GDP growth is projected to increase to over 8 percent in 2004 largely because of the coming on stream of MOZAL II (the expansion of the aluminum smelter) and the gas pipeline, and end-year inflation is targeted to fall to 9 percent, both of which suggest that the government is on course.

The fiscal program for 2003 sought to contain the domestic primary deficit at 3.7% of GDP, while the projection for 2004 is 3.4%, largely due to further strengthening of the revenue position, and also reflecting steps taken to address the significant increase in the government wage bill in recent years.

For 2003, the external current account deficit after grants was expected to widen to 15% of GDP (12% in 2002), reflecting an increase in investment in the mega projects during the second half of the year.

At the October 2003 Consultative Group (CG) meeting, international partners reaffirmed external assistance commitments for 2004 of around US$790m, of which 75% was in grant form.

2.4 External cooperation and financing

2.4.1 Harmonization

As the recipient of the highest per capita development assistance in Africa, and with a large number of both bilateral and multilateral agencies active in the country[6], the issue of harmonisation is important in Mozambique. The government participated in the February 2003 meeting in Rome of aid recipient countries and development organisations, which resulted in publication of the Rome Declaration on Harmonization[7], and is committed to strengthening harmonization of government and partner systems and procedures. To date, the experience is seen as positive, with a number of processes already in place, such as regular donor meetings, annual sector assessments, jointly agreed performance indicators, and work on joint policy development and coordination. Sectors where some degree of harmonisation in financing is in place include education, agriculture, public sector reform health, water, sanitation, housing and planning[8].

The PARPA has been agreed as the basis for bilateral assistance, and partners are working on the development of a common framework of conditionalities and triggers for increased budget support. A joint World Bank/NORAD/SIDA Country Financial Accountability Assessment is under way as part of this process.

2.4.2 Budget support for poverty reduction

In common with other countries in the region, Mozambique is increasingly moving towards general budget support (GBS) as the preferred channel for external resources, for the usual reasons regarding the potential efficiencies of harmonised practices in support of a common programme of poverty reduction and economic development. In 2004, an estimated 40% of total financing for development is expected to be channelled through budget support (www.worldbank.org/afr/mz/cg2003/index.htm).

Mozambique currently benefits from two main sources of such support:

- Funding under the Poverty Reduction Growth Facility (PRGF) of the International Monetary Fund (IMF), which succeeded the Economic and Structural Adjustment Facility, negotiated for an initial three year period in July 1999 and extended to June 2003, and which amounted to around US$113 million (IMF 2002 – NB02/48). A successor programme is currently under discussion; and
- The Joint Macro-Financial Aid Programme or Joint Donor Programme (JDP) supported by nine bilateral donors and the EC (Batley 2002, p27-28).

In addition, World Bank support through a Poverty Reduction Support Credit is expected to start soon (Sjolander 2003, p 1). ***<<is there a date for this? Can't find anything on the web>>***

The process towards provision of general budget support by bilateral development partners was initiated as the Joint Macro-Financial Aid Programme in 1999, agreed between ROM and Belgium, Denmark, the European Commission, Ireland, the Netherlands, Norway, Sweden, Switzerland and the UK. A common framework agreement outlining terms and procedures for budget support was signed with ROM in November 2000, and France joined in 2002 making up the so-called "Group of 10". The goal of budget support is to contribute to poverty reduction, and dialogue is maintained with ROM on three main issues: the poverty

[6] A recent paper refers to 23 significant bilateral donors, 23 multilateral agencies, and up to 150 international non-governmental organisations offering grants, loans and/or technical assistance (Batley 2002, p10).
[7] Available on www.aidharmonization.org
[8] www.airharmonization.org

reduction programme; domestic resource mobilisation; and public sector financial management.

Under the terms of this budget support, ROM provides quarterly reports on both general budget execution and specific financial execution of the Joint Donor Programme. Annual audit reports are provided, again for both government budgetary execution and the JDP, together with a value for money performance audit of funds spent. In addition, a “joint donor review” is undertaken of the programme annually in collaboration with government, and provides the basis for commitments for the following year. A tentative disbursement schedule is agreed at this review, confirmed at the end of the financial year, with funds deposited in a common foreign exchange account.

A Performance Assessment Framework (PAF) was developed during 2003 to serve as the basis both for monitoring progress of the PARPA, and to inform future developments within the GBS programme. Other objectives identified for the PAF included:

- greater transparency and predictability in the link between policy, implementation, and the level and timing of GBS flows, thereby facilitating improved ROM planning and management;
- enhancing the incentives for ROM to deliver, notably through improved policy dialogue; and
- reduced transaction costs through increasing harmonisation of donor conditions ***<<ref>>***.

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

2.5 Administrative setup

Mozambique comprises ten provinces plus Maputo city which has the status of a province. Each province is administered by a Provincial Government who is a Presidential appointee, and who oversees a Provincial Government whose members are appointed by ministers of the economic and social sectors.

Districts in Mozambique are headed by a District Administrator, working together with District Directors of the various sectors active in the district.

Decentralisation in Mozambique, while on the policy agenda, is politically sensitive, and has proceeded gradually to date. Capacity in public administration is generally weak at local level.

Own revenues at the provincial level are limited, representing around 3% of national revenue in 2000. Provincial recurrent expenditure accounted for around 38% of total national recurrent spending, but was largely for employee compensation.

3 The Government planning and budgeting framework

3.1 Planning and budgeting systems

As in other countries, the Mozambican government employs a variety of instruments for planning and budgeting over different timeframes. Linkages and relationships between medium and operational plans and budgets are given in Annex B.

3.1.1 Medium Term

A number of medium term planning and budgeting instruments currently co-exist in Mozambique. The PARPA currently provides the overall national medium term plan, highlighting priority strategies for the reduction of poverty in the country, based on a sound macroeconomic foundation, and covering a period of five years. This builds on earlier indigenous medium term planning instruments such as the Lines of Action for Eradication of Absolute Poverty ***<<year?>>*** and the Government Programme 2000 – 2004.

In addition to the PARPA, each province and sector ministry also prepares a strategic plan covering a period of three years, although this is less developed that at central level.

Financial planning in the medium term is articulated through the Medium Term Fiscal Scenario (sometimes referred to as the Medium Term Fiscal Framework ***<<check>>***, which provides for the operationalisation of sectoral strategic plans and budgets.

The Public Investment Programme covers a period of three years, and reflects investments in each sector, but is expected to be abandoned soon (Pavignani et al 2002, p19).

3.1.2 Operational

The Economic and Social Plan pulls together sectoral operational plans to provide the annual basis for government action. Preparation is coordinated by the MPF, and it is approved by the Council of Ministers and the Assembly of the Republic.

The State Budget is also prepared on an annual basis, drawn from the Medium Term Fiscal Scenario. The financial year runs from 1 January to 31 December. Again, sectoral budgets are prepared by line ministries, coordinated by the MPF.

In theory, both the ESP and the SB are based on the medium term plan and budget frameworks. For 2001, the government reports that progress in this area was inadequate, with the ESP failing to *"explicitly achieve the required level of consistency between actions to be taken and PARPA proposals"* (ROM 2003, p5 **– PARPA PR**). However, this was attributed in large part to delays in the approval of the PARPA with respect to the annual planning cycle, and a much more optimistic picture is painted for 2003: *"..intersectoral discussions are now being based on PARPA and other medium-term instruments, so integration and consistency are likely to be greater and more explicit"* (ROM 2003, p5 **– PARPA PR**).

3.1.3 System constraints

The Mozambican planning and financing systems have been subject to substantial criticism in recent years. The 2001 PEMR concluded that *"the budget system continues to suffer form inadequacies that hinder efficiency, transparency and accountability. Incomplete coverage even of own resources and expenditures, inappropriate functional classification, outdated accounting procedures, weak cash management and deficient controls and audits are among*

the critical areas negatively affecting budget management in Mozambique" (World Bank 2001, p4).

Others have commented on weaknesses including:
- the multiplicity of planning instruments, not all of which relate to a budget document;
- absence of an over-riding objective of macroeconomic stability within the budget process;
- inflexibility of budget structure which does not permit addition of new programmes;
- failure to capture internally generated revenues from within the sectors within the budget;
- inadequate capture of available donor funding within the budget;
- a multiplicity of government bank accounts; and
- poor budget execution and frequent liquidity crises.

Funds captured "on-budget" represent a minority of those actually available for public expenditure, thereby *"violating the principles of universality and integrality, and undermining the effectiveness of the budget as a tool of public policy"* (World Bank 2001, p4).

Some of these issues have been addressed since the 2001 report, as noted in Section 3.2.2 below, but the 2003 PER noted that there had been little progress in improving the completeness of the budget in terms of receipts and expenditures, nor of consolidating the many government bank accounts.

3.2 Monitoring and evaluation

3.2.1 Performance monitoring

As with other countries, the publication of a PRSP is one of the conditions of obtaining debt relief under the HIPC Initiative also requires annual reporting of progress in its implementation. The ROM therefore produced its first progress report in early 2003[9].

The progress report refers to two monitoring systems under development, one related largely to processes, and one to impact, both of which relate to the PARPA. Information taken from the ESP Balance Sheets and State Budget Execution Reports are used to monitor the process of PARPA implementation. The monitoring of PARPA impact is to be undertaken through both quantitative and qualitative poverty assessments to be undertaken by academic or other non-public institutions.

In addition, a Poverty Observatory has been established at national level, to serve as *"a consultative forum whose primary function is to monitor PARPA objectives, targets and actions"*. (ROM 2003 PARPA-PR, p6). The Observatory is expected to function alongside existing sectoral and provincial fora, and to include civil society and cooperating partners, while being coordinated by government. Six monthly evaluation meetings are held to analyze monitoring reports and to assess compliance in government and other planning documents with the broader poverty reduction strategy ***<<is this operational?>>***.

