REPUBLIC OF MOZAMBIQUE

MINISTRY OF HEALTH

Strategic Plan for the Health Sector (PESS) 2001 – 2005 – (2010)

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List of acronyms

ACS	Community Health Agent
APE	Basic Polyvalent Agent (Community Health Worker)
BdM	Bank of Mozambique
CFDMP	Medium Term Expenditure and Financing Framework
CPS	Primary Health Care
DAG	Administration and Management Directorate
DAG/DM	Administration and Management Directorate /Maintenance Department
DAM	Department for Medical Assistance
DAP	Department for Personnel Administration
DFC	Department for Continuous Training
DHSM	Demographic and Health Survey, Mozambique
DNPO	National Budget and Planning Directorate (of MPF)
DPAC	Provincial Support and Monitoring Directorate
DPAG	Provincial Administration and Management Department
DPG	Planning and Management Department (Personnel)
DPPF	Provincial Directorate of Planning and Finances
DPS	Provincial Health Directorate
DRH	Human Resources Directorate
EHTP	Essential Health Technology Package
FC-PESS	Common Fund Health Sector Strategic Plan
FI	Initial Training
FIMAT	Financial Information Management Assessment Tool
GdM	Cabinet of Ministers
GT-SWAP	MISAU – Donors SWAP Working Group
HIS	Health Information System
IAF	National Household Survey of Living Standards
IdF	Training Institute
IDS	Demographic Health Survey
IDSM	Demographic Health Survey, Mozambique
IS	Information Systems
LB	Live Births
MAE	Ministry of State Administration
MISAU	Ministry of Health
MOST	Management and Organization Self-assessments Tool. (MOSTambique)
MPF	Ministry of Planning and Finances
MSH	Management Sciences for Health
NGO	Non Governmental Organisation
OE	State Budget
PAT	Annual Work Plan

PATA	Pooling Agreement Technical Assistance
PDI	Institutional Development Plan
PDRH	Human Resources Development Plan
PERMAS	Strategic Plan for Sector Administration Reform and Modernisation
PESS	Health Sector Strategic Plan
PETS	Public Expenditure Tracking Survey
PI	Integrated Plan
PNI	National Integrated Plan
PRSS	Reconstruction Plan for the Health Sector
PSI	Sectoral Investment Plans
PT	Traditional Birth Attendant
SDC	Swiss Development Co-operation
SIP	Personnel Information System
SNS	National Health Service
SWAP	Sector Wide Approach to Policymaking
SWAp	Sector Wide Approach to Programming
TA	Administrative Tribunal
IT	Information Technology
USAID	United States Agency for International Development
USD	United States of America Dollar
WB	World Bank
VEN	Essential Needs: classification to prioritise the acquisition of medicines and medico-surgical articles.

Preface

Formulation of the Health Sector Strategic Plan (PESS) is an important step in the process of reaching a consensus about the ways in which the serious health problems affecting the population of our country can be solved. The present document is the final version of the plan, although it does not represent the end of the process. In reality, it marks the beginning of another complex journey: to transform ideas and strategic options into concrete, visible, measurable activities which are, above all, felt and appreciated by our citizens. The true value of the PESS may only be verified by people's level of satisfaction with the health system. The basic criteria for assessing the execution of this plan should be whether it meets the citizens' expectations.

The PESS that will now be implemented is an instrument for managing change. It identifies a range of strategic options and measures for achieving the reforms that are underway in the Health Sector. These changes will be made in the context of public administration and state apparatus reforms with the aim of significantly improving the performance of the whole health system, both public and private. The complexity and magnitude of our society's health problems, allied with Mozambique's present stage of socio-economic development demands a clear definition of priorities and criteria for allocating resources. These must be in line with the Government's political guidelines, presented in its five-year plan and in the national agenda for accelerated economic development and alleviation of absolute poverty. The contribution of PESS falls under this ambit. The plan raises multiple issues for MISAU, which is responsible for co-ordinating the country's health system. It has been impossible to analyse every issue in appropriate depth before taking decisions: MISAU does not possess all the necessary elements for delineating policies and strategies with confidence in every area. Studies and analytical work are needed if further advances are to be made.

This document has a very special characteristic. It is the result of numerous debates inside and beyond the sector. The participatory approach of the PESS formulation process is fundamental to building a sense of ownership by health workers, users and non-users. Valuable, heated debates have been taken place over the past three years. It is possible that some of the aspects that were debated do not appear in this plan in the form that some would wish. MISAU chose to concentrate on crucial and structural aspects which affect the workings of the sector; we are confident that this is the most appropriate approach. In order to provide appropriate preventive and curative health care, the PESS identifies health advocacy and individual and collective capacity building as key MISAU interventions. Institutional development is considered to be crucial for the success and sustainability of national health development. The Institutional Development

Plan (PDI) was developed with this in mind, and constitutes one of the PESS's main components. In this plan, principle actions are identified which strengthen MISAU's role at every level. The PDI also sets out new management options for the health system, which may prove difficult to achieve and carry some risks. The proposed approach is incremental and takes MISAU's limited institutional capacity into account. Our concern is to find a way to break the vicious circle– the inertia and reactive attitude to problems caused by limited capacity. We need to be bold and to take risks while remaining aware of our responsibilities.

In formulating and editing the PESS, MISAU has expressed its wish to reassume leadership in a sector where numerous participants play various roles, motivated by different desires and agendas. The government greatly appreciates the contribution of all these players in mitigating the significant shortcomings in the health sector. However, the process of implementing a diverse range of activities to support the sector has not always been efficient and effective, for various reasons. When formulating the PESS, MISAU was aware of the need to raise the productivity of its co-operation with partners and thus to increase the efficiency of support to the sector. To achieve this, the PESS attempts to facilitate collaborative relationships between MISAU and its international and external partners in the context of the Sector Wide Approach to Policymaking (SWAP), as well as promote the Code of Conduct signed by MISAU and its partners in May 2000. It is our belief that MISAU's leadership will thus be strengthened and consolidated and that everyone will benefit from a stronger, more cohesive MISAU which can focus on its leadership role.

For this reason we would like to ask all health workers, partners, communities and society in general to execute the strategies presented here to achieve better health for Mozambicans in the not-so-distant future. The challenges that the plan presents are significant but not insuperable. We should go forward with both confidence and unselfishness. Together we can win the fight against disease and poverty.

O MINISTRO DA SAÚDE

DR. FRANCISCO FERREIRA SONGANE

MAPUTO, MAY 2001

Introduction

The Health Sector Strategic Plan (PESS) is a process by which the Ministry of Health (MISAU) defines and disseminates, in a transparent manner, its sectoral policies and main objectives for several years. MISAU's leadership role and the transparency of the process will help to improve co-ordination between all internal and external partners involved in health service provision.

PESS should incorporate mechanisms to deal with continual external change. The plan needs to be updated periodically to ensure that it remains relevant and functional. PESS's contribution can be seen in its participatory, flexible and adjustable manner of formulating and adopting macro policies. These policies are clearly prioritised to guide the implementation of activities while avoiding unnecessary involvement in diverse operational options.

This plan presents clear guidelines in various essential and complex key areas such as:

- The continual need to prioritise disadvantaged population groups and focus activities on poverty alleviation;
- Consolidating significant post-war reconstruction investments rather than continually expanding the network;
- Prioritising quality (consolidation) and increasing access (expansion) only for reasons of equity;
- Correcting inequalities in the geographical distribution of Health Centres and other essential resources for service provision;
- Developing quality hospital care.

MISAU favours the adoption of a *Sector Wide Approach to Policymaking* (SWAP) which illustrates its desire to assume the leadership of the Health Sector in the country as a whole i.e. in both the public and private sectors.

The health sector's recent history shows that efforts made by the various health care providers do not always produce satisfactory results. There are opportunities for optimising the use of the sector's resources. This relative inefficiency is largely due to the 'crisis management' model predominant in MISAU over the past 10 to 15 years as a way of confronting the huge health problems in Mozambican society. Laudable efforts have been made under difficult circumstances, with extreme shortages of resources, during a phase of national reconciliation and after a period of turbulence lasting almost two decades. The effects of this turbulence are still evident in Mozambicans' lives and health. This 'crisis management' approach has been aggravated by the variety of approaches, interventions, philosophies and agendas by which the various partners supporting the sector identify themselves in their relationships with national partners. The indirect and undesirable result of this is the fragmentation of the sector, a lack of coherence and the inefficiency of external support. The international health arena's approach to external support has changed significantly. The vision for internationally supported projects has evolved from Programmes to Sectoral Investment Programmes and finally to SWAP. SWAP is a natural approach for MISAU given the circumstances of the health sector and the country, particularly if the sector's capacity is taken into consideration. SWAP is MISAU's preferred mechanism for collaboration with external and internal partners; it is a way of working with all the sector's participants under the government's leadership. MISAU sought to develop a vision and clear, shared priority objectives in a participatory manner with all the key players in the sector including the final beneficiaries i.e. the Mozambican population. These elements, which are essential for the success of SWAP, are an integral part of PESS. PESS is a referential framework for collaboration within the entire sector and creates conditions for

greater coherence and harmony between the various interventions while reinforcing MISAU's leadership role. The inclusive nature of the PESS preparation process incorporates the spirit of SWAP.

MISAU needs to strengthen its regulatory role and relax its prescriptive influence over policy implementation. It should observe the principles of equity, flexibility, transparency and efficiency at all times. Gradual decentralisation will be required in parallel with capacity-building in the more peripheral management units. As a mechanism for collaboration and reforming the role of every player, SWAP will contribute towards a collaborative culture based on *honesty, transparency, partners' autonomy and strong national leadership*.

The PESS preparation process

Strategic Planning is not an isolated occurrence and publication of the plan in April 2001 does not mean that the process has ended. Within MISAU, the contributions to the strategic planning process in certain areas have not been particularly participatory or wide-reaching.

Planning was carried out during different periods and determined the content and the type of preparation process. This publication is the result of this process, which used source documents, experiences and accumulated institutional memory. This, in turn, fed into a process of participatory and inclusive reflection aimed at achieving greater autonomy and improved leadership within MISAU. The sector's history was taken into account when developing PESS, but the plan represents a challenge and the start of a process of change in MISAU's approach to work at every level.

Figure 1 below, summarises the significant events during the process of debate, consultation, analysis and finally the publication of PESS.

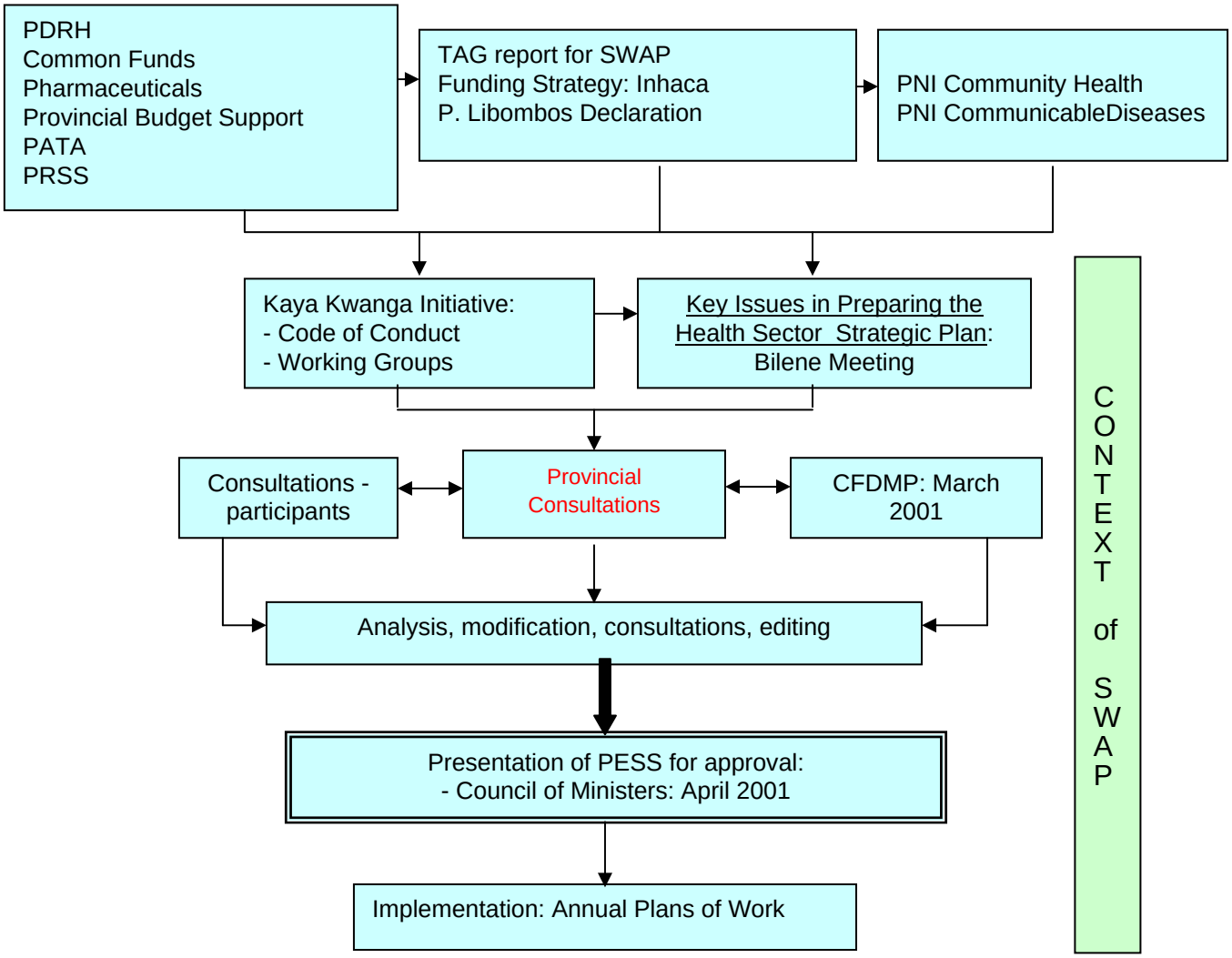
PESS constitutes a referential framework for sector programming, as stated in the Code of Conduct adopted by MISAU and its partners. PESS has to conform with the Medium Term Expenditure and Financial Framework in indicating the sector's major priorities.