3.2.2 Financial management

Following publication of the 2001 PEMR, some actions have been taken by ROM to improve financial and public expenditure management. A Financial Management Law was passed in 2001, and its associated regulations approved in 2002. A new functional budget classification system was also agreed in 2001, although implementation was delayed the introduction of the SISTAFE (see below).

[9] ROM (2003x). *PARPA implementation evaluation report 2001*. Maputo: February 2003

Mozambique is currently in the process of introducing a new integrated financial management information system (known as SISTAFE[10]) throughout government, with the intention of improving public expenditure management in general, and fiscal transparency. The timetable for its introduction has recently been revised with implementation beginning in 2003 and expected to take two years. However, experience in other countries has led some observers to comment that this is wildly optimistic and that 8-15 years is a more realistic time frame in a country such as Mozambique (Pavignani et al 2002, p22; Sjolander 2003, p 3).

SISTAFE has two main features. Firstly, the introduction of a computerised budget execution system intended to cover all structures introduced by line ministries and all available financial resources, which can only be as good as the budget structure it uses. ***<<Clarification required - Sjolander refers to use of current and very old budget structure, yet World Bank docs refer to UN COFOG system to be introduced as part of SISTAFE>>*** Secondly, the system uses a *Conta Unica*, whereby all payments are registered at one point in the system on daily basis, and which represents a substantial improvement on the existing scenario.

Commentators argue that the chosen design of SISTAFE (focusing on the budget structure and its execution rather than being based on an accrual accounting system) will result in its primary use being financial control, whereas it could have been designed to better serve as a development tool, facilitating improved planning, results-based management, and poverty monitoring. However, in the context of very poor financial management in the past, even this improvement is seen as a positive step forward, and the model could apparently be adjusted to include off-budget funds if discipline can be maintained in reporting on such funds.

As a corollary to this, work is also underway to bring all extra-budgetary activities within the overall budget framework, whereby they can then be captured and monitored through SISTAFE. This does not necessarily require funds to be channelled through Treasury systems. As pointed out in the 2001 PEMR, *“the emphasis should be on capturing the information in the budget rather than the funds themselves”* (World Bank 2001, p 4). The IMF has urged commitment to this process, not least because of the potential expenditure pressures of forthcoming elections.

4 Health sector context

4.1 Administrative setup

4.1.1 Central level structures

The health sector in Mozambique is referred to as the National Health Service (SNS), and comprises public, private for profit and private not-for-profit providers, in a pluralistic health system in which the public sector still dominates.

The Ministry of Health (MOH) is the overall body responsible for sectoral policy-making and coordination, with a mandate which includes: definition of strategies and objectives; budgeting and allocation of resources to the various entities within the sector; procurement and distribution of drugs and medical supplies; logistics and the maintenance of equipment; and regulation of the governmental and non-governmental agencies providing heath care.

MOH comprises the Office of the Minister of Health, together with 4 directorates:

- National Directorate of Health (DNS) which is responsible for community health, epidemiology and pharmaceuticals.

[10] Sistema Integrado de Administração Financeira do Estado

- The Directorate of Human Resources (DHR), which covers training;
- Directorate of Administration and Financial Management (DAG), which has responsibilities for budgeting and financial management; and the
- Directorate of Planning and Cooperation (DPC), responsible for planning, international cooperation, and the maintenance of the resource centre.

The Ministry is currently in the process of disengaging itself from a role of direct provider to focus more on the regulatory activities required within a pluralistic health system. This change in role forms part of the broader reform of the state and public administration in the country, necessitated in part by the national policy of decentralisation.

4.1.2 Provinces and districts

At the provincial level, there is a Provincial Directorate of Health (DPS). The role of the DPS at present is largely administration of the decentralised component of the state budget, which largely comprises funds for personnel costs and other recurrent expenditures in the province, and funds to maintain the operation of the DPS and the District Directorates of Health (DDS), general and provincial hospitals and other institutions in the provinces. This is channelled directly from the Treasury through Provincial Directorates of Finance. The DPS also manages the provincial portfolio of sectoral investment projects, and some external funds from co-operating agencies or NGOs. Recent estimates indicate that only 23% of total health expenditure is executed at the provincial level[11].

The PESS envisages a greater role in the future for the province in terms of management and planning, with strategic planning having been initiated in some provinces at the time of preparation of PESS, and expected to be in place in all provinces by 2002.

At the district level, seen as the *"basic level for health programme planning and implementation"* according to the PESS (p13), the DDS is responsible for the day to day implementation of activities at district level, in particular the delivery of primary health care services through the network of Level I facilities in the district and, in the few districts having them, the rural or district hospital[12]. In addition, the DDS is responsible for the management and distribution of resources allocated by the DPS.

4.2 National health policies and strategies

The health sector is currently implementing the **Strategic Plan for the Health Sector 2001 – 2005 (- 2010)** (PESS) which was developed through a lengthy, participatory process, and approved by the Council of Ministers in 2001. Although developed at the same time as the PARPA, consultation enabled consistency between the two documents.

Seen as both a statement of policy, and outlining the major strategies for medium-term action within the sector, the PESS articulates both a mission statement and a number of guiding principles for the sector. The sector mission is *"to promote and preserve the health of the Mozambican population, to promote and preserve sustainable health care of good quality, while gradually making these accessible to all Mozambicans with equity and efficiency."* (PESS, p20). Guiding principles are: efficiency and equity; flexibility and diversification; partnership and community participation; transparency and accountability; and integration and co-ordination. Three fundamental interventions are identified to enable the sector

[11] MPF (2003). *PARPA implementation evaluation report*. Maputo: February 2003

[12] 28 of 141 districts (excluding Maputo City) have either a rural or a general hospital. Selected others have access to Level III or Level IV facilities, but the majority have only health posts and health centres.

contribute to improving the nation's health: Improved health care provision; capacity building of individuals and communities; and health advocacy.

Concerns have been raised that national policies are not adequately articulated in the health sector, and that the PESS does not state priorities for the sector, although it is seen as consistent with broader development policy.

4.2.1 Health system organisation

The Mozambican health system is organised according to four levels, following the typical pyramidal pattern. Level I covers both health posts, which are typically basic both in terms of facilities and staffing, and health centres, which have a number of auxiliary staff, more sophisticated equipment and facilities, and which may include maternity and inpatient wards. Level II comprises the first level of referral care, provided through rural and general hospitals. Common services at this level include emergency care, simple surgery, and obstetric and trauma interventions. More complex cases are, in theory, referred up the pyramid to the provincial hospitals which form Level III, or to Level IV, the central hospitals. In addition to these four levels of the SNS, there is a network of community facilities, managed by community financed village health workers. Table 11 shows the distribution of health facilities of different types by category of district.

Table 11 Health facilities by district type,

Type of district	No of districts	Central and psych. Hospitals	Provincial hospitals	General hospitals	Rural hospitals	Health centres and posts
Rural districts without rural hospital	105					740
Rural districts with rural hospital	26				26	268
Urban districts without general hospital	9		7			86
Urban districts with general hospitals	2	5		5		47
TOTAL	**142**	**5**	**7**	**5**	**26**	**1,141**

Source:

4.3 Health planning, financing, procurement and management

- **Planning and budgeting**

National level planning is the remit of the Directorate of Planning and Cooperation (DPC) within MOH, with some input from the provincial authorities. As described in Section 3.1 and Annex B, MOH, along with other sector ministries, is responsible for the development of both a medium term plan (the PESS in the health sector), and an annual plan, the Operational Plan ***<<is this the same as the Plano Economico e Social – Componente Saude mentioned in Pavignani et al?>>***. In addition, as mentioned in Section 4.1.2, there is an ongoing effort to strengthen provincial annual and strategic planning. The annual planning cycle is described in Annex C.

The DPC is also responsible for the preparation of a Medium Term Expenditure and Financing Framework (MTEFF) for the sector, which covers the same period as the PESS[13]. Unlike the sectoral budget which reflects government resources and that proportion of donor funds which are captured on-budget, the MTEFF is intended to be comprehensive in terms of financing sources and areas of expenditure, and is seen as both an internal management tool for MOH and also as a basis for negotiation with funding partners within and outside government, ie the MPF and cooperating partners. Expectations of the MTEFF are given in Box 1 below.

[13] MOH (2001). *Medium-Term Expenditure and Financing Framework for the health sector 2001 – 2005*. Working document for the annual meeting with donors in the health sector. Maputo: June 2001

Box 1 Role of the MTEFF in the health sector

"Through the MTEFF, the MOH intends to:

- *Improve the coherence of planning, based on integrating the totality of financing and expenditure;*
- *Impose financial discipline: prioritise within the context of realistic projections regarding the availability of resources;*
- *Avoid unexpected adjustments; ensure greater sustainability, balancing recurrent and capital expenditure through the use of a medium-term perspective;*
- *Move from incremental programming to programming by activities, programmes and finally by objectives and impact."*

MOH (2001), p1

Preparation of the annual budget and financial management is primarily the responsibility of the MOH Directorate of Administration and Management (DAG), with some support from the DPC. Ceilings are set by the MPF, and budgets prepared by central and provincial bodies are consolidated by DAG and DPC. No guidelines are issued at the start of the process and, according to a recent review, *"[b]udgeting is therefore a largely incremental exercise, where additional funds (when available) are distributed across lines and institutions, without taking into account previous achievements and performance."* (Pavignani et al 2002, p19). In addition, there is limited effective dialogue between central and provincial entities in relation to planning and budgeting, resulting in substantial imbalances between provinces.

In addition to the regular planning and budgeting entities within the MOH, an Office of Planning and International Cooperation (GACOPI) was created in 1989 under the DPC to manage funding under a World Bank project supporting post-war reconstruction of the health sector infrastructure. To date, GACOPI has handled about US$ 200,000,000 largely from development banks. The office also consolidates information about central level investment, although it is viewed as having only a partial view of peripheral and smaller scale projects.

- **Health financing**

There are several sources of finance to the health sector, primarily from government and donors, but also through contributions from individual users of health services. Government and donor financing is covered in Section 4.5 below.

Official cost-sharing takes place within the health sector under two schemes. The first permits charging for consultation, and inpatient, laboratory, x-ray services, and revenues are retained at the facility level and contribute to general running costs[14]. This scheme was established with the aim of educating the public about rational use of the health system, and to promote equity through granting of exemptions to the more vulnerable. However, revenue raising has generally taken priority. The second scheme involves the sale of medical supplies, with revenues intended to ensure continuity in such supplies. Such schemes are considered to have increased in terms of the share of costs recovered at the operational level, although services remain heavily subsidised.

The recent Health Sector Expenditure Review estimates that household contributions amounted to around 2.6% of total expenditure in the sector (p23). A list of exemptions exists, but is not applied effectively, with the result that most people pay and the poor are therefore discouraged from seeking care. In addition, unofficial charges are often made by SNS health personnel, and over-charging is common. Fees are not currently included in the budget, and the figures in the HSER are noted as likely underestimates. Failings in application of the costs-sharing policy led the 2003 PER report to conclude that *"[t]he user fee system needs a complete overhaul"* (World Bank 2003, p 30).

[14] At so-called Special clinics in the central hospitals, staff are also able to keep a share of revenue in an attempt to retain them within the public sector.

As of 2000, there was limited information about willingness and ability to pay for health services, although anecdotal evidence suggests that even those under the poverty line would be willing to increase their expenditure if quality of services improved.

Health insurance has been considered in the past, and contributions were made by public employees at the rate of 2% of salaries to the Medical and Medicines Assistance Fund managed by the Ministry of Planning and Finance. However, at the time of PESS development, it was felt that conditions did not warrant expansion due to problems with ability to pay, lack of a high cost, good quality health service to attract potential members, and the high management costs of health insurance. However, with the continued expansion of the private sector, this has not been ruled out in the future.

- **Management systems**

The PESS is quite frank on the issue of health information systems, noting that *"MOH has a variety of uncoordinated information subsystems which result in fragmented processing and partial analysis of data"*, with a lack of objective validation of indicators provided by these subsystems, and staff who lack motivation, training and supervision (PESS, p67). The view is stated, and reiterated elsewhere, that *"the dominant management culture in the sector does not encourage the use of information in decision-making processes"*.

However, there is a functioning Health Information System at levels I and II of the health system, and some capacity has been established. For example, the annual MOH plan for 2003 presents data on 19 indicators, a subset of 53 included in the PESS. Further development of an integrated information system is proposed in the PESS, to enable performance monitoring and evaluation both in terms of services and resource management.

Financial management in the MOH is the remit of the DAG, but a 2000 review by Price Waterhouse Coopers (PWC) identified five main "financial management systems" within the health sector as a whole. These related to the State Budget, two of the common funds (drugs and recurrent expenditure), GACOPI, and the accounting unit within DNS (Pavignani et al 2002, p19). In addition, the multitude of projects within the sector, channelling significant levels of funding, are said to have resulted in *"an extremely fragmented financial management structure representing a large number of biased "local" interests at the ministry opting for continued individual control of uncoordinated financial flows*" (Sjolander 2003).

It is openly acknowledged that financial management in MOH at the time of PESS development was weak. The 2000 PWC report, cited in the PESS, states that *"..systems are manual, out-of-date and slow, particularly in the area of expenditure reimbursement and fund transfer. This has a negative impact on the speed and efficiency of service provision. The accounting plans is "traditional" and unable to meet the new need to describe costs per activity or level of care, vital information for better planning, distribution of resources and service provision."* However, more recently the sector has taken several concrete steps to improve the position in advance of the full launch of the FCG, as shown in Box 2.

A 2003 report commissioned to review financial management within the MOH in order to *"propose financial mechanisms so that the MoH and in particular DAG be in a position to manage the funds for the Bill Clinton Foundation and the GFFATM (Global Fund for Aids, Tuberculosis and Malaria)"* concluded that: donors should be encouraged to use the FCG, and that given the weaknesses in the SISTAFE; that initially funds should remain off-Treasury; and that sectoral financial management systems should be strengthened, in consultation with the Agriculture and Education sectors, in order to strengthen the position of the three line ministries in relation to guiding further improvements to SISTAFE in the future (Sjolander 2003).

Box 2 Health sector action to improve financial management

- Introduction as from July 2003 of a Code of Conduct for *all* funders of MoH activities
- Introduction as from July 2003 of a Memorandum of Understanding for all funders of the Common Fund (*FCG)*.
- Introduction during 2003 of a sector applicable procurement manual
- Introduction of a Financial Management Committee and its Technical Working Group
- Introduction as from July 2003 of the Common Fund *(FCG)*
- On-going introduction of a modern accounting system at the entity in MoH responsible for the management of the *FCM* (CMAM)
- Introduction of a modern accounting system at the entity in MoH responsible for investment project management (GACOPI)
- Instalment of a physical intranet in the MoH building
- On-going recruitment of a consultancy team to DAG
- DAG application for additional staff
- Financial advisers operating at provincial administrations (DPS)
- Planned introduction of an ambulating "super accountant" at DPS

Source: Sjolander (2003), p

4.3.1 The Mozambican Sector-Wide Approach[15]

The definition of the Sector-Wide Approach (SWAp) in Mozambique is given in Box 3 below. Discussions regarding move to a SWAp in the Mozambican health sector began as early as 1998, and in 2000 the Kaya Kwanga Commitment, a Code of Conduct intended to guide partnership for health development, was signed by government and several partners in the sector.

Box 3 Mozambican definition of Sector-Wide Approach

SWAp/SWAP: Sector-wide approach to programming/policy-making
"Sustainable collaboration based on the budgeted strategic plan (CDFMP) with the main partners in the sector to improve coordination and provision of health care across the whole sector, using national management systems to formulate indicators and aims, revising performance and negotiating future contributions, taking the capacity of the health system into account" (PESS, p77)

A number of cooperating partners are considered to be operating within government 'within' the SWAp, defined as contributing to one or more funding pools (notably Norway, UK, EU, Switzerland, Ireland and the Netherlands). These pools are described in more detail in Section 4.3.3 below. At the same time, multilaterals such as WHO and UNICEF provide support through their parallel approach, while France and Denmark are described as being 'passive' partners, and Sweden, Italy, Spain, Portugal and Germany as being outside the SWAp[16].

MOH and unspecified partners have undertaken to implement the current PESS through a SWAp, based on a *"coherent, comprehensive, and transparent planning and budgeting process for the sector"* (MOH 2003 **– operational plan**, p3). Given the changing context in which the SWAp is developing, with the finalisation of the PARPA and the PESS, the Code of Conduct has recently been revised. Key principles articulated in the Code of Conduct include a collective commitment to:

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[15] MOH distinguishes in the PESS between a SWAP, defined as a Sector-wide approach to policy-making, and a SWAp, used to refer to a sector-wide approach to programming. This distinction is not taken up in this document as other documents are not always clear as to which they are referring. In addition, the definition in Box 2, as given in the PESS, covers both.

[16] IHSD 2003. Mozambique questionnaire. June 2003

- Ensuring the inclusion of all public sector health activities within the annual operational plan;
- Using standard national planning , budgeting and evaluation instruments and system, for the management of health priorities and resources;
- Ensuring that procurement is undertaken in accordance with internationally accepted principle and good practice, using ROM procedures where possible;
- Reinforcing the capacities of Mozambican institutions involved in development of the health system;
- Developing and maintaining *"a climate of transparency, openness, accountability and honesty in all relations and transactions"*;
- Agreeing to proceed gradually towards budget support as far as possible;
- Facilitating the MOH and partners to develop rolling three year plans and budgets (MOH 2003 - KKC).

Among the SWAp structures and processes in place, there is a SWAp Working Group (GT-SWAp) which meets fortnightly and which is the forum for information sharing and discussion on a day-to-day basis. The GT-SWAp is also responsible for taking forward to the decisions of the Sector Co-ordination Committee (CCS), which is convened twice a year, in June and November, and which provides the main forum for dialogue and coordination between national authorities and co-operating partners within the health sector. A secretariat in the MOH Technical Planning Unit supports the CCS (MOH 2003**, KKC**)

4.3.2 GFATM target diseases

The GFATM target diseases are all identified as priorities within the PARPA (see Table 8), the PESS (pp28-29 and pp30-31), and the Operational Plan of MOH for 2003 (pp13-14). Between them they contribute substantially to the burden of disease within the country, and interventions are included within the PHC strategy followed by the sector. According to the PESS, management of principal health programmes in Mozambique is still largely vertical, although efforts to integrate began some years ago.

An Integrated Health Programme – Communicable Diseases (known as PNI-DT) was defined under the Directorate of National Health Services in 1998, covering the GFATM target diseases[17], and also the support systems required to operationalise the programme. The overall objective of the PNI-DT was to reduce mortality and morbidity from chronic and acute illness through four main strategies:
- Reinforcing mechanisms for integration between health programmes and the sector in order to improve efficiency in the use of available resources at all levels;
- Supporting the process of decentralisation to ensure improved capacity for planning, implementation and monitoring of communicable diseases within the provincial and district health management systems;
- Improving inter-sectoral coordination and collaboration within MOH, among donors, and at different levels of care;
- Ensuring gradual implementation of the PNI-DT, particularly within priority districts.

Funding for the programme was provided by NORAD, the EU, WHO and UNICEF, and an evaluation was undertaken in late 2002 (Chabot et al 2002). Findings included an observed weakness in integration and coordination between different disease programmes, and limited definition of an overall strategy for communicable disease control. Monitoring of programme results over the period of implementation was insufficient to permit firm conclusions regarding the extent to which objectives had been met. Improvements in drug provision were

[17] Among others, including: vaccine preventable diseases (measles, diphtheria and tetanus); diarrhoeal diseases, including cholera and dysentery; and acute respiratory infection.

attributed in part at least to the drug pool rather than to the programme, and opportunities for sharing costs had not really been exploited.