The process of preparing the Provincial Strategic Plans

The Provincial Health Departments (DPS) should assume increasingly greater responsibility for sector management at their level. The DPS play an important role in implementing major national strategies to fulfil the sector's mission. The DPS will be more involved in formulating their own plans and programmes and their leadership role will be strengthened within the Provincial health sector, where other players provide health care.

The DPS are also important in modernising health management. The modernisation of management implies transparency, clearly defined priorities and accountability concerning these priorities.

Figure 1: Chronogram of main events in the PESS preparation process



It is our belief that the provincial strategic plan will facilitate relationships with other sectors and partners. For example, the Sector Wide Approach in the provinces and at national level requires the optimal use of existing scarce resources. Financing mechanisms will need to be integrated and adjustments will have to be made to national management, monitoring, evaluation and accountability systems. The result of all this should be greater efficiency and quality of services. These arguments justify the need for and relevance of provincial strategic planning. The process of developing provincial strategic plans should be supported and technically guided by MISAU's central body to ensure that the plans are coherent and in harmony with the sector's agenda. It should be emphasised that PESS is not a synthesis of provincial strategic plans: designing these plans before PESS was completed will not necessarily cause conflict. PESS should be the umbrella under which the provincial plans are formulated.

The provincial strategic plan provides a medium and long term vision of the needs and resources available at provincial level. This approach will facilitate the development of institutional capacity in the DPS, DDS and Health Units (US) in co-ordination with partners.

Part I: Situational Analysis

Context

Geography

There are 799,380 Km2 of national territory including inland bodies of water. The country is relatively flat, particularly in the coastal regions. From the coast to the interior in an east-west direction, there is a coastal plain (with the highest population density); plateaux with altitudes of 200 to 1000 metres and finally high plateaux and mountains over 1000 metres[1] high (ISDM, 1997). Mozambique's Indian Ocean coastline stretches for approximately 2500km from the extreme south (26°52′S) to the extreme north of the country (10°27′S). The country is relatively long and thin (lying between the meridians 30°12′E and 40°51′E), particularly in the extreme south where the capital city, the nation's politico-administrative headquarters, is situated. The country's characteristics are favourable to agriculture which occupies approximately 70% of the population[2] (IAF, 1997). Mozambique frequently suffers from floods, cyclones and droughts that sometime reach disastrous proportions. These disasters have caused the deaths of people and animals, mass population displacement and other direct negative effects on agricultural production, infrastructure and the national economy. The proximity of the sea and the richness of the Mozambican River basins favour small scale and industrial fisheries. The length of the coastline makes the country a natural corridor providing neighbouring countries with access to the sea. The country is rich in wildlife and the natural environment makes it suitable for tourism. The subsoil contains certain resources such as coal and natural gas which are exported within the region. Other documented resources include minerals which are yet to be exploited, precious and semiprecious stones and limited quantities of precious metals.

Demography

Mozambique's population is approximately 17,600,000[3] (INE) Annual Population Projections by Province (1997 - 2010). The country's demographic structure is characteristic of a developing country: the demographic pyramid has a very wide base and a flattened top (ISDM, 1997). The proportion of children under 15 years old, projected for 2001, is 44.5% of the population, and the degree of dependence is approximately 90%. This means that Mozambique's population is young with a greater propensity to consume than to produce, owing to the high proportion of dependants. This has implications in certain areas of socio-economic development such as health, education, water, housing and employment (ISDM, 1997). The level of dependency may be aggravated by the spread of the HIV/AIDS virus which disproportionately affects the economically active sector of the population. The natural growth rate of the population is 2.4% (census). About 75% of the population lives in rural areas but in the past 10 to 15 years, there has been significant migration to cities due to the war (1976 - 1992). The groups that formed around the cities and towns have settled there, causing problems of urban organisation, sanitation and waste management.

Economy

The Gross Domestic Product (GDP) per capita in Mozambique was estimated at 230 USD in 2000[4] (PARPA, version B, 2001). The structure of GDP by economic activity indicates that agriculture, the manufacturing industry and commerce are the largest areas in the primary, secondary and tertiary sectors respectively (UNDP, National Human Development Report, 1999). Growth in GDP was estimated at a little over 10% between 1996 and 1999 (PARPA, version B, 2001). Despite this significant growth, the levels of poverty in Mozambique are extremely high. The Household Survey (IAF) carried out by INE estimated that absolute poverty rates stood at about 70% of the population as a whole, with significant differences between the regions of the country and between urban and rural zones (IAF 96/97). According to this study, the variables that determine poverty are:

i) Slow economic growth until the beginning of the 1990s;
ii) Low educational level of economically active household members, particularly women;
iii) High rates of dependency within households;
iv) Low family agricultural productivity;
v) Lack of work opportunities both within and outside the agricultural sector;
vi) Poor development of infrastructure, particularly in rural areas.

Given its high rate of external debt and considering the positive macro-economic performance mentioned above, the country benefited from the Highly Indebted Poor Countries (HIPC) initiative. Financial resources that were previously used for debt servicing were redirected into the social sectors. A considerable proportion of these resources was made available for the health sector. Funds were used for programmes which had a direct impact on poverty levels, including the national strategic plan for the prevention and control of HIV/AIDS.

Political and Administrative Organisation

The Mozambican Constitution[5] sets out in article 1 of its fundamental principles that 'the Democratic Republic of Mozambique is an independent, sovereign and unified state with social justice.' Administratively, the country is divided into 10 provinces and Maputo city, the national capital, which has the status of a province. The President of the Republic is the Head of State and Head of Government. The President is elected by direct, secret and individual universal suffrage. Executive power is held by the Council of Ministers, which is the Government. Legislative power is held by the Republican Parliament, elected by direct, secret and individual universal suffrage. Judicial power belongs to the tribunals.

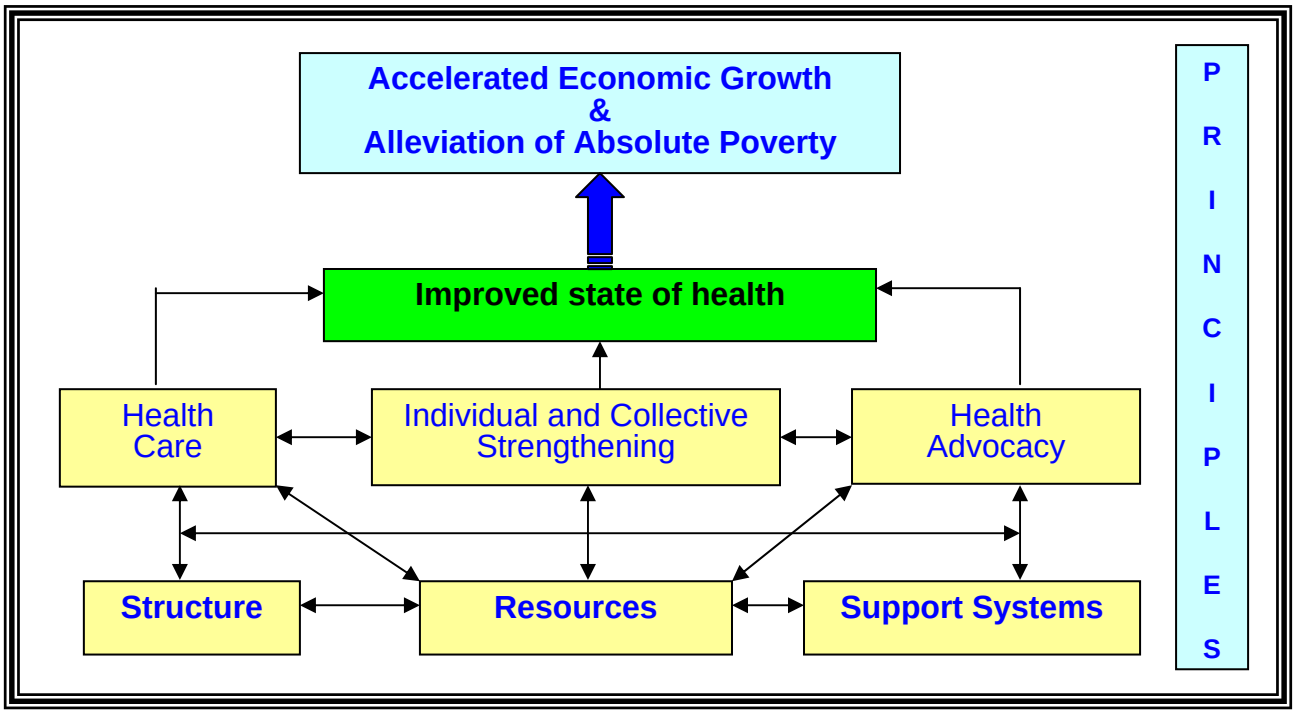
Each province is administrated by a Provincial Governor, appointed by the President of the Republic. The Provincial Governor directs a provincial government whose members are nominated centrally by the sectoral ministers of the economic and social areas represented in the provinces, in consultation with the provincial authorities. The capital city is a Municipality with the status of a province. The Municipalities are local government bodies administrated by a Municipal Council (executive organ) and directed by a President and by a Municipal Assembly (decision-making organ). At the district level, the district government is comprised of district directors of the various sectors, and is directed by a District Administrator. Thirty-three district headquarters, cities and towns throughout the whole country have the status of Municipalities.

National Development Policy

The Mozambican Government designed a strategy for reducing absolute poverty with key interventions for the sustainable economic and social development of the country. The Action Plan for the Reduction of Absolute Poverty (PARPA) was recently formulated which condenses various elements of government programming and planning, namely, the Lines of Action for Eradicating Absolute Poverty (1999), PARPA 2001 - 2005 and the Government Programme 2000 - 2004, among other programming instruments (PARPA, version B, 2001).

The government intends to achieve accelerated economic growth, projecting average annual growth at 8%. Accelerated, inclusive and sustainable economic growth is seen as the basic essential condition for reducing poverty. Investment in the development of human capital is considered as one of the priority interventions for reducing poverty and is at the same time a necessary condition for the sustainability of economic growth. In this context, the health sector plays a fundamental role in improving the well-being of the poor and the quality of human capital. PESS is part of this national development strategy, as can be seen in the conceptual framework presented in Figure 2.

Figure 2: PESS Framework: National sustainable development agenda



The health sector should prioritise interventions which, in a cost-effective way, reduce the high levels of disease, mortality and incapacity, or in other words, reduce the burden of disease in the country. The backbone of the sector's activities should comprise interventions under the ambit of a strategy for Primary Health Care (CPS). These include the prevention and treatment of endemic diseases (mostly communicable and preventable) with special attention given to HIV/AIDS and to the most disadvantaged groups.

Figure 3 illustrates how PESS fits into the national agenda. The aim of the sector's contribution to this agenda is to improve the population's state of health through three fundamental interventions:

i) Health care provision;
ii) Capacity building of individuals and communities;
iii) Health advocacy.

Supporting individuals and communities is essential if people are to assume increasing responsibility and control over their own health and lives. Democratic processes are important for encouraging participation in national life (particularly community participation in health management). They help to strengthen the community and develop national health in partnership with the citizens, under the slogan **health for all and all for health**. The citizen should be the object and subject of health promotion.

Health Advocacy emphasizes the role of the sector in relation to the factors determining health status. These are usually elements of social and economic life that are beyond MISAU's jurisdiction. Advocacy also aims to increase the subjects' and communities' role in health promotion through improving people's knowledge and information about health issues and healthy lifestyles.

The **provision of health care** is essential for:
i) Preventing illnesses, permanent or temporary incapacity and premature death;
ii) Mitigating suffering and incapacity;

iii) Restoring normal physiological functions through rehabilitation.

These three key interventions to improve health, work synergistically. The specific selection of activities should follow cost-effectiveness criteria and the guiding principles for sectoral activity.

For the sector to succeed in implementing the interventions mentioned above, PESS outlines the development of a suitable **structure** and organisation, the mobilisation and efficient use of **resources** and the establishment and consolidation of **support systems** for modern management that are appropriate for the situation in the sector. PESS is essentially a detailed version of this conceptual model.

For the period 2001 to 2005, the national development policy has the following major objectives:

1. Reduce the present levels of absolute poverty (70%) to approximately 60%;
2. Bring about rapid and sustainable economic growth, prioritising rural areas;
3. Reduce regional inequalities.

Situational Analysis of the health sector

Health Requirements

The population's state of health and epidemiological profile are largely the consequence of the present level of socio-economic development as well as being a condition for the growth of this level. The epidemiological framework in Mozambique is largely pre-transitional, i.e. dominated by communicable, infectious diseases and parasites, namely malaria, diarrhoea, respiratory infections, tuberculosis and the rapid increase of HIV/AIDS. Estimates of the burden of illness give malaria a weight of approximately 15% in the total burden of illness in Mozambique[6] (PRSS, SAR, WB, 1995). Tuberculosis was considered the major cause of internment in rural hospitals throughout the country in 1997[7] (Epidemiological Department, MISAU).