- **Malaria**

Malaria is hyper-endemic in Mozambique, and is the major contributor to the disease burden in Mozambique, primarily affecting women and children. Although limitations in data quality were noted, Chabot et al (2002) refer to malaria as the cause of 30% of all reported deaths in the community, and of 40% of paediatric in-patient deaths in 2000. Malaria and malaria-related anaemia contribute to high maternal mortality, and are the leading cause of low birth weight. In 2001 three million suspected malaria cases (clinical fevers) were reported[18]. Child and adult malaria case fatality is included among sectoral indicators.

Although included under the PNI-DT, interventions are implemented by the Malaria Control Programme, which still largely functions as a vertical programme. Unfortunately, no detailed documentation was available regarding malaria control strategies in the country. However, the country is in line with international initiatives such as Roll Back Malaria, and strategies identified under PNI include: vector control; early diagnosis and treatment; health education; and advocacy for environmental sanitation.

The primary intervention according to the 2003 MOH operational plan is prompt and appropriate case management at every level. Resistance to chloroquine had resulted in the tabling of a new combination therapy treatment policy[19], which was expected to have serious financial implications for the sector.

Limited internal residual spraying, promotion and subsidy of insecticide treated nets (ITN), and the introduction of intermittent presumptive treatment for pregnant women, are also being implemented in Mozambique, although the 2003 MOH plan refers to the latter two as being at an early stage (p13). Chabot et al (2002) refer to ITN coverage in pilot areas of two provinces, and indicates that although a strategic plan for malaria had been prepared covering the period 2002 – 2005, the RBM initiative itself had not been launched.

- **HIV/AIDS**

Mozambique is one of the ten worst HIV/AIDS-affected countries in the world, with an estimated prevalence of almost 1.5 million inhabitants, ie 8% of the general population. This figure is expected to rise to nearly 1.65 million by 2005. Over 500 new infections occur daily, and it is estimated that HIV incidence will not begin to plateau until the end of the decade. The situation is worst in urban areas, with 20% of adults in cities affected, compared with 13% of the overall adult population. Over the decade, the epidemic is expected to contribute to a reduction in life expectancy from 50.3 to 36.5 years.

There has been an active National AIDS Control Programme within MOH since the 1980s, focusing on prevention. Included among its achievements are: the standardisation of condom distribution around the country; implementation of a national policy on blood safety requiring all donations to be tested; training on infection prevention for health staff; development of national guidelines on Voluntary Testing and Counselling (VCT) and Prevention of Mother to Child Transmission of HIV (PMTCT), together with introduction of VCT and PMTCT services.

A National Strategic Plan to combat Sexually transmitted disease and HIV/AIDS was approved in October 1999[20] (WB/IMF 2003 – JSA), covering the period 2000 to 2003, although the floods prevented much activity in 2000. Although there is no overarching multi-

[18] An increase on previous years, this was attributed in part to the effect of the floods.
[19] Not specified in the version seen.
[20] National Strategic Plan to combat STD/HIV/AIDS in Mozambique, 2000 – 2003.

sectoral HIV/AIDS strategy in Mozambique, unlike other countries within the study, cross-sectoral input to the health sector strategy was included.

The National AIDS Council (NAC) was established in 2002 with a mandate to ensure coordination of the prevention, education and care activities within the country between various sectors of government, civil society, donors, and NGOs, both national and international.

Chabot et al (2002) concluded that STD/HIV/AIDS activities in the country had suffered from the change from a sectoral to a multi-sectoral programme. However, there were no output figures on which to assess performance, though this in itself suggests problems within the programme.

- **Tuberculosis**

Mozambique is classified as a high burden country for tuberculosis, with the disease presenting the third leading cause of hospitalisation, and with roughly 21,000 new cases per year. An increase in cases in recent years is attributed both to the link with HIV/AIDS, with co-infection rates of 30-32%, and to improved reporting through the programme.

The National Tuberculosis Control Programme (NTCP) was established in 1977, with responsibility for planning and coordinating activities country-wide, training, management of TB drugs, and collection and analysis of TB-related data for planning. Tuberculosis is also included within the PNI-DT.

Chabot et al (2002) noted progress towards the NTCP goal of curing 80% of new smear positive cases by 2003, with the cure rate showing an improvement from 65% in 1998 to 73% in 2000, largely through a reduction in defaulters. The death rate remained at 10-11%.

Short course treatment for smear-positive cases is the main intervention, with centralised treatment in a district centre for the first two months, and subsequent continuation in peripheral units. Although in theory this had been fully introduced by 2000, effective coverage was estimated in 2002 to be around 40%, primarily benefiting the urban populations (CCM 2002, p29)

4.4 Sectoral expenditure overview

4.4.1 Overall health spending

Recent figures from the Health Sector Expenditure Review (HSER) of 2002 suggest that total expenditure in the health sector in Mozambique has risen from US$ 4.6 per capita in 1997[21] to US$ 7.5 per capita in 2000, representing an increase of about 65% over a four year period[22]. Much of this is attributed to an increase in the (domestically financed) State Budget to health, which has been due both to increasing political commitment to the sector and to the inflow of HIPC resources (MPF/MOH 2002), as can be seen in Table 12 and Figure 2 below.

[21] This contrasts with a figure cited in the PESS (p 15) of US$8.84 in 1997 of which government spending accounted for US$1.97 (from A Beattie and D Kraushaar, *Health financing studies.* Management Sciences for Health. 1998.

[22] MPF/MOH (2002). *Health sector expenditure review*. Draft report for discussion. Maputo: November 2002

Table 12 Total health expenditure at constant 2000 prices, 1997 - 2000

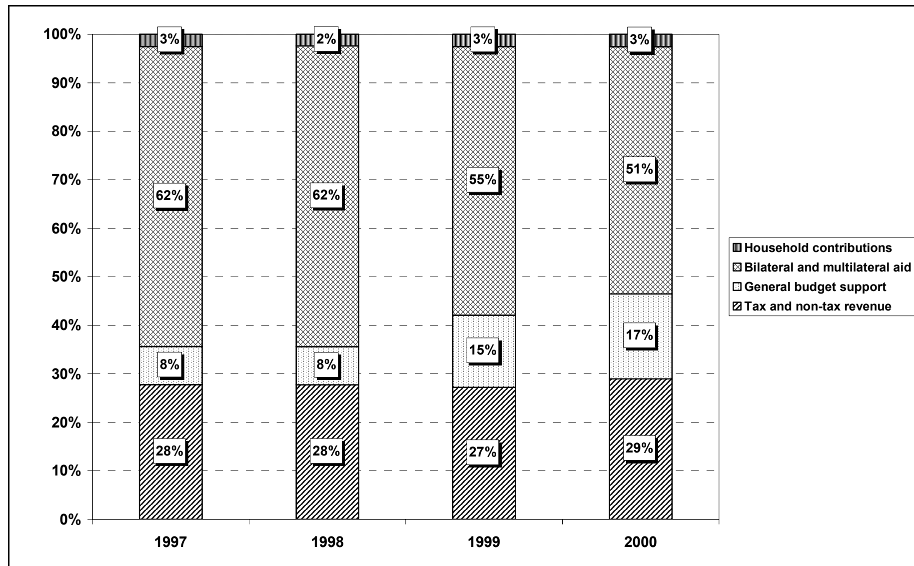
	1997	1998	1999	2000
Total expenditure (Mt billion)	**1,117**	**1,312**	**1,649**	**1,974**
Annual real growth rate		*17.5%*	*25.6%*	*19.8%*
Per capita Total expenditure				
In Meticais	69,482	79,750	97,890	114,502
In US dollars	4.6	5.2	6.4	7.5
Per capita contribution by source				
Tax and non-tax revenue	19,291	22,099	26,609	33,141
General budget support	5,466	6,262	14,593	20,033
Bilateral and mulateral aid	42,955	49,463	54,219	58,382
Household contributions	1,771	1,925	2,468	2,945

Source: MOH and MPF (2002), Table 4.2, p 27

Notes: Tax and non-tax revenue and General budget support are both provided through the State Budget; Bilateral and multilateral aid covers grants and loans from agencies to the health sector; and household contributions are estimates based on a 1999 study which is likely to underestimate the contribution.

Table 12 shows that there has been steady real growth in the absolute value of health sector expenditure in Mozambique, at the aggregate level, in per capita terms, and for each individual source of funding. The changing share of the various sources is shown for the period in Figure 2 below.

Figure 2 Changing composition of health sector financing, 1997 - 2000

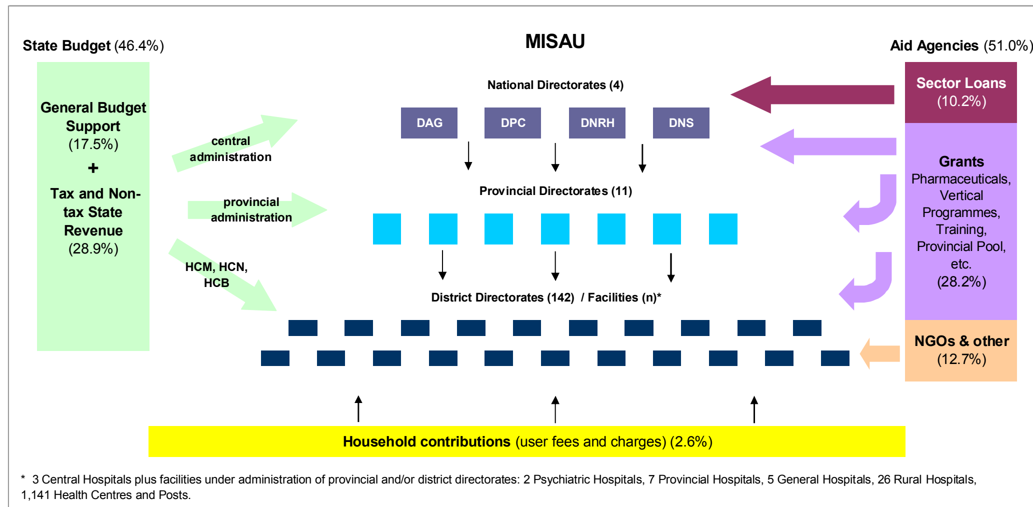


Source: MOH and MPF (2002), as per Table 13 above.

Figure 2 shows that although the State Budget remains below 50% of total funding to the sector in 2000, it increased its share quite substantially from 36% to 46% over the four years. This is almost entirely due to the increase in GBS, which more than doubled its share, rather than to domestic revenues whose contribution grew by only 1%. Bilateral and multilateral aid to the sector has shrunk accordingly as donors move towards GBS as an alternative avenue for their support. Household contributions, though underestimated, remain relatively insignificant at the aggregate sector expenditure level.

Figure 3 gives a more detailed breakdown of the source of sector funding in 2000, and shows how these funds were channelled to the different institutions and levels of the health sector that year.

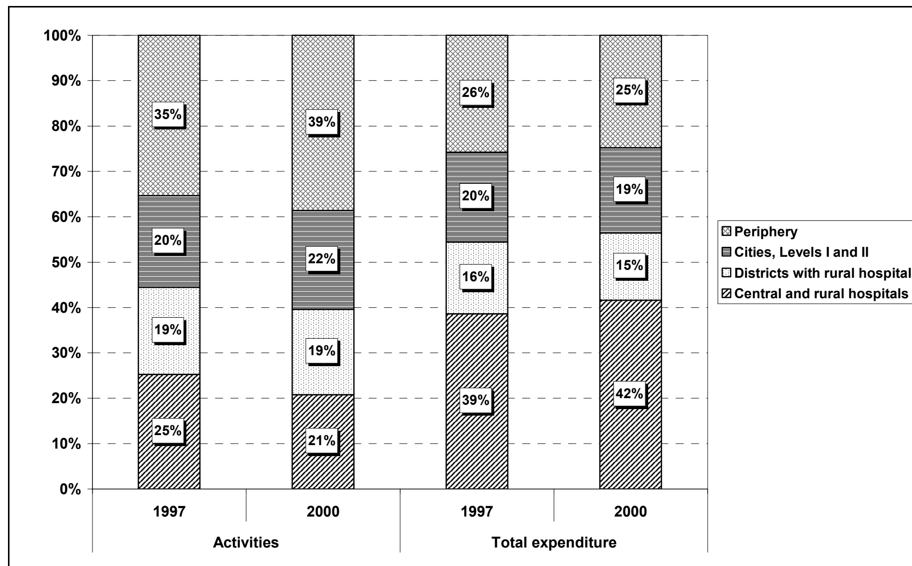
Figure 3 Flows of funds in the health sector, 2000



Source: MPF and MOH (2002), Figure 4.1, p23

The allocation of spending within the health sector is still very largely skewed in favour of the hospital sector, despite a long-standing commitment to primary health care. Figure 4 below shows a relatively crude measure of activity[23] in comparison to expenditure at four different levels of the health system, showing the change between 1997 and 2000.

Figure 4 Activity and expenditure by health system level, 1997 and 2000



Source: MPF/MOH (2002), Table 5 in Appendix 1

Figure 4 shows that although there has been a 4% reduction in the share of activities performed at the central and rural hospital level, the share of expenditure allocated to this level has increased by 3%. This is largely due to an increase in the share of pharmaceutical expenditure allocated to the hospitals over the same period. The HSER goes on to state that

[23] presumably defined in terms of **Hospital Units of Activity** (defined as 9*Days/beds occupied + 12*Births + 1*(Outpatient + emergency consultations) + 2*Stomatology consultations + 20*Operations) and **Service Delivery Units** (defined as 12*Deliveries + 9*Bed occupancy days + 0.5*Immunisations + External Consultations + Safe Motherhood Initiative consultations).

the Maputo Central Hospital benefits disproportionately within the hospital sector, claiming 80% of central hospital resources in 2000.

4.4.2 External funding in the health sector

As evident from the data in Section 4.4.1, the Mozambican health sector benefits from substantial external input. A recent report identified a total of 27 different partners involved in the sector in 2001 (Pavignani et al, p16). Both loan and grant funding are provided, with the former generally coming from multilateral cooperation agencies and Development Banks, and the latter from a variety of sources, primarily bilateral.

Loans are managed by the sector, as are a substantial proportion of grants. All funds for the acquisition of pharmaceuticals for the NHS are managed centrally by the Pharmaceutical Department of MOH through the Common Fund for Drugs (FCM), pooled funding which accounts for up to 46% of external resources to the sector. In addition, MOH manages a common pool for technical assistance, funding for national integrated programmes such as Maternal and Child Health (SMI), and one of the largest integrated provincial programmes (Zambézia)[24].

Other provincial programmes are managed by their respective donors, eg DANIDA in Tete, and FINNIDA in Manica provinces. In addition, the Swiss Agency for Cooperation and Development (SDC) is responsible for the management of the Common Fund for Provincial Authorities (FCP), which originated as a bilateral initiative at a time when SDC were the 'focal' donor in the sector. More recently, the fund has channelled resources from a number of bilateral donors directly to the provinces, as described below, with the intention of complementing state budget allocations to the provinces and districts, and improving the equity with which provincial resources are allocated.

As mentioned above, there is a stated intention to move more aid expenditure in the health sector 'on planning' and 'on budget', ie to bring it under government budget management systems in MPF. At the moment, as seen in Figure 5 below, much of this is currently managed by MOH, provincial authorities, or directly by the funders. However, concerns remain among stakeholders in the sector that financial controls may be weakened and the predictability of releases to spending units undermined. While there may be differences of opinion in the sequencing and timing of this move, most agree that it is essential

4.4.3 Project versus programme support

With its exceptionally high levels of external support, Mozambique suffers 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).

The desire by various partners to move towards or expand sectoral budget or programme support has resulted in a number of studies which define and assess the risks associated with various aid management mechanisms. Perhaps the most comprehensive, Pavignani et al (2002) distinguishes between the following:

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[24] Supported by the European Commission at a budgeted figure of US$21m (MPF and MOH 2002).

- 'on-planning' – including all activities, and thus all resources regardless of source, within a comprehensive consolidated annual plan for the sector, presented to the Ministry of Finance in the required structure;
- 'on-budget' – defined as *"all sources of funding being presented and included in the state budget documentation"*, whether earmarked or untied, and therefore dependent on an 'on-planning' process;
- 'on-accounts' – included in state accounts, which at present means in the budget follow-up, as per the current plans regarding SISTAFE (see Section 3.2.2);
- 'on-payment or on-Treasury' – arguably the most inclusive and difficult definition, requiring channelling of funding through government bank accounts and ultimately merged with state resources;
- 'on-audit' – requiring all resources included within the state budget to be audited both by the internal audit body, the *Inspecção Geral de Finanças* within the MPF, and by the country's supreme and independent audit body, the *Tribunal Adminisitrativo*;
- 'on-Parliament' – whereby all resources presented in the state budget are subject to parliamentary approval, even if such resources are not 'on-payment'.

At present, programme support in the Mozambican context is provided through the various common pools. Three such pools of funding to the sector are currently operational: one for pharmaceuticals, one for the provinces, and a relatively new one, the "**Fundo Commun Geral**" (FCG), which grew out of joint donor support to the formulation of the PESS. A Memorandum of Understanding is being drawn up ***<<status?>>*** to govern the workings of this latter pool, and the intention is that ultimately this could take over the functions of the other pools. In addition, in the past there has also been a pooling arrangement for sourcing and funding medical specialists at tertiary hospitals.

The Common Fund for Drugs was the first to be established in 1997/98and is generally felt to be working very successfully. The pool has an annual turnover of US$15-20 million, form partners including Switzerland, Norway, the Netherlands, Ireland, Denmark, France and the UK. The pool is under MOH control, uses transparent and competitive procurement procedures, and is stated as having been increasingly able to programme drug purchases and distribution in line with priorities through dialogue with partners (Pavignani et al 2002, p29). However, it is not yet included within the state budget, and therefore although 'on-planning' within MOH, it remains 'off-planning' and 'off-budget' for ROM as a whole.

The Common Fund for Provincial Authorities was created in 1999 when Ireland and Norway joined a decade-old Swiss-supported scheme to supplement recurrent expenditure (largely) at the provincial and district levels. Following an intensive programming exercise, during which available resources from all sources are linked with activities, funding is managed by the Provincial Planning and Finance Department, largely following state budget procedures. Although the absolute amount channelled through this pool is not particularly large, the fact that it is not subject to central bureaucratic delays and is therefore generally available at the provincial level increases its importance in terms of service delivery. Again, funding through this pool is not registered within the state budget.

Work in progress, from a survey of external donors in 2003, indicated that funding to the pools was expected to increase both in absolute terms, and as a share of total external aid between 2003 and 2004. Table 12 below shows predicted future funding of the pools in Euros[25].

[25] Data for 2005 and 2006 have been removed form the original table as they were incomplete.