The country's Maternal Mortality Rate is considered among the highest in the world, at approximately 600 to 1100 per 100,000 live births. Infant/child mortality stands at 219/1000 live births and the prevalence of chronic malnutrition is A/I < 2 Z score = 36% (IDSM, 97). Other social indicators are among the highest in the sub-region and in sub-Saharan Africa, as presented in Table 1.

Mozambique is vulnerable to frequent outbreaks of cholera, dysentery, meningococcal meningitis and bubonic plague. These epidemics are more likely to occur in precarious environments, particularly in urban areas, and are caused by over-population in cities and towns by people who migrated in search of security during the 16-year-long war.

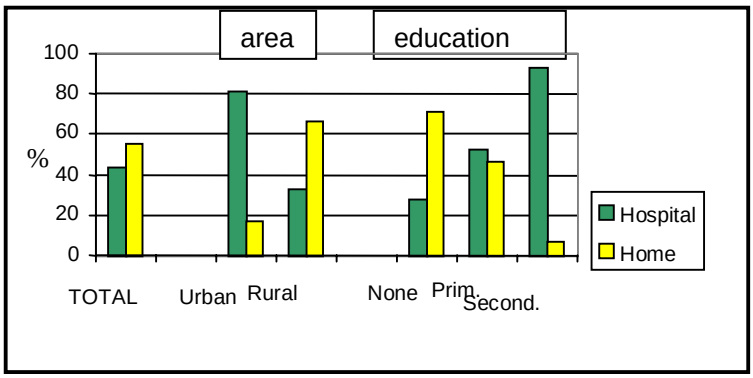
Table 1: Social Indicators in Mozambique, some SADC countries and the average in the Sub-Saharan Africa

	Mozambique[a]	Malawi	Zimbabwe	Zambia	SS Africa[b]
Infant mortality rate[c]	147 ‰	134 ‰	56 ‰	109 ‰	91 ‰
Mortality rate < 5 years	219 ‰	234 ‰	74 ‰	197 ‰	Not known
Maternal mortality rate	1083/10^5 LB[d]	620/10^5 LB	153/10^5 LB	649/10^5 LB	Not known
Gross mortality rate	21.2[8]	22.4	14.6	18	17.7
Low birth weight[e]	20%	20%	14%	13%	Not known

Despite the pre-transitional epidemiological profile described above, some data indicate a rise in non-communicable diseases of worrying proportions. Traumas of various types, particularly those caused by road accidents, have reached epidemic proportions. In a study of causes of death in Maputo city in 1994, chronic degenerative illnesses were increasingly significant[9].

The health situation is maintained and exacerbated by the following determining factors:

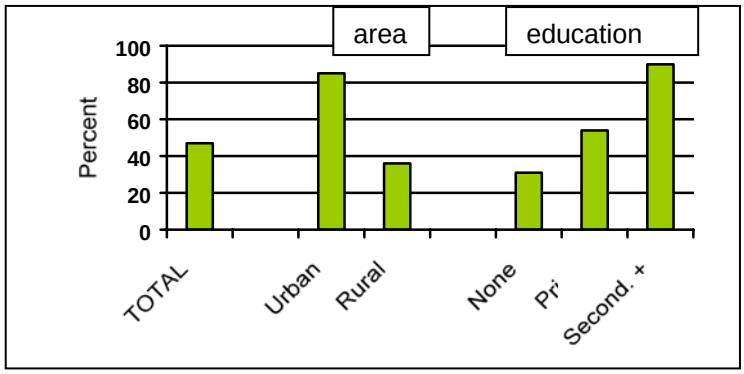
i) The population's **low level of education** in general and of women in particular, with markedly lower rates in the countryside than in the cities. The most recent Demographic and Health Survey demonstrated a strong link between rural or urban residence and the level of women's education (which are also co-related) and the location of childbirth (see Graph 1). This same association can be seen by analysing the pattern of use of services by children. Graph 2 demonstrates the association between the vaccines given to children and certain characteristics of the mother. Clearly this pattern repeats itself when other indicators are analysed such as coverage and state of health, underlining the importance of this determining health factor.



Graph 1: Childbirth locations by socio-demographic characteristics, IDSM, 97

Although this factor is not specific to the sector, it has a great influence over the results which the sector is able to obtain. Implicit in this analysis is the fact that the place where people live has an important influence over health indicators. There is a correlation between the place of residence and level of schooling and the use of health services.

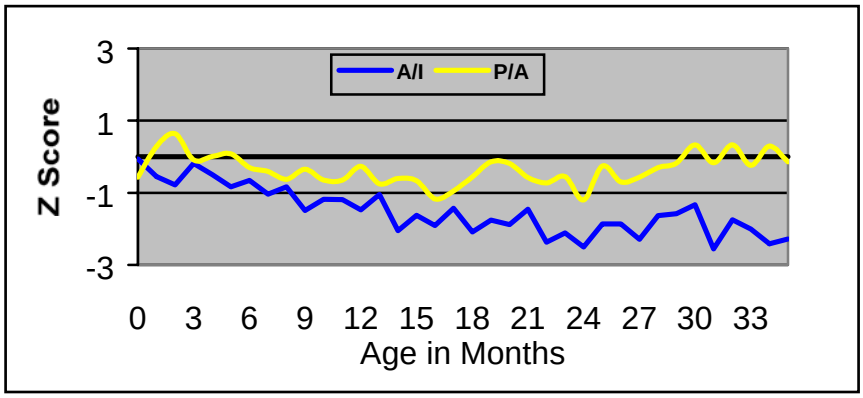
In the countryside, opportunities for education and access to the health centres are comparatively low compared with the cities. This fact serves to justify the option of prioritising rural zones when providing health and education services.



Graph 2: Percentage distribution of children between 12 and 23 months who receive complete vaccinations: BCG, measles, 3 doses of DPT and Polio, according to maternal socio-demographic characteristics, IDSM, 97

[a] Data for Mozambique are from IDS 1997, MISAU reports.
[b] Data for sub-Saharan Africa (SS) are from World Resources, 1998 –1999.
[c] Data for Malawi, Zambia and Zimbabwe were collected for the SADC Health Sector annual report, 2000-2001.
[d] Source: Country Assistance Strategy, World Bank, 1997.
[e] Estimated 1994 figures, World Resources, 1998-1999.

ii) **Deficient nutrition,** above all chronic malnutrition and deficiencies in micronutrients (particularly iodine, vitamin A and iron). Graph 3 presents the prevalence of chronic malnutrition measured according to the anthropometric height / age index (IDS, 1997). Note the progressive rise in the prevalence of chronic malnutrition with increase in age. This suggests that children become vulnerable when they begin to share the family's eating habits. Graph 3 also makes it clear that the prevalence of acute malnutrition (measured according to the weight / height index) is low.



Graph 3: Children's nutritional status < 3 years, mean divergence from the reference (z score) by age, IDSM 97.

A/I = Height for Age (chronic malnutrition).

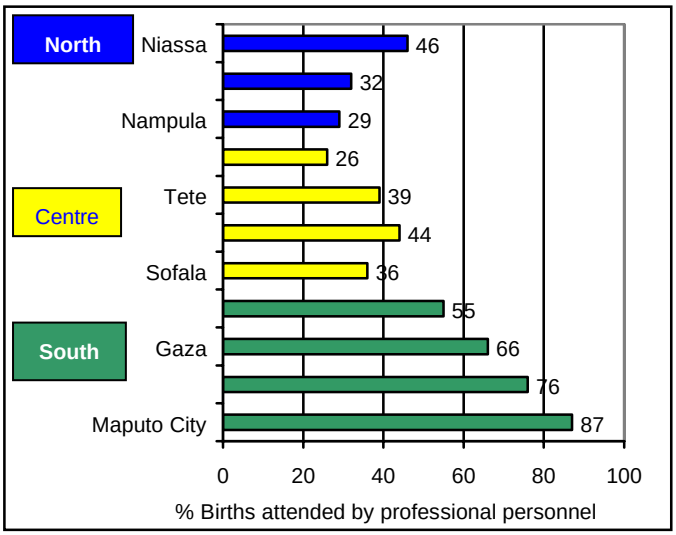
P/A = Weight for Height ("acute "malnutrition).

iii) **Unfavourable environment** to good health, particularly in the large cities, partly due to over-population, poor treatment of litter and human excrement and the presence of stagnant rain water due to poor drainage. The fact that cholera, meningitis and dysentery have become endemic is in part due to MISAU's inefficient advocacy concerning these determining health factors. It is also due to other sectors' difficulties in complying with their mandates in the spheres of urban organisation, rainwater drainage, waste removal and processing and unhygienic food vending in the informal sector, among others. Citizens' habits and behaviour (related to their level of education and socio-economic status) also contributes to perpetuate this situation.

iv) The **Limited supply of drinking water,** which only reaches approximately 25% of the country's population is another factor. Water is essential for improving individual and collective levels of hygiene. Water treatment is also important to prevent the transmission of diseases.

v) **Regional disparities in access and consumption of health care.** Inequalities in access to health care between regions of the country and between the countryside and city have been well documented. These disparities originate in the socio-economic, cultural and historical factors of the various regions in the country and in the sub-continent. There are substantive differences in the consumption of obstetric services between different regions of the country, as presented in Graph 4. In the southern region, the lowest coverage (55%) is higher than the coverage rate in any of the central and northern provinces. The cause of these differences may be unequal development and availability of health resources between regions, and cultural factors and behaviour interacting with one other. It is important to note that a similar pattern can be observed in education levels, another important determining health factor.

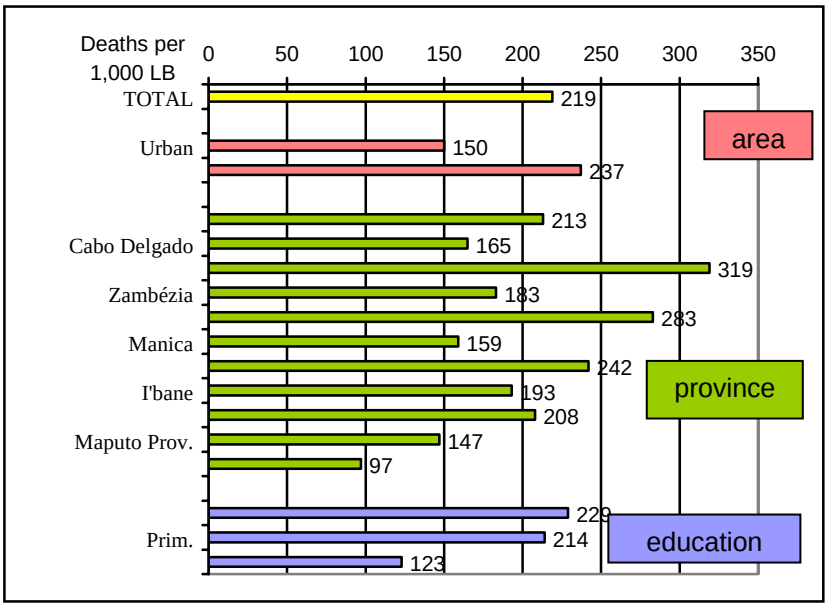
Graph 4: Childbirth attendance by a doctor or midwife by province ISDM, 97.



Gender equality and poverty

The epidemiological profile described above represents a social burden of illness which disproportionately affects certain more vulnerable groups: women, children and those living below the poverty line.

Despite the efforts of the Health Programmes, it is women and children who suffer from the principal health problems in the country, with high registered levels of morbidity and mortality. For example, the infant/child mortality rate (under 5 years old) is excessively high, with differences linked to the mother's place of habitation and educational level, as illustrated in Graph 5. These discrepancies were also revealed in the household survey's findings concerning access to basic educational services, inferred from illiteracy levels of the over-15s (IAF, 96/97).



Graph 5: Infant/Juvenile mortality rate, by selected socio-demographic characteristics of the mother, by province, IDSM, 97.

The illiteracy rate among women is higher than that amongst the population in general. This suggests gender inequity in access to education (Table 2). Note the correlation with infant mortality (0-11 months).

Province	% illiterate women and men > 15 years	% illiterate women > 15 years	Incidence of poverty (%)	Infant mortality per 1,000 LB
Rural Zones	**72.2**	**85.1**	**71.2**	**160.2**
Urban Zones	**33.3**	**46.2**	**62.0**	**101.2**
Niassa	69.0	84.2	70.6	150.7
Cabo Delgado	75.0	88.5	57.4	174.4
Nampula	71.7	85.9	68.9	172.8
Zambézia	70.3	85.2	68.1	183.2
Tete	66.8	81.0	82.2	127.4
Manica	57.7	74.8	87.9	143.8
Sofala	56.2	73.9	62.6	134.0
Inhambane	54.2	66.4	82.6	114.1
Gaza	52.7	63.0	64.7	117.7
Maputo Província	34.3	45.9	65.6	85.4
Cidade de Maputo	15.0	22.6	47.8	60.5
National average	**60.5**	**74.1**	**69.4**	**145.7**

Source: PARPA, 2nd draft, version B, 2001

Table 2: Distribution of Poverty index and illiteracy rate by province

There are also related factors influencing physical access to health care. These are referred to below in the analysis of the referral system, namely the communications and transport network.