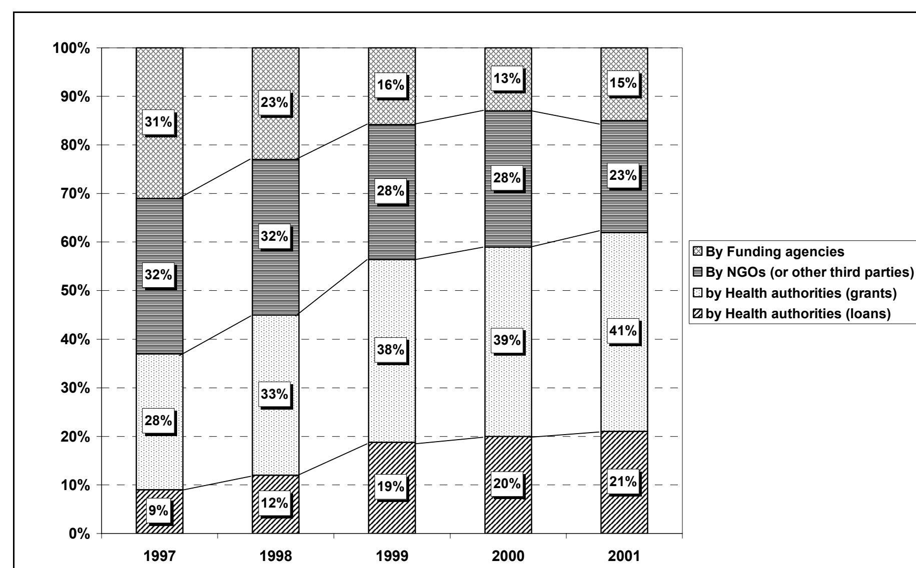
Table 13 Estimated funding of common funds, 2003 and 2004 (Euros)

Year	FCG (general)	FCM (drugs)	FCP (provinces)	Total
2003	8,526,075	20,751,349	6,216,061	35,493,485
2004	15,484,797	16,668,562	8,757,291	40,910,650

Source: IHSD (2003), Mozambique annex.

In addition, the management of external funds within the sector has changed significantly in recent years, with increasing health authority (central and local) control over funding at the expense of direct donors. Figure 5 shows this graphically.

Figure 5 Changing picture of external resource management, 1997-2001



Source: IHSD (2003), Mozambique annex

Over a period of 4 years, the share of external financing managed by the funding agencies themselves has more than halved, from 31% in 1997 to 15% in 2001. This can be seen as an indicator of increased confidence of the donors in the government systems.

In their assessment of the risks of moving towards increased use of government systems, Pavignani et al (2002) propose that for the FCG and the pharmaceutical pool, there is little risk, the latter as it is already well-established and effectively on-planning and budget within MOH. The FCG, as a new aid mechanism, is well-placed to build on experience both within the sector, and within the Agriculture and Education sectors, both of which have evolving and generally successful sector budget support programmes. Increased use of such a mechanism would give leverage to sector donors in the allocation of funds within the health sector, and enable MOH to channel these unearmarked funds to sectoral priorities. However, given the particular failings in the state budget mechanism in relation to transfers to provincial and district administrations, they urge caution with respect to moving the provincial pool on-payment.

4.4.4 External financing for HIV/AIDS, Malaria and Tuberculosis

As in other countries, the GFATM target diseases benefit from a variety of funding sources, channelled both through project and programme support. As mentioned above, together they have benefited from funding through the PNI-DT, although actual execution was relatively limited.

Malaria

The additional submission to GFATM indicates a substantial number of agencies providing external support for malaria, although the actual financial contribution is generally not specified (CCM 2002c, pp28-29), and cannot be converted to an annual amount. ROM through MOH covers programme management and some operational financing, through the PNI-DT, while a variety of bilateral, multilateral, NGO and private agencies support different activities.

As of mid-2002, UNICEF was providing US$6m over two years to support community-based activities such as ITN and community-based treatment, together with epidemic response and health education. The World Bank is supporting vector control, and infrastructure and equipment supply. Vector control is also supported by the Australian government and USAID, while DFID (through UNICEF) supports personal protection, and epidemic and emergency aid. The latter, largely ITN distribution, is also provided by NGOs such as World Vision International and Save the Children Fund (US). Malaria-related research was ongoing in three local academic institutions, and three private companies were either supporting training or malaria control activities.

Tuberculosis

As for malaria, the government through MOH, is responsible for programme management and financing of tuberculosis activities in the country, as part of the PNI-DT. In 2002, WHO was providing both technical support and training, while NORAD was funding drugs, training, and financial support which included top-ups to the NTCP staff and national and regional levels. A number of NGOs were supporting implementation of the programme in specific provinces, although the document implies that not all provinces were covered by such support.

HIV/AIDS

As in other countries, HIV/AIDS activities in Mozambique are funded by a large variety of agencies, both international and domestic, government, and non-government, and mapping the complete potential resource envelope available for tackling the epidemic has proved very difficult. However, a number of the major sources are known, and attempts to factor them into existing planning and budgeting systems is ongoing to varying degrees.

The World Bank is currently disbursing funds under its Multi-country AIDS Project (MAP) which has a total budget of US$55m over five years. MOH is expected to benefit from US$16m of this total amount.

Mozambique is one of four countries selected to benefit from assistance from the William J Clinton Foundation (known as the Clinton Foundation), which aims to sharply increase the number of people accessing antiretroviral treatment in developing countries. In Mozambique, the intention is to provide coverage to an estimated total of 351,000 HIV positive individuals, of whom 132,000 will receive ARV therapy. The 6th draft of Care and Treatment plan[26] includes a total budget over five years of US$329m. However, this includes other sources of funds which are contributing to the Care and Treatment Plan objectives (such as MAP and GFATM resources), and the additional proposed investment is US$294 over five years. The plan proposed that these funds be channelled through the FCG in MOH. The extent to which these funds are actually available is not currently known.

[26] Republic of Mozambique and Clinton Foundation (2003). *Strategic Plan to scale up HIV/AIDS care and treatment in Mozambique*. Business plan 6.0. 25 May 2003

Support to HIV/AIDS prevention and control activities is also provided by most of the European bilaterals and USAID, the EC, and the UN agencies. Some of this is channelled through the FCM, some through a common pool maintained by NAC along the lines of the FCG, and some to the National STD/HIV/AIDS programme.

5 GFATM and specific issues for the tracking study

In January 2002, Mozambique submitted its first application to the GFATM. Covering three components (HIV/AIDS-TB, HIV/AIDS, and Malaria), this first proposal included a combined budget of US$ 243,453,923 over five years. The application was returned for revision, and a second version was submitted in September 2002, with similar components, but restructured and scaled down to a total request for US$ 155,594,941 over five years. This was approved, although protracted negotiations about the Principal Recipient and Local Funding Agency meant that the grant agreement was only signed in April 2004. At the time of writing, no funds have therefore been disbursed.

The planned future inflow of funds arising from this proposal[27] is likely to have implications both for the health sector, and potentially for the economy and for achievement of broader poverty-reduction objectives in the country as a whole. These are outlined below.

5.1 Broad macroeconomic issues arising

The level and share of external financing of the Mozambican budget is generally described as both exceptional and temporary. At the macro level, concerns have been raised regarding the dependence of the budget on such external funds as a means of enabling the rapid growth in public expenditure seen during the late 1990s and early 2000s, despite the success of the country in raising social spending.

As discussed in Section 2.1.3, the overall fiscal position in 2002 was described as unsustainable, with an overall deficit before grants of almost 19% of GDP, and an estimated deficit after grants of 7.8% of GDP (World Bank 2003, p22). Fiscal discipline is therefore a priority for ROM in coming years.

The revised Mozambican application to the GFATM represents total potential funding of US$155m over five years, representing an additional $25m in the first year gradually rising to a budgeted US$38m in year 5, should the future performance-related disbursements be made. The planned phasing of GFATM monies by component is shown in Table 14 below.

Table 14 Proposed phasing of GFATM monies (current prices)

Component	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
HIV/AIDS	12,718,750	16,974,082	22,155,327	26,349,619	31,140,995	**109,338,773**
Tuberculosis	5,372,214	6,809,120	2,099,016	2,197,816	1,712,830	**18,190,996**
Malaria	7,008,252	5,259,870	5,347,070	5,179,210	5,270,770	**28,065,172**
Total	**25,099,216**	**29,043,072**	**29,601,413**	**33,726,645**	**38,124,595**	**155,594,941**

Source: CCM 2002a, p4

As grant funding, GFATM monies have no impact on future debt service or principal repayments, and as such are to be preferred to loan funding. However, this will be to the extent that it can be used to provide general or sectoral budget support, which is not the case

[27] and potential future submissions, although the government has expressed reluctance to go through the application process again before seeing the fruits of the current agreement (see Starling.

although the use of the FCG will increase its efficiency, or to free up other funding to ensure that other poverty reduction priorities are met. The amounts in Table 14 roughly translate as an additional 28-39% of external funding to the MOH[28], and ___ % of overall external grant funding to ROM[29].

As discussed in Section 1.2, the potential "Dutch disease" effect of aid depends in part on the extent to which additional aid-financed consumption is targeted at non-tradable goods and services. Although the GFATM proposal documents are not sufficiently detailed to be able to determine the exact planned proportion of tradeable items, it is possible to make a crude distinction between largely imported items such as drugs and commodities, and other largely untraded items. Table 15 below shows the breakdown, by year, of these categories over the period of the proposal. The breakdown for each particular component is given in the subsections below.

Table 15 Estimate of tradeable content of Mozambique GFATM proposals

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Drugs	4,173,965	7,616,415	10,322,602	12,067,442	13,974,395	48,137,638
Commodities and products	5,459,904	6,944,336	4,439,725	5,563,764	5,644,390	28,052,119
Total	**25,099,206**	**29,043,072**	**29,601,414**	**33,726,646**	**38,124,596**	**155,594,752**
Drugs %	*17%*	*26%*	*35%*	*36%*	*37%*	*31%*
Commodities %	*22%*	*24%*	*15%*	*16%*	*15%*	*18%*

With the exception of the first year, around half of the proposed funding is programmed for drugs and other commodities, and can therefore be expected to be exchange rate neutral. Given the size of the overall proposal, this still leaves an additional US$15.5 million in the first year, rising to US$18.5 million in the fifth year, which will potentially impact directly on the domestic economy.