Health Care

The National Health Service: Referral System

The Mozambican National Health Service (SNS) comprises the public sector, the private profit-making sector and the private non-profit-making sector. To the present day, the public sector is the National Health Service's major health care provider at the national level. The SNS is organised into four levels. Levels I and II are the most peripheral, implementing the CPS strategy and receiving referrals for clinical conditions which cannot be treated at level I (such as complications in childbirth, trauma and medico-surgical emergencies). Levels III and IV are fundamentally designed for more specialised curative care, and can receive referrals from the lower levels. Over the past ten years, the referral system has been distorted, resulting in the poor performance of the most peripheral units. These levels operate below the minimum standards, mainly due to the war and the economic situation in the country over the past two decades. In the health units, this situation is characterised by chronic shortages of supplies essential for health care provision which has negative repercussions on quality, particularly in rural areas. As a consequence, the referral system is presently barely operational, and patients frequently use any level of SNS provision. The weakness of the most peripheral levels (health centres and rural / general hospitals) can also be attributed to:

i) Inequalities between health teams, particularly the poor qualifications of professionals working in the most remote regions;
ii) Continual and chronic lowering of employees' morale, motivation and professional ethics, as a result of difficult working and living conditions and low salaries;
iii) Unhygienic infrastructure in a poor state of repair;
iv) A lack of basic equipment, or poorly functioning equipment;

v) Inadequate supervision by higher levels;
vi) Users' perceptions that health care is of poor quality.

On the other hand, the referral system is based on the premise that the territorial distribution of referral units should be more equitable and that the health units should possess conditions and means to evacuate patients, at least the most urgent cases. To develop the secondary hospital network, conglomerations of districts surrounding each rural/general hospital will need to be created, serving a health area corresponding to about 500 to 600 thousand inhabitants.[10] To implement this idea, 35 rural / general hospitals should be operating countrywide. Presently SNS runs 27 units of this type, many of which perform far below the minimum criteria and requirements established by the regulations. The hospitals are unevenly distributed throughout the country.

Besides the spatial distribution and performance of rural / general hospitals, the communications and transport network is important to the functioning of the health care provision system organised by level and was one of its fundamental presuppositions. Owing to difficulties in road transport, long distances between peripheral units and referral units and the absence of regular transport between the districts and localities, physical access to referral units has been severely limited. At present, the referral system organised by level is not practicable for reasons mentioned above. The situation needs to be re-examined with the aim of exploring viable alternative means of offering health care, including options such as the use of mobile land or air units, at least temporarily.

The consequences of the partial collapse of the referral system are:

i) Overloading the hospitals that provide specialist services (principally in urban zones) because of increased demand for health care at this level;
ii) The provision of high cost basic health care which could be provided at a lower cost, resulting in constant increases in the costs and expenditure of the large hospitals;
iii) Lowering of the quality of services in referral hospitals. The situation in the hospitals is likely to worsen due to the increased morbidity associated with HIV/AIDS, particularly if treatment at the peripheral levels does not improve considerably.

Private Sector

The profit-making private sector is developing gradually, especially in the large cities. There has been a growth in private individual and collective practices specialising in different areas. The continued growth of these businesses is dependent on an increase in household incomes.

The present health policy recognises the role of the private sector in providing health care. Policy declarations concerning the promotion of partnerships with other participants in the health market have not been implemented in practice nation-wide, and public-private partnerships have not been explored sufficiently.

Treatment in special clinics in the public sector has been seen as a public subsidy for private activity, competing unfairly with the private sector. One of the advantages cited for special clinics is that they help to retain qualified professionals (specialists) in the public sector. These professionals play a teaching role as well as providing health care. A recent study carried out into this type of activity clearly revealed a need for more transparent regulation and management. The present consensus is that management models should be combined for this type of service, as long as they do not prejudice routine service provision and access for citizens with limited purchasing power.

Health care in the non-profit-making private sector is essentially provided by foreign Non-Governmental Organisations (**NGOs**) and some religious groups, in agreement with MISAU. The national NGOs are gradually developing and implementing essential

community health care programmes in the areas of prevention, disease control, and education and information. These partnerships have not attained their maximum potential, particularly in the most disadvantaged regions. Health care provision could theoretically be increased by the involvement of individual players supported by MISAU, such as retired people.

The non-allopathic Sector

This sector includes practitioners of traditional medicine, herbalists and more recently some practitioners of ayuverdic medicine. Classifications for this type of practitioner are out-of-date. Although the present health policy is in favour of collaborating with the traditional medicine sector, in practice few advances have been made apart from some collaborative research into medicinal plants. MISAU does not have the instruments to fulfil its mandate of protecting citizens against certain practitioners who claim that they are able to treat illnesses such as AIDS. It is possible that there are medicinal plants which can ease and perhaps cure illnesses, but these practitioners' claims require objective scientific scrutiny which can only take place after appropriate studies have been made. As HIV/AIDS is a very serious problem for society, unproven claims to cures for the disease could conflict with the government's efforts to educate people and change their behaviour. The potential of partnerships and collaboration with traditional medicine practitioners and other non - allopathic agents who provide diagnoses and treatment remains to be explored, particularly as a significant proportion of Mozambicans use these types of services exclusively or in conjunction with SNS services.

Community Health Agents

The quality and quantity of acting Community Health Agents (ACSs) is unknown. It is estimated that some of these agents are in some way linked to the SNS and others to NGOs. They are not always recognised by SNS because of their different levels of training, because they are not certified and/or because of the services they provide. The issue of Community Health Agents raises the problem of health care access, mainly in the more remote, sparsely populated areas of the country. These agents may provide the only form of health care in these areas, giving rise to questions of capacity-building, supervision and evaluation. Traditional Birth Attendants usually maintain links with SNS and have increasingly demanded a contractual relationship. The appropriateness of training Traditional Birth Attendants has been debated as a secondary strategy to reduce complications in childbirth and maternal mortality.

Municipalities

Health care provision in the Municipalities is an issue in need of greater clarification. In principle, the Municipalities should gradually assume a more visible role in providing basic health care. The possibility has been discussed of devolving the responsibility of CPS to the Municipalities but the details of such devolution need to be better defined. There is a risk that some of the gains that SNS achieved when providing CPS would be lost if the process of devolving the Municipalities was poorly planned. It is important to ensure that devolution does not aggravate inequity of access to CPS. This is an area which needs to be carefully examined.

Hospital and District Management

The district is seen as the basic level for health programme planning and implementation. The Government and MISAU's commitment to expanding CPS throughout the whole country signifies that the sector must undertake an extensive training effort for health care professionals. The majority of personnel affected in the districts are professionals in specialised areas who also assume health management and administrative roles. Until very recently, the sector tended not to admit specialists from different management areas (such as economists, accountants and managers) and other categories of managers and administrators in general. During the process of building the SNS, MISAU trained some professionals in the areas of management of health and social units, but the quantities of trained personnel still fail to meet the global requirements of the sector. The question is currently being asked whether MISAU

should involve itself in training hospital managers and administrators and others at a time when specialised training institutions are appearing in the market in these areas. The training of doctors is the responsibility of the faculties of medicine (education sector) while the role of MISAU (the main beneficiary at present) is to provide training placements and to facilitate the teaching process for professionals they employ.

Another factor responsible for the shortage of this type of professional is the supply of better-paid jobs in the market. Given the present state salary structure, the health sector is unable to compete. As a consequence, the management capacity at district level is severely limited due to the shortage of human resources. The present management systems do not ensure that employees are given increased responsibilities. They do not provide incentives for better performance, particularly in financial management and the use of available information when taking decisions.

The situation in the hospitals is more complex. To a great extent, the SNS hospitals' income level is low. The specific management problems in the large hospitals deserve a closer analysis. Some of the SNS hospitals are in a very poor state of repair. There are various problems with infrastructure, medico-surgical equipment is inadequate and the general catering equipment is non-existent or in an advanced state of disrepair.

The perceived quality of curative health care has been questioned by different sectors of society and recently the media have focused on this issue. The problem will be treated in following chapters: it is a very sensitive issue which involves the analysis of many variables.

Human Resources

By the middle of the 1990s, during the implementation of the Human Resources Development Plan (PDRH), the structure of the SNS work force was characterised by an excessive proportion of elementary and basic level technical personnel with a smaller percentage of medium level and university-trained personnel. The PDRH successfully corrected this distortion, according to its objectives. A PDRH evaluation report[11] states that the proportion of medium level personnel increased considerably while the proportion of university-trained personnel rose slightly (see Table 3).

Table 3: Development of Human Resources (90 - 99)

	1990		1997		1999		2000		Difference 1990-2000
	No.	%	No.	%	No.	%	No.	%	
Higher	207	**1,3**	424	**2,7**	568	**3,8**	583	**3,7**	376
Medium	865	**5,4**	1.989	**12,9**	2266	**15,0**	2.489	**15,6**	1624
Basic	5.197	**31,2**	4.264	**27,5**	4409	**29,2**	4.635	**29,1**	-562
Element.	1.660	**10,3**	1.583	**10,2**	1597	**10,6**	1.679	**10,5**	19
Auxiliary (1)	8.231	**50,8**	6.857	**44,2**	6242	**41,4**	5.030	**31,6**	-1691
Others (2)			383	**2,5**		**0,0**	1.510	**9,5**	
TOTAL	16.160	**100**	15.500	**100**	15082	**100**	15.926	**100**	-234

Sources: PDRH 1992/2002 and SIP. N.B. there are at least several hundred individuals contracted locally or waiting to be posted. Auxiliaries: Health Unit functionaries; Others: also includes basic level employees such as heavy vehicle drivers.

Despite these developments in training and promoting personnel, the sector still has a significant shortage of qualified personnel. The shortage is particularly acute in the areas of general and specialised hospital health care. Shortages are even more severe in the sphere of management and administration where the situation has negative effects on the global efficiency of SNS, particularly at district level. Another fact which is illustrated in Table 3 is that the proportion of elementary personnel has not changed

significantly and the reduction of the proportion of basic level staff is mainly due to their promotion to the medium level by means of formal training. This has had consequences for the health units which employ nurses and other personnel at this level who leave to participate in medium level courses. To rectify this situation, elementary level personnel training was resumed after an interruption to increase personnel qualification levels.

Human resources problems in the health sector can be summarised as follows:

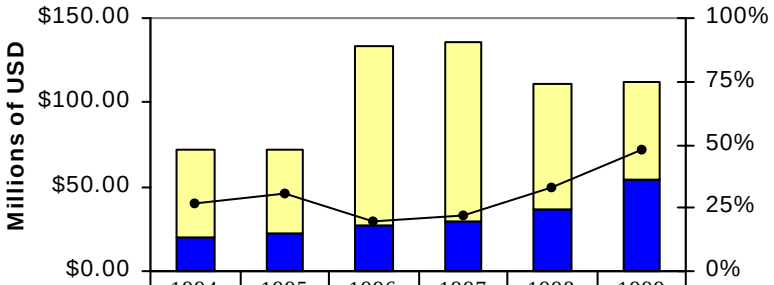
i) Distorted distribution of professionals, with most qualified personnel concentrated in urban areas;
ii) Poorly qualified work force, where only 18% of personnel have higher and medium level training;
iii) Low quantity and quality of professionals in the management area;
iv) Poor personnel management and placement;
v) Complex process of career advancement.

Financial Resources

Chronic under-financing of the sector explains the majority of the sector's shortfalls, and was one of the factors that accelerated the need for reform. However, Government financing has risen substantially as shown in Graph 6.

This effort still fails to satisfy basic health needs. In fact, in 1997 total expenditure per capita in the health sector was estimated at 8.84 USD of which 1.97 USD corresponded to Government expenditure[12]. This level of expenditure is manifestly lower than the World Bank's estimated 12 USD per capita[13]to finance the basic service package, and the 9.24 USD per capita estimated by the World Health Organisation[14] to fund level I and II health care. According to the same study, per capita expenditure for levels I and II was 2.24 USD in 1997. Another issue which this study brought to light is that since 1994, health funding from the state budget has tended to increase while international assistance has decreased (Graph 6)[f].

Graph 6: Government and International Assistance financing tendencies between 94 and 00 (USD) in budgeted sums *(Source: MISAU-DAG, exchange rate: BdM See: Glossary)*



	1994	1995	1996	1997	1998	1999
Internal Funds	$52.44	$49.59	$106.83	$106.69	$73.94	$58.34
External Funds	$19.61	$22.17	$27.02	$29.41	$37.08	$54.33
% IF of Total	27%	31%	20%	22%	33%	48%

This graph clearly demonstrates the Sector's high level of dependency on external financing. The Medium Term Financing and Expenditure Framework concluded that external funds essentially cover investment programmes and projects.

Cost recovery is a common practice in SNS, and the proportion of costs recovered has risen continually. Prices charged by SNS are mostly far lower than the actual prices and

[f] Medicines and other current expenses of investment projects are not included in these current expenses.

costs of internment, medicines and examinations, with the exception of prices charged by the specialist clinics. Payments are made at various points in the health units, a practice which tends to encourage misappropriation.

About 3% of MISAU's total expenditure is recovered[15]. According to the funding study mentioned above, about 10% to 35% of interviewees said that they had not used health services because they could not afford to in the two weeks preceding the survey. Financial planning in the sector is hampered by a lack of objective information about the costs of services at different levels.

Pharmaceutical Area

The chronic under-funding of the public sector leads to shortages of medicines, medico-surgical supplies and laboratory reagents in the public health centres. In the private sector, the number of private operators is growing throughout the country, particularly in the large cities and their suburbs. There are accounts of exorbitant price systems practised by private pharmacies. Inspection activities are presently ineffective largely due to the shortage of inspectors and the absence of specific programmes in this area.

The situation in the SNS pharmaceutical sub-sector is characterised by:

i) Limited resources for purchasing medicines (about 1.99 USD per capita is spent on medicines);
ii) Frequent lack of pharmaceutical and reagent stocks;
iii) Excessive dependency on external financing;
iv) The sub-sector has attempted to improve co- ordination in the areas of planning and pharmaceutical purchasing. This has been done by adopting a common fund whereby all partners participate in the pharmaceutical management cycle.

The large hospitals have absorbed a large proportion of total expenditure on medicines, partly due to the fact that levels III and IV consume more expensive pharmaceutical products and medical supplies.

The levels III and IV hospitals together spend approximately 58.4% of the total volume of pharmaceuticals and medico-surgical materials distributed countrywide. At present, a framework is being designed to proportionally increase expenditure on level I and II medicines until 2005. This type of medicine distribution framework will be in line with the priority given to levels I and II and with the government's programme for alleviation of absolute poverty.

Partnership and the role of the community in health administration

Community participation is considered important for health promotion but the exact role of the community in health administration matters has not been clearly defined. There have been many experiences of community participation throughout the country, and the innovative and positive ones should be systematised and disseminated. In general however, the role of the community is presently one of passive collaboration.

Health care provision

CPS is still the dominant strategy of health intervention to reduce the high mortality and morbidity rates caused by the main communicable diseases, namely malaria, STD/HIV/AIDS, tuberculosis, leprosy, diarrhoea and acute respiratory infections. Reproductive health problems associated with high levels of maternal mortality are also priority areas within the Sector's programme. All interventions under the ambit of CPS are important components of PARPA.

From the end of the 1970s to the mid-1980s, Mozambique accumulated valuable experience from the implementation of the CPS strategy. The foundations for health care provision were very solid and helped to prevent the total collapse of the system during the war and post-war years. The war and its effects on the economy caused an

acute, chronic crisis in the supply of resources for the health sector which was reflected in CPS services and the sector programmes in general. In parallel, efforts to expand the health network brought about significant increases in the sector's productivity i.e. an expansion in the coverage of the third DPT (Diphtheria, Whooping Cough and Tetanus) dose and of health units per inhabitant (Table 4).

Table 4: Selected indicators from 1995 to 2000.

	1995	1996	1997	1998	1999	2000
% CS/PS with Kit A/B *		40%	88%	84%		86%
% CS/PS with trained personnel *	70%		86%			93%
DPT Coverage (3rd dose) *	57%	59%	63%	77%	81%	92%
Health Units/inhabitant	2.47	2.54	3.13	3.09	3.26	3.44
Inequity of Access Index *	5.40	3.60	3.40	3.60	3.50	3.60

Data from the Pharmaceutical Department and Health Information Department. * are PFP and enhanced HIPC initiative indicators. (March 2001). Data from 1999 and 2000 are still incomplete and could be subject to alterations.

There has also been an improvement in the availability of medicines and qualified personnel which indicate improvements in certain aspects of quality. The inequity Index has decelerated over past years which could be due to various factors. Data for 2000 has still not been consolidated, and the loss of part of the provincial health network in the 2000 and 2001 floods needs to be considered. The management of the principal Health Programmes is still organised vertically although the integration process began almost five years ago. The activities of these Programmes have mainly been aimed at levels I and II and focus on the illnesses described below:

Malaria is hyper-endemic in Mozambique and related illnesses (e.g. anaemia) are the main causes of sickness and death among children under five, together with diarrhoea and acute respiratory infections. The large-scale use of insecticides was abandoned (with the exception of certain regions) due to the results of entomological studies. Very recently the use of mosquito nets treated with insecticides has been introduced. Malaria is a common cause of premature death. The ' **Roll back Malaria'** campaign launched by WHO a few years ago is a window of opportunity to accelerate the fight against this disease.

The **HIV/AIDS** pandemic is a worrying reality. Over the past five years, the number of registered cases has risen vertiginously. PNC's estimates for STD/AIDS indicate that up to the end of 1998 there were 1,140,000 people infected with HIV with a prevalence of 14.5% among the adult population (people over 15 years old). Three important factors should be considered when analysing the epidemiology of this disease:

i) HIV/AIDS infection is spreading in groups with high-risk behaviour and among the population in general;
ii) Children and women are the worst-affected groups;
iii) The heterogeneous distribution of HIV-positive cases suggests that the HIV/AIDS epidemic will present itself in a dispersed form.

An exhaustive analysis of the evolution of HIV/AIDS and associated factors is presented in the Strategic National Plan for Combating STD/HIV/AIDS document which the government approved at the end of 1999. The STD/HIV/AIDS Programme is a high priority and its approach emphasises the need to mobilise the whole of society to confront this serious problem.

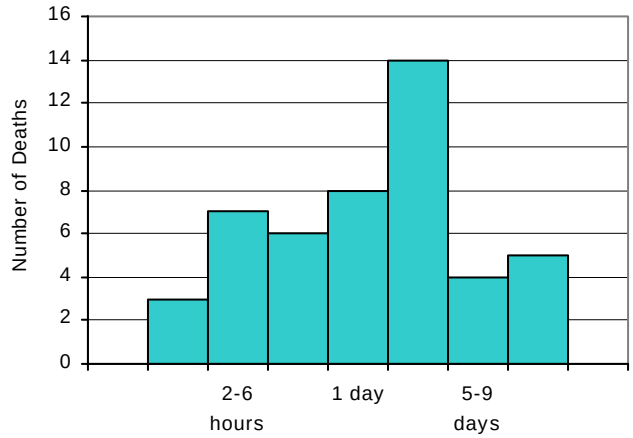
Tuberculosis is one of the major endemic diseases in Mozambique, and the fight against it is another of MISAU's priorities. The annual rise in cases of tuberculosis may be explained by the increase in notification from the districts and also by the AIDS epidemic which is associated with a higher incidence of tuberculosis. The implementation of this Programme has produced encouraging results, but it will be

necessary to ensure that the reform processes (devolving the Municipalities, for example) and the continuing rise of HIV/AIDS do not reverse these gains.

Despite the 50% reduction in cases of **leprosy** by 1999, Mozambique is still among the countries worst-affected by the disease. It is the second most endemic country in Africa (after Nigeria) and the seventh in the world. The Mozambican government subscribed to a resolution to eliminate leprosy as a public health problem. The term 'eliminate' refers to the WHO definition: a reduction in the prevalence of leprosy to a level which no longer constitutes a public health problem, i.e. a rate lower than 1 case per 10,000 population at all levels (national, provincial and district).

Community health

Attention to women of reproductive age, (including adolescents, young people and children) is being directed, executed and supervised in an integrated, complementary manner with mutual reinforcement to increase effectiveness and profitability.



Graph 7: Time taken to seek health care and maternal deaths in Mozambique,1998/9.

Considering the high maternal mortality rates mentioned above, the present approach to reduce these deaths is to increase the supply and use of essential basic and complete obstetric services so that all women with obstetric complications have access to these service and receive timely, good quality services. This increase in supply will be brought about by implementing a referral system between levels of attention, principally between levels I and II. The role of Traditional Birth Attendants will be the object of a study as mentioned in the section concerning community health agents. Recent studies of maternal death rates suggest that there are other factors which influence the demand for obstetric health care. These must be considered when adopting strategies (Graph 7).

Basic Health Care and Quality Assurance

MISAU has still not established a basic health care package which should be gradually made available to every citizen throughout the country.

The practical consequences of this package must be considered, in terms of the composition of teams, the materials necessary to provide services as well as the financial implications. The package should be designed in keeping with the Integrated National Programmes.

The quality of health care is mentioned as a priority in MISAU's policy declarations, and has been questioned by different sectors of society. Quality analysis will focus on structure and processes and the results and impacts (Donabedian's quality

measurements[16]) will be addressed under the ambit of the monitoring and evaluation systems.

Structure refers to infrastructure where the process of health care provision is carried out, and also includes human resources, equipment and other materials necessary for good health care. These issues have been covered in earlier sections of this document. The process relates to the activities carried out to provide health care or, in other words, the optimal combination of resources and technologies (which do not have to be sophisticated) to achieve certain ends. It also considers users' expectations and their behaviour in obtaining health care. The results refer to the effects of various health interventions. There is presently some anecdotal evidence of certain health professionals having ethically questionable attitudes when providing health care. Although progress has been registered in certain areas, there is evidence that the impact / results achieved in other areas could be improved.

Health Advocacy

Health advocacy includes every intervention that influences factors that determine health, which are not MISAU's direct responsibility. Examples are as follows:

- Sanitation and drainage of areas of stagnant water that reproduction of vectors for malaria;
- Supply of safe drinking water;
- Educating the population in general and women in particular;
- Adequate, balanced nutrition;
- Control of road and rail traffic;
- The use and abuse of tobacco, alcohol and drugs;
- The communications and transport network;
- Women's social and economic status.

Advocacy encourages the various sectors and partners to implement actions that promote health, and counts on the proactive involvement of the health sector in partnership with other social sectors and agencies. In some cases it uses legal and fiscal instruments to create incentives for practices that lead to good health and disincentives to practices that endanger health.

At present, MISAU has made little use of the legal instruments at its disposal to comply with its mandate as the agency with technical authority in health matters. One of the main constraints may be its poor capacity to enforce regulations. There are already some positive experiences of health advocacy, for example, the work of the groups promoting the fight against HIV/AIDS. MISAU recognises that communication is an important area for health advocacy. Communication is one of MISAU's three essential priority public health functions, namely: Information, Education and Communication.

At present, communication is implemented erratically, and the way in which this function has been institutionalised suggests that MISAU has not fully recognised its importance.

Structure, organisation and management culture

In common with other sectors of the state apparatus, MISAU's management is excessively hierarchical. Superior levels have authority and control over the execution of programmes and plans designed for central levels. In recent years the more peripheral levels have played a more active role although where decision-making power has been transferred to peripheral levels, there is a certain inertia resulting in the centralised management of the sector. Centralised management in itself need not be negative, but the practice of this type of management has often been inefficient (such as human resources management). It needs to be recognised that the choice is not between centralisation and decentralisation but between approaches that lead to more efficient and flexible management, and meet citizens' expectations under the present

circumstances. Such approaches should be uniform in every sector of State Administration.

Vision

The Sector's vision is inspired by the national social and economic development plan. Over the coming 25 years, the Sector envisions 'achieving health levels for Mozambicans that approach the average in Sub-Saharan Africa, with access to good quality basic health care through a Health System that meets citizens' expectations.'

Insert 1: Mission Statement

Mission Statement

MISAU's mission consists of realising the sector's vision. The vision encapsulates the citizens' rights to medical and health assistance and their obligation to promote and defend health, consecrated in article 94 of the Republic's Constitution. Implicit in the declaration is the recognition that this right, for various reasons, is still not universal and is a target that should be gradually worked towards.

MISSION

To promote and preserve the health of the Mozambican people, promoting and providing good quality, sustainable health care which will gradually become accessible to all Mozambicans with equity and efficiency.

Guiding Principles

The guiding principles indicate the way in which priorities are identified and policy is formulated, implemented and evaluated. The sector interprets the principle of **EFFICIENCY AND EQUITY** in terms of maximising benefits obtained from the use of available resources. This is a principle which guided health policy revision on the eve of peace in Mozambique.[17] In this context, the benefits are good quality, sustainable health care distributed equitably. The benefits in terms of health should be measured in reductions in the burden of disease in society. Viable measures of the burden of disease should be developed to achieve a more objective evaluation of the benefits, particularly for assessing the impact of interventions on disadvantaged groups, and to judge how far the objectives of the fight against poverty have been attained. Equity also includes the gender perspective: a method of objectively monitoring and assessing gender inequalities also needs to be devised.

GUIDING PRINCIPLES

EFFICIENCY AND EQUITY

FLEXIBILITY AND DIVERSIFICATION

PARTNERSHIP AND COMMUNITY PARTICIPATION

TRANSPARENCY AND ACCOUNTABILITY

INTEGRATION AND CO-ORDINATION

Under present circumstances, MISAU plans to base health care provision on the principles of **FLEXIBILITY AND DIVERSIFICATION** in order to take advantage of the opportunities offered by other agents already operating in the health market. The intention is to increase the options within a health care package. This principle includes the free choice of provider by health service users.

Insert 2: Guiding Principles

The decentralisation of certain functions and responsibilities in the sector as seen as an essential way of improving efficiency and creating the opportunity for more significant and active community participation. These are the reasons for adapting the principle of **PARTNERSHIP AND COMMUNITY PARTICIPATION**. Community participation can improve the quality of services and offer the communities a chance to influence their

individual lives more directly: **empowerment!**. The question of decentralisation will be treated below in the analysis of institutional development.

TRANSPARENCY AND ACCOUNTABILITY intend to contribute towards a more clearly articulated system, for example through contracts which should encourage good performance. The information system should, as a consequence, include provision indicators (of quantity and quality). The separation of provision functions on the one hand, and of financing and regulatory functions on the other (a long term objective) should improve transparency and accountability. In this context, the contract could be, for example, an annual plan of work or another programming instrument which should be adopted by consensus.

INTEGRATION AND CO-ORDINATION is necessary for the optimum implementation of any sectoral policy. Co-ordination implies adjusting tasks and responsibilities according to the global strategic mission. The aim is to avoid duplication and incompatibility and promote functional efficiency. Co-ordination and integration should exist in both in the Ministry of Health and between the Ministry and its external partners. The absence of co-ordination weakens the ability of all these bodies to achieve their maximum potential, and is inherently inefficient.

MISAU's Role

At present, MISAU and SNS tend to be confused with each other. MISAU is responsible for formulating policies and strategies. It is the financing agent and also the direct health service provider. It is also the responsibility of MISAU at its various levels to regulate the sector and the governmental and non-governmental agents that provide health care.

Separating the regulatory, financing and provision functions has been approached timidly up to now, and has achieved no obvious results. It is clear that new ideas gain greater clarity if MISAU concentrates its efforts and attention on strategic issues and defining standards and norms. This implies the gradual (functional) separation in the medium and long term of MISAU's direct health care provision component, which at present is being implemented by SNS. This change in MISAU's role necessitates a very close examination of its structure and human resources, particularly at the central and provincial levels.