5.2 Sectoral issues arising

5.2.1 General

The inflow of a planned increase in the volume of external funding to the sector, to the tune of 28-39%, can be expected to have some impact, although this will of course be mitigated by any delays or shortfalls in release. As such a substantial individual source of funding, it might be expected to result in priority being given to activities within the proposals, particularly in a context of human resource and other capacity constraints. The fact that future releases are performance-based is likely to enhance this effect.

Following much discussion (with representatives of GFATM rather than among partners in-country – ***<<Mary, is this fair comment?>>***, the decision has been made to channel the GFATM monies through the FCG and the Common fund under the NAC, with MOH and NAC as Principal Recipients. This is welcomed as, to the extent that such funding is included within the plan and budget of MOH (and NAC), it will further the efforts of partners to harmonise the management of the multitude of available funding sources, and enable a more rational and comprehensive discussion about the allocation of other funds among priorities within the sector. This was explicitly referred to in the proposal as a potential benefit of GFATM funding: *"The Global Fund process will catalyse the establishment of the Health*

[28] Using Sjolander's figures of US$40m through the common funds and $25-50m through project aid (Sjolander 2003, p1).
[29] Using IMF data on grants of ………………….

Common Fund, and speed up the abolition of the existing fragmented financial arrangements for donor support within the MOH" (CCM 2002a).

The share of multilateral and bilateral aid in health sector expenditure (excluding GBS) fell between 1997 and 2000 as shown in Figure 2. This reflects a deliberate policy move by many donors to channel funding through government systems and as unearmarked general budget support. Although GFATM funding to MOH will pass through the FCG, it will still be included within the category of multilateral and bilateral aid to the sector, and may therefore reverse this trend. However, as stressed in Pavignani et al (2002), the key issue is not that support to the sector should necessarily be 'on-payment' at present, but that the degree of 'on-plan' and 'on-budget' funding in the sector be enhanced, as a minimum within MOH, and ideally within MFP.

GFATM funds are expected to be additional, as per the Grant Agreement signed (Article 9). This implies that the health sector (including NAC) should benefit from an extra US$25m in the first year. Roughly calculated from the figure for total health expenditure in 2000, this represents an additional 19%. Although arguably ambitious, the recent PER recommended that the sector required additional allocations in its favour in order to help mitigate the effects of HIV/AIDS on the health system: *"While the study did not quantify the marginal welfare impacts of competing sectoral investments, it is hard to avoid the conclusion that some further reallocations in favour of health will be called for, merely in order to protect the gains made so far, since the health system's resources will be increasingly captured by HIV/.AIDS patients with opportunistic diseases."* (World Bank 2003). GFATM funding could potentially contribute towards this aim.

There does not appear to have been any discussion to date about overall sectoral ceilings within the country Medium-Term Fiscal Scenario, possibly as a result of the relatively weak state of public expenditure management generally in Mozambique. The addition of earmarked grant funding is therefore not necessarily likely to impact on the allocation of more flexible state budget funds (including general budget support), although this should be monitored.

5.2.2 HIV/AIDS

The GFATM proposal has two sub-components related to HIV/AIDS, the first of which is aimed at prevention and mitigation of the effects of the epidemic, focussing on prevention among young people, social mobilisation, and the care of affected communities and in particular orphans and children. The second sub-component, aims to strengthen care, treatment and support for persons living with HIV/AIDS, through a strategy of creation or upgrading of 50 Integrated Health Network sites, building on existing health services but using NGOs to speed up implementation through circumventing the shortfalls and delays inherent in the public service regarding recruitment of additional medical and health personnel.

Two separate grants have been agreed under the HIV/AIDS component, relating to these two sub-components. The Principal Recipient for the first is the NAC, while the second will be managed by MOH.

In terms of tradeable content, the HIV/AIDS budget shows a steady increase over the five years, as shown in Table 16, largely due to the increase in antiretroviral drug procurement as the IHNs become more established and ARV treatment centres become operational ***<<this is an assumption as the relevant table is not included in the main proposal and I don't have the annex>>***.

Table 16 Crude estimate of tradeable content of HIV/AIDS component

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Drugs	1,945,600	4,937,192	8,364,680	10,109,520	12,105,960	37,445,952
Commodities/Drugs	1,771,415	1,965,993	2,740,382	3,873,421	4,365,047	14,716,258
Total	**3,717,015**	**6,903,185**	**11,105,062**	**13,982,941**	**16,471,007**	**52,162,210**
Drug %	*15%*	*29%*	*38%*	*38%*	*39%*	*34%*
Commodity %	*14%*	*12%*	*12%*	*15%*	*14%*	*13%*

The non-tradeable part of the HIV/AIDS proposal could potentially contribute an additional $12m in the first year alone, and may therefore have an inflationary effect.

The inclusion of anti-retroviral treatment within the proposal is subject to similar concerns as have been raised in other countries, ie the extent to which funding for the intervention is sustainable and sufficient, given the relatively short-term commitments of external funders, and the shortfalls in terms of actual disbursements in contrast to the fact that ARVs are a lifetime commitment, with serious consequences of non-compliance. The step to substantially scale up access to ARVs should not be taken without serious analysis of financial sustainability of the strategy. ***<<is there any such document for Mozambique?>>***

5.2.3 Malaria

The component of the GFATM proposal related to malaria aims to reduce malaria morbidity and mortality by at least 25% in the ten districts in which is to be implemented. The component has four objectives:

- To expand capacity and strengthen systems for malaria control at all levels, and to scale up RBM implementation;
- To scale up community-based malaria prevention and treatment, through use of ITNs, IPT during pregnancy, and the early recognition and treatment of malaria symptoms;
- To improve the effective diagnosis of malaria at health facility level, and strengthen referral systems in the ten districts, in order to improve case management; and
- To provide Indoor Residual Spraying as a preventive measure in suburban areas (CCM 2002c, p7).

The fact that a medium term plan for Malaria in Mozambique was being developed during 2003, ie following submission of the successful GFATM proposal, means that there is little advantage in discussing the extent to which the proposal was appropriate in relation to the existing programme context. However, the fact that the country had already adopted the RBM initiative, and that the proposal aims to implement this within ten districts, suggests that there was congruence between the two.

Given that the malaria component only covers a limited geographical area, ten districts in five provinces, representing roughly 7% of the total population, it would be useful to know how the strategies are to be scaled up elsewhere around the country. Unfortunately, it has not been possible to obtain the malaria strategic plan ***<<check title and period covered>>*** to determine what other activities are included, at what cost, and the extent to which they are funded.

Drugs account for between a quarter and a third of the budget each year, as shown in Table 17 below, due to the increased costs of the new combination therapy. As with other components, these are expected to be procured using existing channels, and therefore to be exchange rate neutral. An additional 16-23% of the budget is potentially tradeable, meaning that the macroeconomic effect of the inflow is potentially halved.

Table 17 Crude estimate of tradeable content of Malaria component

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Drugs	1,777,506	1,777,506	1,777,506	1,777,506	1,777,506	8,887,530
Commodities/products	1,633,489	868,343	877,343	868,343	868,343	5,115,861
Total	**7,008,252**	**5,259,870**	**5,347,070**	**5,179,210**	**5,270,770**	**28,065,172**
Drug %	*25%*	*34%*	*33%*	*34%*	*34%*	*32%*
Commodity %	*23%*	*17%*	*16%*	*17%*	*16%*	*18%*

5.2.4 Tuberculosis

Financially, The TB component is the smallest of the three components within the proposal. Its stated goal is *"to strengthen TB services to be able to expand efforts towards health posts and communities to reach 100% of the population particularly under-served groups among which, women, children and the poor"* (CCM 2002d). This will build on the current estimate of 40% coverage which largely reaches those within reach of district capitals. Four main strategies are identified:

- Improving access to information on TB prevention
- Correct diagnosis of cases
- Early and effective treatment and cure for TB patients within an expanded DOTS framework.
- Strengthening of public-private partnership in the TB control.

Improving laboratory capacity around the country is a major activity, with repair, replacement and purchase of microscopes, recruitment of an additional 60 laboratory technicians, and ensuring continuous supplies of reagents and other supplies. This will have positive externalities for the system as a whole.

In terms of potential macroeconomic effects, the component is the least likely to impact due to its relatively smaller size. Table 18 shows the same crude estimate of tradeable content. The proposal explicitly states that purchase of 150 computers and 150 motorbikes to strengthen monitoring and evaluation is expected to take place locally rather than through import, thereby impacting on the local economy.

Table 18 Crude estimate of tradeable content of Tuberculosis component

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Drugs	450,859	901,717	180,416	180,416	90,929	1,804,156
Commodities/Drugs	2,055,000	4,110,000	822,000	822,000	411,000	8,220,000
Total	**2,505,859**	**5,011,717**	**1,002,416**	**1,002,416**	**501,929**	**10,024,156**
Drug %	*8%*	*13%*	*9%*	*8%*	*5%*	*10%*
Commodity %	*38%*	*60%*	*39%*	*37%*	*24%*	*45%*

The proportion of the TB component budget accounted for by drug procurement is much lower than for the other diseases, although there is some confusion here as the figures in Table 18 above do not tally with those detailed for the first year of implementation[30]. NORAD currently provides the TB drugs for the 40% of the population covered. However, the inclusion of commodities (not spelled out in the proposal) takes the total potential tradeable share to 55% over the five year period, so that more than half the overall budget could be exchange-rate neutral.

[30] The table under Section 30.1 in the expanded proposal (CCM 2002d) indicates a total requirement for drugs and commodities of US$1.8m, which solely refers to TB drugs. This contrasts with the US$2.5m shown in Table 18. This may be due to inclusion of the existing supplies, but it is not clear.