This redefinition of MISAU's role is part of a much wider reform of state apparatus and public administration. Decentralisation has implications for defining the mandate of different MISAU bodies at different levels. The institutional development plan, an integral part of PESS, will present the decision-making approach in more detail.

Insert 3: Quotation by Prime Minister, Dr. Pascoal Mocumbi [18]

...”We want a Public Sector that transmits efficiency ... a new culture for public administration should be developed that allows us to advance in the direction of a market system.”...

Prime Minister, Dr. Pascoal Mocumbi (1998)

This introduction allows us to appreciate that we are dealing with a complex issue. There is not enough objective evidence for more informed decisions to be taken. The government's position has been made clear through declarations by its high-ranking members (see Insert 3).

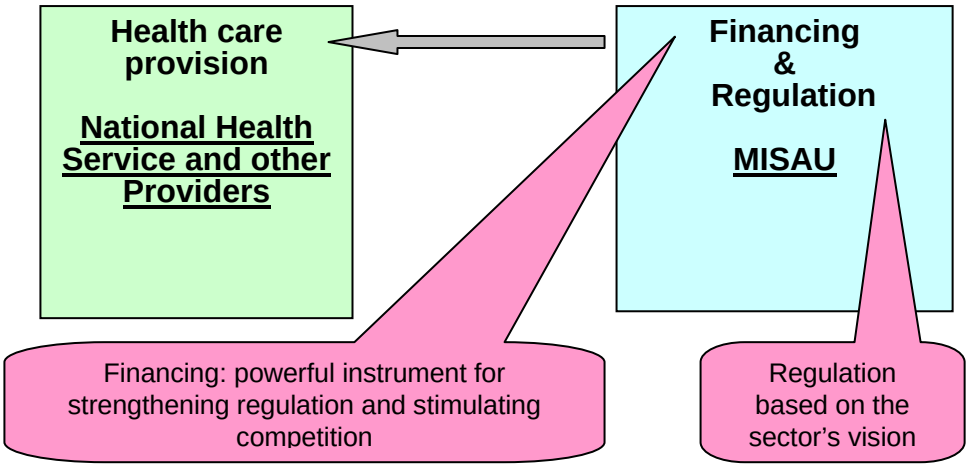


Figure 3: The functions of MISAU's provision and regulation in relation to health care providers.

The separation of functions clearly establishes the roles of the different participants in health care provision. It implies changes in the role of MISAU emphasising the principles of transparency and accountability.

PESS should guide all the sector's participants and internal and external partners when carrying out their programmes and activities. Its objectives are as follows:

- Guide MISAU in managing the sector more coherently, and in managing the changes which sector reforms will bring about with the minimum disruption to health care provision;

- Provide an agenda for the next 5 years to guide collaboration between MISAU and its partners in implementing the process of national health development;

- Clarify and attribute sector priorities in line with the poverty alleviation policy.

Part II focuses on key issues which are presently considered to be priorities. PESS is intended to provide general guidelines without detailing activities or nominating all the participants in the process of providing health care. The following section of PESS begins with the framework proposed in Figure 3 and describes aspects of health care and individual and collective strengthening, including gender issues. It also covers health advocacy, institutional development (structure), resources (financing strategy, medicines and personnel) and the support system.

Part II: Preparation of Key Issues

A. Health Care

A.1. Access: consolidation and equity of access

Analysis of the situation and definition of the problem

After almost a decade of reconstruction and rehabilitation, the Health Sector faces fundamental concerns over its functioning. The Sector is influenced by external circumstances over which it has little control: free market forces, the dynamics of a young democracy and the growing diversity of external partners.

Besides this, MISAU needs to establish norms and standards and monitor the public and private sectors more effectively. The rights and obligations of users are not adequately established and those that exist are not well known. The legal system is ineffective in its treatment of malpractice and SNS interventions that result in harm or death. There is no register or transparent accreditation of health professionals, which are essential for professionals' and users' protection.

Policy

In order for MISAU to respond more efficiently to the environment of rapid change, it should be guided by the needs of its users, and more importantly by the needs of non-users. It is important to canvas the opinions of (potential) beneficiaries and explain the nature of MISAU's mandate i.e. its objectives and how it mobilises other sectors to achieve the common good: HEALTH.

MISAU plans to consolidate and reconstruct, with an emphasis on improving quality and creating more equitable access to health care. Expansion should only take place for reasons of equity.

Strategies

- Formulate an Investment Plan based on criteria for allocating resources that improve equity of access;
- Formulate a legal document concerning the rights and obligations of National Health Service users;
- Formulate a statute for medical professionals and paramedics to protect them and regulate their profession;
- Provide incentives to create organisations that formally defend user's interests;
- Explore the possibility of creating a tribunal based on arbitration laws. This will be aimed at resolving conflicts under the ambit of regulations specified in the legal documents mentioned above.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

The development of an Investment Plan will depend on a consensus over the classification of the health network.
MISAU depends on co-operation with the Ministry of Justice to develop juridical activities.
The co-operation of civil society is essential to provide spokespersons for users.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Investment Plan: see EHTP and Financing Strategies.	X					DPC & DNS
Formulate a legal document on the rights and obligations of the SNS users.		X	⇒	⇒	⇒	Legal Advisor & DNS
Formulate a statute for medical professionals to protect and regulate them.		X	⇒	⇒	⇒	Legal Advisor & DNS
Encourage the creation of a formal representation of user's interests to defend the user.			X	⇒	⇒	DPC & DNS
Explore the possibility of creating a tribunal based on arbitration laws to resolve conflicts under the ambit of the regulations specified in the legal documents mentioned above.			X	⇒	⇒	Legal Advisor
Resources required:	Capacity-building within the Legal Advisor's Office: provision of Technical Assistance					

A.2. Gender[19,20,21,22,23&24]

Analysis of the situation and definition of the problem

The gender issue should be analysed from the point of view of social justice and human rights. In this context, one of the most important aspects is related to possible discrimination in access and use of health services associated with gender. This discrimination may originate in the health services themselves or from within the family[25]. Although there is no evidence of any differences in access practised in the health services, certain health professionals' attitudes may reduce the consumption of certain services (such as childbirth). The pattern of consumption of services by gender and associated factors are not sufficiently well known. Such knowledge is instrumental in designing more solid policies based on evidence.

It is known that certain types of health problems affect women and men differently. For example, in Maputo[8] in 1994, out of the total 316 people killed in road accidents (adults aged between 15 and 59) 80.6% were men. Out of the 189 homicides that occurred during the same period and age-group, 88.8% of the victims were male. On the other hand, the high death rate associated with illegal abortions, violence against women (including sexual assaults) and the disproportionate prevalence of sexually transmitted diseases that affect women are significant public health problems. These situations clearly show that the gender dimension should be incorporated in the conceptualisation of health care.

It has been reported that socio-cultural, religious and ethnic problems are determining factors which contribute to gender inequality in Mozambican society, with negative repercussions for health. Access to pre-natal and childbirth care and the decisions about the choice of health care are examples which illustrate this assertion. Although Mother/Child health is a priority in Health Sector policy, efforts that have been made under the ambit of the Mother/Child Health Programme have not lived up to women's expectations. Access to institutional deliveries is low and does not reflect the efforts made in reconstructing and expanding the health network.

Policy

Strengthening the gender perspective in every health programme is essential if a more just and socially equitable policy is to be implemented. A more equitable health policy should be based on the principle of equality of access and use of health services by both sexes, taking into account the health problems which have the greatest negative impact on society.

Strengthening women and men in society should aim to give them both greater control over their own lives and destinies. Above all, men and women should be informed about their rights relating to crime (violence, sexual assault) and reproduction.

More detailed knowledge about the gender equity problem is needed to guide the Sector's activities.

Strategies

- Incorporate data about gender (access and use of health care) into the monitoring system.
- Carry out specific sociological research to analyse the relationship between gender and health in various regions of the country;
- Educate communities using community participation initiatives about health issues that are relevant to their lives, particularly mother and child health;
- Train health personnel at all levels about gender issues and their health implications, and the options for promoting gender equality;
- Disseminate and promote reproductive health rights and legal measures for protecting against sexual abuse and physical and domestic violence;
- Build alliances and communication with other sectors, institutions and NGOs at the national, regional and international levels to influence specific policies that promote greater equity in health, with particular emphasis on gender.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

To achieve greater gender parity more awareness and social education are needed about gender. Positive experiences of social gender equality should be shared and public opinion should be mobilised by means of social communication. Better knowledge of social, cultural and ethnic factors associated with inequality between women and men and a long term vision for achieving greater gender equality is essential for the success of this policy.

The present lack of a formal national gender policy hampers the incorporation, monitoring and evaluation of sectoral policies in this area.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Adopt policy and strategies	X					GdM
Define indicators	X					GdM & GTP
Training	X	X	X	X	X	GdM
Research	X	X	X	X	X	GdM
Dissemination/promotion of women's health rights	X	X	X	X	X	GdM
Resources required:	For research, training, policy dissemination and legislation.					

A.3. Quality Assurance [26,27,28&29]

Analysis of the situation and definition of the problem

Many aspects related to quality have been described in the analysis of the situation, namely, resources, infrastructure and the referral system. This part of the analysis will focus on quality assurance as well as SNS's management methods. Quality assurance for services is a relatively recent concept and was introduced experimentally in some health services nation wide. The difficulty that the sector has in guaranteeing basic supplies for health care meant that the adoption of specific plans for controlling health care quality took second place. For this reason there is presently little adequate technical and organisational support for quality assurance. However, there have been some positive experiences in quality improvements and training which permit preliminary guidelines for quality assurance policies to be formulated.

Policy

Quality should be seen as an integral part of Health services and as being essential in attaining the sector's general objectives. Quality management is one of MISAU's fundamental functions and a cornerstone of its mandate and mission. Quality assurance must be institutionalised, based on the positive experiences that already exist, using resources available to the sector.

MISAU should encourage and create a culture of improving quality at all levels of SNS, adapt quality assurance instruments and build the capacity of personnel to use them. MISAU should encourage the participation of all health professionals' associations in defining standards and criteria for improving quality and implementing initiatives. This should be done through a body that will be established for the purpose and directed by the National Health Department (DNS).

Strategies

- Gradually introduce quality management at all levels of SNS using Quality Assurance methodology;
- Define norms to approve appropriate instruments and increase provincial capacity;
- Encourage the creation of Quality Assurance groups in the central and provincial hospitals;
- Co-ordinate with supervision to improve technical quality;
- Carry out research and studies to examine users' and non-users' perceptions of SNS quality;
- Establish appropriate channels for responding to citizens' complaints;
- Identify priority services and programmes for quality improvement (e.g. maternity, medico-surgical emergencies);
- Produce educational material and encourage debate between professionals to promote a culture of quality for the services which need to be strengthened in the supervision process;
- In the long term, institute a certification and accreditation system for the Health System's health units, including the private sector.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

For implementation to take place, personnel need to be trained at the national and provincial levels, giving greater power to those provinces that already have some experience. A specific budget should be allocated for this activity which will mainly be carried out at DDS and health unit level. It is necessary to make a great effort to increase the analytical capacity of DDS so that opportunities for improving quality can be identified.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Define organisational aspects	X					DNS
Define indicators	X	X		X		DNS-DPC
Prepare teams at the national and provincial levels		X				DNS
Begin quality assurance processes		X	X	X	X	DNS
Revise aims				X		DNS-DPC
Resources required:	Long term Technical Assistance & working funds for technical capacity building course, specific projects and changes in the quality culture.					

A.4. Integrated Supervision [30,31&32]

Analysis of the situation and definition of the problem

From a technical point of view, supervision has been implemented inefficiently. Monitoring, retro-information and incorporating supervision into management systems as a way of resolving problems have all been poor.
Well-focused individual effort with positive results has been scarce at provincial level. In general, and at every level, the resources allocated to this activity are inappropriate and incorrectly used. Visits are carried out in the name of supervision with little or no impact on services. Supervision has the potential for raising employees' morale and improving skills, and raising the implementation of activities and the quality of services in the dynamic, collective processes of management improvement. Continuous training needs can be detected through supervision and the effects of training can be assessed. At present, many of these aspects are not recognised as people feel that supervision is actually an inspection activity.

Policy

Supervision is one of MISAU's basic tasks and should produce concrete results in improving services. It should be a permanent method of support and serve as a means of administrative follow-up to established plans. Supervision should be closely related to the monitoring processes, annual plans and the results of previous supervision. It should include technical aspects that focus on the preparation, implementation and follow-up phases at all levels of health care provision and management.

Strategies

- As far as possible, integrate supervision guidelines to allow implementation of the contents of priority plans with the knowledge of those being supervised;
- Develop criteria for determining the frequency of supervisory visits at all levels;
- Make resources available for carrying out supervision at all levels;
- Develop the capacity of multi-disciplinary teams in specific technical aspects related to supervision and improve supervisory and adult education skills;
- Develop strict criteria for appointing the supervision team based on skills, knowledge and attitude;
- Plan supervisory visits in agreement with the institutions being supervised, including the date and duration of visits;
- Ensure that the results of the supervision are immediately conveyed to those being supervised, who on their part should agree with the results and with the measures to overcome the problems identified;
- Institutionalise supervision by including a summary of the results in the agendas of periodical meetings.

Indicator(s)

Prepared guidelines.
Provinces with active supervisory teams.

Conditions for success and constraints to implementation

Supervision should be an important part of service management at all levels and its findings should enrich the management dynamic. Results should be disseminated as institutional knowledge to councils or collectives, and should also be made known to the personnel supervised and the supervisors. The budget should be managed by the Director of the relevant level to guarantee that the results are acted upon.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Preparation of updated guidelines	X	X		X		National Directorates
Testing the supervision guidelines	X	X				DPS,DPC
Integrated supervisory teams	X	X				MISAU, DPS, DDS
Building the capacity of the teams	X	X	X			MISAU, DPS
Supervisory visits		X	X	X	X	MISAU, DPS, DDS
Supervision reports		X	X	X	X	MISAU, DPS DDS
Assess the supervision process				X		National Directorates
Resources required:	Long term technical assistance & working funds					

A.5. Priority Programmes

Continual integration of Priority Programmes is one of MISAU's priorities. The Institutional Development Plan describes this process in more detail. Integrated Supervision and Quality Assurance are also areas which should be seen as priorities.

A.5.a. HIV/AIDS [33,34]

Analysis of the situation and definition of the problem

The magnitude of the present and future impact of HIV/AIDS in the country and the Southern African Development Community (SADC) means that the HIV/AIDS programme needs to be approached separately from the other sub-components that are part of the Integrated National Programme of Communicable Diseases sub-component.

The Government views the fight against HIV/AIDS in Mozambique as of capital importance to its sustainable economic and social and economic development plan. The creation of the National Council to Combat AIDS clearly demonstrates the vision, leadership and commitment of the Government in the fight against HIV/AIDS and underlines the multi-sectoral strategy and nature of this effort.

Studies carried out in neighbouring South Africa[35] on the macro-economic implications of HIV/AIDS suggest that deterioration in economic growth is due to changes in the Government's current expenditure. This is increasingly directed at the health sector, worsening the budget deficit and reducing total investment expenditure. The seriousness of HIV/AIDS is such that even if the transmission of infection were interrupted today in Mozambique, the social and economic impact of the epidemic would be tangible for more than 10 years. It is likely that the Mozambican economy will

decline because of the cost of various AIDS interventions, to the detriment of other development programmes in the country[36].

The spread of the epidemic will mainly affect the economically and sexually active sector of the population. Highly-qualified people with economic power have higher levels of consumption and investment: any illness affecting this group will have a more serious economic impact. In the private sector (for example in the transport companies) the structure of the labour force will alter to include very young, inexperienced people with low levels of training. This will increase training costs, insurance and health care.

Poverty continues to be a constraint for Mozambicans and every indicator suggests that the epidemic will aggravate this situation and increase the number of people living in poverty.

Policy

The fight against HIV/AIDS involves a national response, placing the issue in a broad social and economic context. The approach to the epidemic is multi-sectoral, involving every level of society, communities throughout the whole country and associations of people living with HIV/AIDS.

Strategies

The National Strategic Plan to Combat STD/HIV/AIDS presents strategies that are based on direct analyses of the situation and analyses of the national response, and are in line with MISAU's vision and strategies.

Indicator(s)

- Average internment time.
- Prevalence of HIV among pregnant women in the sentinel surveillance centres.

Conditions for success and constraints to implementation

The results of the national response depend on society's level of involvement as a whole. Civil society, the communities and above all the vulnerable groups must play a fundamental role in combating the epidemic and ensuring the political, social and cultural viability and technical and administrative practicability of the plan.

Steps to be followed

See: Action Plan for the Combat of HIV/AIDS in Mozambique, Resources required for 2001 - 2003.

A.5.b. National Integrated Plan (PNI) for Community Health [37,38,39,40,41]

Analysis of the situation and definition of the problem

Insert 4: The principal Sub-components of The National Integrated Community Health Programme.

- Maternal Health/Family Planning
- Infant Health
- Expanded Programme of Immunisation
- School and Adolescent Health
- Mental Health
- Oral Health
- Nutrition
- Information, Education and Communication

The PNI component of Community Health is undergoing a complex process of change aimed at integrating the management of its diverse sub-components. This process of integration has only just begun. Linking the components listed above will not in itself bring about effective integration, i.e., uniform management of resources and integrated provision of services at the peripheral level. In some areas the integration movement is already underway. The more complex areas which are in need of clarification are: the implications of integrating working teams, the processes of health care provision and the financial repercussions of the transformation.
There are some risks involved in the process of integration, so the approach needs to be prudent. The programmes included in PNI have produced notable results which should be maintained.

Presently there is a perception that the PNI continues to be a centrally managed programme with its own integration process focusing on the central level, with little practical involvement in service provision. Administration (budgeting and logistics) has still not been transferred to MISAU bodies with a specific mandate for this area. The limited capacity and slow pace of the DAG disbursement processes have been presented as arguments for continuing with management and administration in parallel with the PNIs. It must be admitted that the integration process will mean that programme managers lose various degrees of power / control which will be transferred to other entities. This aspect should be taken into consideration in the transition process to minimise the programmes' operational problems. It should be emphasised that under present circumstances not all programmes will be integrated (for example, the HIV/AIDS and Malaria programmes).

Policy

As part of the process of integrating the community health programmes, tasks and responsibilities will need to be adjusted in keeping with the sector's strategic mission. This will help to avoid duplication and incompatibility, promote functional efficiency and will result in the deconcentration of responsibilities and actions from central to provincial level.

Strategies

- Priority should be given to activities which have a direct impact on services. The programme resources at central level should be used to implement this priority.
- Develop effective management instruments using the present flows of financial information.
- Prepare health teams in the peripheral health units to provide integrated services, via formal and continuous training.
- Consolidate the joint planning of activities between the Programmes and their partners.

Indicator(s)

- Proportion of health centres providing integrated services;

- % of State Budget made available for: Mother/Child Health; Family Planning; Vaccination Programme; School and Adolescent Health; Oral Health; Mental Health; Nutrition.

Insert 5: Objectives of PNI for Community Health sub-components

Maternal/Family Planning Component – Reducing maternal mortality by expanding and increasing the use of essential basic and complete obstetric care, and by implementing measures including family planning and pre-natal, childbirth and post-natal care.
Infant Component – Reducing infant mortality by expanding the supply of services and improving the quality of care.
Expanded Programme of Immunisation – Reducing infant death and illness resulting from illnesses that can be prevented by vaccinations. Improve the availability of equipment, material, vaccines and the required cold chain and transport equipment.
School and Adolescent Health – Improve school-age children and young people's state of health by preventing and curing the greatest causes of infant and adolescent morbidity[g].
Mental Health – Ensure that the institutional framework of for the treatment of patients with mental illnesses is more humane, particularly in community treatment, using existing infrastructure and where possible rehabilitating infrastructure for providing more appropriate treatment.
Oral Health- Oral health activities should be co-ordinated with other activities aimed at school-age children.
Nutrition – Improve the nutritional status of the population, particularly of women and children.
Information, Education and Communication – Improve the present mechanisms of communicating with other health sectors and with the mass media.

Conditions for success and constraints to implementation

Some advances have been made in the field: most of the routine PNI activities in the districts have been integrated into the district plans with funds allocated accordingly. At the provincial level there has been a progressive increase in funds made available for current expenditure from both the government and donors. There have also been improvements in the rational use of funds due to integrated planning.
The constraints at the district level are related to a lack of consolidated information about funds made available by NGOs; the different administrative procedures to justify funds demanded by the donors and poor capacity in the areas of accountancy and accountability. All these elements have caused delays in the release of funds which has severely limited implementation capacity. There is also a shortage of Mother/Child health staff, with distribution distorted in favour of urban areas.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Conflict management to readjust priorities in the sub-sectors	X	⇒	⇒	⇒	⇒	MISAU's leadership
Co-ordination with others outside the health sector: multi-sectoral approach	X	⇒	⇒	⇒	⇒	DNS,
Organise financial information in keeping with budget lines	X	⇒	⇒	⇒	⇒	DNS/DAG
Co-ordinate external assistance	X	⇒	⇒	⇒	⇒	DPC, DAG
Resources required:	Increase by 50%: immediate personnel requirements. Managers. Basic Equipment. Working funds.					

[g] Sexually transmitted diseases and premature, unwanted, high-risk pregnancies, maternal deaths for reasons associated with age.

A.5.c. National Integrated Plan (PNI) for Communicable Diseases [42]

Analysis of the situation and definition of the problem

The approach to the most serious communicable diseases (endemics) in the country is still essentially vertical and will probably remain so in some cases for years to come. The process of integrating the PNI sub-component for communicable diseases is only just beginning. An effort is being made to improve the rational use of transport and training opportunities. There are still difficulties in implementing and prioritising the traditional vertical programmes (e.g. tuberculosis, malaria). An important area in this Programme is information and epidemiological surveillance. Despite the great efforts made to monitor data about compulsory notification illnesses and causes of hospital admission, information on specific incidence rates is still unavailable. Collaboration with research institutions has still not explored the potential and comparative advantages of various players in this area.

- Malaria.
- Endemic and chronic diseases such as AIDS, Tuberculosis and Leprosy.
- Epidemic diseases such as Cholera, Meningitis and others.

Insert 6: The main diseases of the Communicable Diseases sub-component.

Policy

The control of communicable diseases should take a more wide-ranging approach which prioritises basic, integrated, sustainable and efficient health services. The programme should also ensure that there is an adequate and prompt response to emergency situations. Given the importance of epidemiological information when defining priorities and policies, co-ordination is essential between the entities that produce this information and SIS in general. There should be a shared database to monitor the temporal evolution of the epidemiological profile.

Strategies

- Gradual integration of the sub-components to ensure that the positive results attained by some programmes are maintained.
- Organisation and management of the basic levels of health care.
- Building the capacity of DPS to act decisively and rapidly when confronted with the frequent emergencies that occur in the country.
- Intersectional collaboration to reinforce district health systems under the ambit of decentralisation.
- Integration of epidemiological information with other information sub-systems.

Indicator(s)

- % of State Budget spent on preventative care
- % of current expenditure allocated to level I. Referral system functioning adequately.

Conditions for success and constraints to implementation

An essential condition for success is the mobilisation of programme managers, enabling them to take responsibility for problems related to vertical programmes and integration. The obstacles to this process of transformation are concerned with the dynamics of change where deeply-rooted management practices have to be abandoned. This could cause some resistance for reasons given above. An information and negotiation process could help to minimise anticipated problems.

Insert 7: The main PNI strategies for Communicable Diseases.

Malaria
- Vector control through household spraying campaigns and promoting the use of mosquito nets treated with insecticide;
- Early diagnosis and treatment;
- Health education;
- Advocacy for environmental sanitation.

AIDS
- Multi-sectoral approach which emphasises the impact of AIDS on social development;
- Concentrating efforts to improve assistance to those affected by illness.

T**uberculosis**
- Active tracing and attention for patients who seek treatment;
- Early treatment of cases using established schemes;
- Chemo-prophylaxis for children of 0 to 5 years;
- Active search for drop outs;
- Compulsory BCG vaccination at birth;
- Free medicines.

Leprosy
- Early diagnosis and treatment of cases, particularly neuritis;
- Make multi-drug treatment accessible for all patients;
- Follow up all cases traced during leprosy elimination campaigns.

Emergency Prevention and Response
- Reinforcing the capacity to respond to emergency situations;
- Multi-sectoral approach.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Management of change/reform	X	⇒	⇒	⇒	⇒	GdM
Integration of resources/provision activities		⇒	⇒	⇒	⇒	DNS
Adapt the basic package for level I	X					DNS
Monitor management mechanisms		X	⇒	⇒	⇒	DNS/DAG
Adapt material and human resources for level II	X	⇒	⇒	⇒	⇒	DNS
Establish intersectoral collaboration mechanisms	X	⇒	⇒	⇒	⇒	DNS
Resources required:	1. Formal and in-service training for personnel. 2. Materials 3. Working funds.					

A.6. Essential Health Technologies Package (EHTP)

Analysis of the situation and definition of the problem

The aim is to identify the most important health problems by region and select the most suitable interventions for each of them. The choice of interventions will depend on the resources that are available or being mobilised. In practice, the sector is not being developed in this way. More commonly, health centres are built before considering what they should be used for and how supplies can be secured.

What should be the criteria for identifying the most important health problems? What is the consensus on the choice of interventions? What are the norms and standards for implementing these interventions? It should be possible to consider all these aspects together. Interventions are implemented in a great variety of ways and there is not enough debate between the participants of each of the components (construction,

resources, programmes) to reach a consensus about norms and standards. As a consequence MISAU has no solid foundations on which to base its regulations.

The Essential Health Technologies Package is basically a compilation of three databases developed by WHO:

- A list of all illnesses;
- A list of all interventions for treating these illnesses;
- A list of all resources which can be used in these interventions.

The package assists in the selection of illnesses to be treated, based on the epidemiological profile and national priorities.
Good practices in the country could be included in the package, specifying the resources being used in selected interventions.

Policy

Establish a consensus on prioritising the main health problems in the country and selecting interventions for treating these problems, taking into consideration local conditions, and the availability and most efficient combination of resources.

Strategies

- Reaching a consensus on sector priorities, bearing in mind existing resources;
- Establish a flexible frame of reference on health care provision which permits the norms and standards for implementation to be regulated;
- Develop an instrument to support policy formulation.

Indicator(s)

- Package adapted to Mozambican conditions;
- % of basic standardised interventions compared with the total number of basic necessary interventions;
- % of basic interventions based on defined standards and with the necessary resources;
- using defined instruments.