The absolute value is higher in the first two years (US$2.5m and US$5m respectively), presumably while the laboratories are equipped. Procurement of drugs and supplies would be undertaken through the Pharmaceutical Pool, thereby using and hopefully strengthening existing systems.

Human resources account for 15% of the budget, with recruitment of an additional 150 nurses in addition to the 60 laboratory technicians. Although GFATM funds are expected to cover salaries in the short term, these staff will later be integrated into the general payroll. Depending on the extent to which there is excess capacity and these persons are currently un- or under-employed, such expansion could have an inflationary impact.

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6 Annexes

Annex A Terms of reference for the macroeconomic and sector background paper

General objectives:

- To summarise the macroeconomic and sectoral context (policy and performance) for each of the four countries
- To flag issues of concern relating to macroeconomics and financing for subsequent tracking during the country studies (both general and, where appropriate, country-specific), and to propose means of addressing these

Specific objectives:

a) To present general macroeconomic issues, as follows:

- To describe country Medium Term Expenditure Frameworks (MTEF), annual budget structures and the pattern of inter-sectoral allocations, in relation to stated country priorities.
- To synthesise available literature on the impact of aid on macroeconomic variables and performance, and to consider the level and planned use of GFATM inflows at the country level in relation to this information
- To review available information on country aid inflows in relation to the breakdown between general and sector budget support and project support, their inclusion within MTEF ceilings; and the level, time-scales and modalities of donor commitments to ongoing funding

b) To present health sector issues, as follows:

- To describe sectoral MTEF and annual budget allocations (to health and other HIV/AIDS activities), and to report recent budgetary performance, comparing planned and actual spending (from MTEF, Public Expenditure Reviews, sectoral budgets, National Health Accounts, etc)
- To summarise current country health policy priorities (particularly relating to HIV/AIDS, TB and malaria) – as reflected in written policy and strategy statements, and budgetary allocations, comparing these with plans and proposed use of GFATM funds
- To summarise current financial management (planning, budgeting, procurement, disbursement, accounting and reporting processes) in each country, in relation to SWAp development and the adoption of common (government) procedures
- To use this information as a baseline for future tracking of the extent to which GFATM processes are integrated with or set up in parallel to existing procedures
- To summarise trends in health sector financing by type: domestic/external, by level of care, across diseases/programmes (where available)
- Where information exists, to review country and sector performance in relation to evidence of absorption capacity (percentage of money released that was spent)
- To analyse existing GFATM proposals in terms of type of support (eg commodity versus systems strengthening; disease specific versus general), and allocations by level of care (e.g. tertiary versus primary or community level interventions)

c) To propose areas for future tracking, e.g.

- Balance of commodity support versus systems strengthening support
- Extent to which GFATM funding is in fact additional or has substituted for other sources of funding (at the country level, and/or by individual development partners)
- Shifts in the modalities of donor support (between budget, sector, project and GFATM support)
- Degree of integration and/or duplication of new with existing financial management and reporting systems
- GFATM funding as % of total sectoral funding (and implications for financial sustainability)
    - Generally, and for specific high value commodities such as ARVs
- Extent to which GFATM funding alters the intra-sectoral allocation of resources by:
    - level of care
    - geographical area (urban/rural, or more detailed)
    - disease/programme
    - type of input
    - general systems strengthening versus disease-specific activities

Methodology:

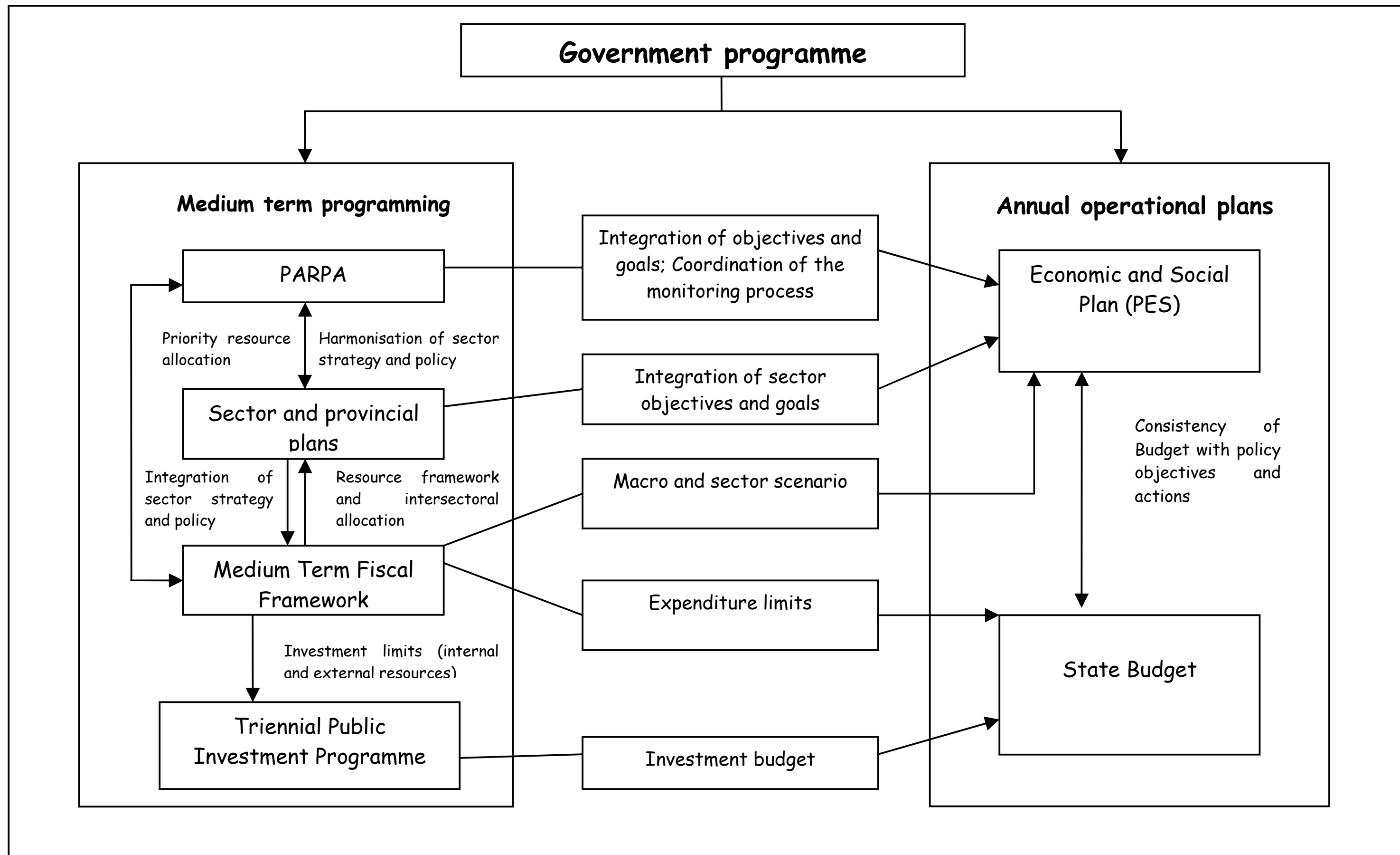
- Participation in meetings of tracking study team:
    - planning of phase 1 field work, January 2003
    - review of findings and planning of next phase of field work, mid 2003

- Desk review of general and available country-specific literature (to be provided, or access to it to be facilitated, by the funders). It should include:
    - General documentation on macroeconomic implications of aid – general and, if possible, sector specific
    - MTEF documentation, with external audit reports, where available
    - Indicative (e.g. 1 and 3 year) health sector basket funding commitments by partners – pooling donors and government
    - Overall general and health sector/HIV-AIDS budgets
    - Breakdown, where available, of non-pooled (e.g. project) support from major donors to health / HIV/AIDS activities
    - Existing and indicative future levels of commitment by donors to general budget support
    - GFATM applications (successful ones for each country, or most recent applications if approval still pending)
    - Key development agency policy documents (general, HIV/AIDS, health, country)
    - National Health Accounts reports
    - Public Expenditure Review reports
    - Sectoral policy documents
    - Current country HIV/AIDS, malaria and TB policies and strategies, where these priorities have been included in GFATM applications
    - Country Financial Accountability Assessments (where available)
    - Available audit reports

Outputs:

- Four country-specific reports, including recommendations for issues to be raised and data to be collected in the tracking study field work

Annex B Public planning system: articulation of instruments



Source: ROM (2001), p8

Annex C MOH's planning, budgeting and monitoring cycle

January - February	• Communication of the budgeting limits approved by the FASAUDE for the current year and adjustment in the respective institutions • Close of the previous year's financial year
April - September	Audit of the previous year's FASAUDE funds and other funds managed at DAG level
March	Joint sector evaluation (MOH – external consultant team) using, among others, the list of PESS key indicators
May	National Co-ordinating Health Council: 1. Presentation of the Health Sector's annual activity and financial report 2. Presentation of the Health Sector's joint performance evaluation report 3. Definition of the Health Sector's annual priorities
CCS June	1. Presentation of the preliminary annual audit report 2. Presentation of the Health Sector's joint performance evaluation mission report 3. Presentation of the Health Sector's priorities 4. Dissemination of budget limits and establishment and communication of the amounts determined by the Signatory Partners for the following year. Partners' indicative financial commitments for a three year period.
June - September	August: Signatory Partners' indicative financial commitments Preparation of the annual operational Plan at each cost centre and at DPC/DAG level Remittance and justification of the budget proposal to the NDPB of the MPF
October	Consolidation of the Operational Plan and presentation of the draft to the WG-SWAp
CCS end of November-beginning of December	1. presentation of the final annual audit report 2. Presentation of the budgeted operational Plan with sector priorities 3. Presentation of the proposal for the allocation of funds to the cost centres
December	Finalisation of the Operational Plan and the budget

Source: MOH 2003 (KKC)