Conditions for success and constraints to implementation

The application of EHTP depends on the collaboration of all the sector's participants. A significant effort is needed to reach the necessary consensus on many crucial aspects in the sector. The rationalisation of resource allocation based on a consensus over norms and standards has implications that will not be welcomed by all the partners.
The EHTP has been developed for use in South Africa. Mozambique needs to be certain that the package can be adapted to meet its particular needs.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Implementation unit/National Co-ordination	X					DPC
Update the health network inventory	X	X				DPC
Study intervention standards at different levels of attention during the provincial pilots	X	X				DPC
Develop criteria for allocating investments for more equitable access	X	X				DPC
Begin the process of reaching a consensus on norms and standards		X	⇒	⇒	⇒	DPC
Begin computer simulations, province by province, and establish planning proposals			X	⇒	⇒	DPC
Resources required:	Technical Assistance and working expenses.					

B. Health Advocacy

B.1. Intersectional Collaboration, Partnership Development and Alternative Medicine [43,44,45,46]

Analysis of the situation and definition of the problem

The following are now defined by law: MISAU's responsibilities and attributes and the Health policy which aims to maintain and improve community health in complement and in collaboration with other sectors[47]. The legal framework and the role and responsibilities of the private sector and foreign NGOs in providing health care is also defined by law [48]. However the nature of collaboration between the different sectors involved in health is still imprecise, possibly due to a lack of operational mechanisms. In other cases, there is little adherence to regulations and other legal devices.

In practice, multi-sectoral collaboration occurs during big events such as the fight against STD/HIV/AIDS, the National Vaccination Days, and the control of the cholera epidemic. There are positive experiences of systematic, continual intersectoral work (e.g. nutrition) and such work can be considered to be one of the Sector's best practices. The actual state of urban sanitation associated with outbreaks of epidemics, the growing number of road accidents, sexual violence and child abuse, alcoholism, smoking and drug abuse among others, indicate that a greater effort is needed to combat public health problems. The present Ministry of Health statute does not provide clear mandates on intersectoral collaboration and advocacy.

In recent years, interaction between MISAU and NGOs has increased and now covers many areas (investment, technical assistance, health care provision, training, community participation and management support). Generally speaking, the experience of working with NGOs has been positive but there are fundamental issues which need to be debated and agreed upon. For example, the NGOs do not always seek agreement about the geographical areas in which they plan to work. For this reason, many actors work in the same areas and rules established concerning collaboration between SNS and NGOs are often not applied. During the First National Meeting between MISAU and the NGOs[49] factors were identified which hampered greater collaboration between the two parties: the lack of regular meetings between MISAU and the NGOs; the difficulty in controlling the quantity and quality of technical assistance recruited by the NGOs and the poor co-ordination between the donors, NGOs and MISAU, particularly in respect to information and the process of presenting projects for funding. This has lead to duplications and inefficiencies in the partnerships and collaboration between the various actors in the sector.

Policy

MISAU needs to play a more proactive role in leading health advocacy. It should raise its profile and strengthen its leadership as the State agent responsible for the defence and promotion of the nation's health, without necessarily involving itself in the juridical issues of other sectors.

MISAU recognises and promotes collaboration between public health services and other forms of health provision such as non-allopathic or alternative medicine. It aims to safeguard the citizens' health against dubious practices or misleading claims, such as those concerning cures for AIDS.

This process is equally important for stimulating the exchange of information and knowledge between non-allopathic and allopathic practitioners and encouraging a more informed approach to research.

Strategies

- Stimulate multi-sectoral collaboration, principally with the Education, Water, Agriculture and Public Works sectors and the Municipalities through formal channels.
- Improve the dissemination of information with greater community involvement and participation at the multi-sectoral level, with emphasis on cultural education to change behaviour and habits that endanger health, with particular attention on the health of women, young people and children.
- Adopt a Code of Conduct as a mechanism for implementing partnership between MISAU and the NGOs.
- Carry out studies and disseminate their findings on the main health problems; create forums for open discussion leading to the nomination of those responsible for the various problems, the role of different institutions and the steps needed to resolve these problems.
- Create a structure that is responsible for advocacy within MISAU to ensure that there is a continuous advocacy process.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

As a starting point, it is important to recognise the strategic importance of advocacy within MISAU and include it in MISAU's organisational structure. The development of a social culture that defends and promotes the health of all is a condition and objective of advocacy. Presently, an obstacle which must be overcome is MISAU's poor institutional capacity for implementing advocacy effectively.

Steps to be followed

	2001	2002	2003	2004	2005	Entity Responsible *
Draw up an advocacy policy	X				X	GdM
Develop an advocacy plan	X	X				GdM and DPC
Draw up indicators		X				DPC
Allocate resources to this department		X				DPC
Implement the plan		X	X	X	X	Selected department
Evaluate the plan				X		Selected department - DPC
Resources required:	Resources necessary to establish advocacy within the health sector and to divulge existing relevant legislation.					

B.2. Community Participation [50,51,52,53,54,55&56]

Analysis of the situation and definition of the problem

Practical experience of community participation has shown that participation is inherent in the dynamics of the communities themselves. The government institutions and NGOs have encouraged community collaboration when implementing their programmes in the Health, Agriculture and Education sectors. Many NGOs have a great deal of experience in this area. They have provided incentives to stimulate community involvement and have appointed activists or community agents, though often in unsustainable ways. This sometimes leads to paternalism which is contrary to the intended objectives of community participation.

In general, community participation is still weak and sporadic. The role of the community in various health activities is often one of passive collaboration with little interaction between the providers and beneficiaries. Few studies and evaluations have

been made on this subject, and the results are rarely disseminated. It is recognised that the community is inclined to collaborate, but MISAU has difficulties in complying with the commitments involved. Up till now, community participation has implied collaboration in the execution of health programmes rather than in planning, monitoring, assessment and management of some health activities. The potential for community participation has not been fully explored, although experiences within the country and abroad show that communities that play a more active role in health can become true partners in health and not mere consumers of health services.

Policy

MISAU wishes to facilitate the diverse processes of community participation, from simple collaboration to self-management of health services. MISAU will focus its attention on creating the conditions for successful community participation, including studies and analyses of the factors required for sustainability in the medium and long term.

Strategies

- Disseminate the principles of community participation and the mechanisms for continuous involvement in health promotion in co-ordination with partners and NGOs, in a way that leads to sustainability.
- Ensure that the basic aspects of community participation can be implemented by the different health programmes, which will be responsible for designing this component.
- Co-ordinate the practice of community participation with NGOs or directly with the Councils of Community Leaders or other similar organisations. Avoid creating new organisations for this purpose.
- Encourage the more active participation of community representatives in managing health units to promote transparency and accountability.
- Encourage community co-management of health units and disseminate the results.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

Successful processes that have been developed by different sectors in any area within the communities are a valuable inheritance. They provide an opportunity for successful community participation. Clear and efficient dissemination of the Ministry of Health's mandate to develop aspects of community participation in co-ordination with the DPS and DDS will also contribute to the success of this enterprise. Advances in the decentralisation process (and particularly in the more autonomous management of health units) is also essential for community participation.

One of the present constraints is the absence of directives in the State Budget for the Ministry of Health for funds to be allocated for community participation activities.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Defining policies and strategies	X				X	DNS-RESP
Defining criteria and indicators for community participation	X					RESP
Preparing for implementation	X	X			X	RESP
Implementation		X	X	X	X	DDS
Evaluation				X		RESP-DPC

Resources required:	Financial and technical support, principally at the district level (the closest level to the communities).

B.3. Community Health Agents and Traditional Birth Attendants

Analysis of the situation and definition of the problem

Community Health Agents (ACS), known in the country as APEs (Elementary Polyvalent Agents), have emerged in the process of primary health care strategic implementation as agents who link SNS to the communities. In the beginning, their main functions were to carry out preventative and promotional activities. Over time they have become more involved in curative care in places where there are no other providers.

The qualification and quantification of Community Health Agents who still continue to operate within the Health System are not known. It is estimated that some of these agents continue to be linked in some way to the National Health Service and NGOs. Many ACSs are not recognised by SNS as their training has not been certified by MISAU.

Although Traditional Birth Attendants have always existed in the community and continue to exist, a major issue to be addressed by the health sector is the particular claims that they make with regard to receiving salaries and in some cases to being recognised within the framework of health personnel. The ACSs are providing services to the population without adequate SNS supervision and evaluation.

Policy

The Community Health Agents play an important role in linking the health units to the community. Trained according to the norms established by MISAU, they should provide services of a mainly promotional and preventative nature in their own communities. As they are not part of SNS personnel they should make their living from initiatives within the community or initiatives between the community and the health unit.

Strategies

- Redefine the mandate and profile of the Community Health Agents in areas of health prevention and promotion and clinical care.
- Clarify and encourage co-ordination between the ACSs and SNS to promote the agents' sustainability, accountability for activities carried out and health information, according to the norms and policies established by MISAU.
- Maintain and improve the Traditional Birth Attendants Programme, particularly in the areas of supervision, capacity building and co-ordination with health units.
- Design a code for the activities of health activists to stimulate the involvement of the community in health issues.

Indicator(s)

- Completed study of Community Agents;
- Existence of an ACS co-ordination plan;
- Revised training curriculum for ACS.

Conditions for success and constraints to implementation

The conditions for success are related to the commitment of MISAU, the community and the Community Health Agents (Traditional Birth Attendants, APEs and activists) in complying with previously-established agreements. Success is also dependent on the commitment of birth attendants and NGOs in complying with legal regulations and

MISAU's policies for community work and training and capacity-building for Community Agents.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Study characteristics of Community Agents	X	X				DNS, DPC, partners
Co-ordination plan for ACS		X			X	DNS, DRH, DPC
Revise the curriculum for ACS						
Agree incentives and support mechanisms for ACS		X				DNS DPS Partners
Update ACS		X	X	X	X	DNS DRH
Evaluate the role of ACS				X		DNS DPC
Resources required:	Working funds: for training, capacity building, supervision and the supply of medicines (KIT C). Studies and Technical Assistance.					

C.

Pharmaceutical Sub-sector

Analysis of the situation and definition of the problem

See part I.

Policy

To ensure that the medicines circulating in the public and private sectors, are safe, of good quality, effective, correspond to therapeutic needs and are reasonably priced.

Strategy

In terms of regulation:

- Establish a structured and functional Medicines Regulatory Authority;
- Ensure that the medicines in circulation are safe, of good quality and reasonably priced;
- Regulate the pharmaceutical market and ensure that regular inspections take place to guarantee that the market is healthily competitive and respects the principles of public health.

In terms of distribution:

- Improve the efficiency and equity of the public medicine supply system;
- Ensure greater involvement of hospitals and provinces in determining needs and establishing priorities;
- Ensure that priority products are permanently available in the distribution and dispensing network.

Indicator(s)

- Expenditure for medicines and medico-surgical articles per person - target of $2.50 in 2006 (see CFDMP).

Conditions for success and constraints to implementation

The separation of the regulatory and supply functions of SNS is a necessary condition for the development of the regulatory area for medicines. This process will facilitate the development of the private sector which serves the more general interests of the health system and the population.

Public supply depends on available resources. There are insufficient resources, and dependency on external support continues. Establishing prioritising criteria (agreed by consensus) is absolutely essential to improve the availability of medicines that are considered to be vital.

Improving management capacity and control of the public storage and distribution system for medicines will help improve supply to the health centres.

Steps to be followed

In terms of regulation:	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Complete the legal framework for medicines: - System for Registering Medicines.	X					COMED
- Establish good practices of pharmaceutical production		X				COMED
- Pharmaceutical Inspection System	X	⇒	⇒	⇒	⇒	COMED
- Improve legislation additional to Law 4/98 of January 14th		X				COMED
- Establish COMED - Medicines Council	?	?	?	?	?	Ministry Council
Improve and continually update the National Medical Formulary		X	⇒			CTTF
Improve laboratory capacity to control the quality of medicines			X			COMED
Improve the rational use of medicines, particularly in SNS	X	⇒	⇒	⇒	⇒	COMED CMAM
Ensure the harmonious development of the private pharmaceutical sector	X	⇒	⇒	⇒	⇒	COMED
In terms of distribution:	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity Responsible**
Improve and continually update the prioritising criteria for SNS supply	X	⇒	⇒	⇒	⇒	CMAM CTTF
Improve the availability of vital medicines for the SNS network	X	⇒	⇒	⇒	⇒	CMAM DPS
Improve the efficiency and effectiveness of the supply system by: - Setting up a national integrated stock management system throughout the SNS supply network.		X	X	⇒	⇒	CMAM DPS
- Improving the information and retro-information system on circulation and use of medicines in SNS.	X	X				CMAM
- Greater co-ordination of purchasing processes and procedures	X	⇒				CMAM External Partners
- More competitive logistics and purchasing within SNS			X	⇒		CMAM
- More equitable distribution of medicines to the provinces, districts and health units	X	X	⇒	⇒	⇒	CMAM DPS
- Simplification and improvement of the cost recuperation system, particularly the pricing policy		X	X			DAG CMAM
- Joint monitoring of the medicine supply system	X	⇒	⇒	⇒	⇒	CMAM External partners
Ensure that the poor have more equitable access to medicines financed by public funds	X	⇒	⇒	⇒	⇒	CMAM DPS
Resources required:	Technical Assistance, working expenses, funding for the purchase of pharmaceutical necessities.					

D. Financing Strategy [57,58]

D.1. Medium Term Expenditure and Financing Framework (CFDMP) [59]

Analysis of the situation and definition of the problem

The CFDMP has been developed with the Ministry of Planning and Finances (MPF) to define sector priorities, taking the shortage of resources into consideration. It is essential for CFDMP that expenditure is analysed in an integrated, inclusive, coherent intra-sectoral manner that considers the sector's strategic objectives and available resources.
CFDMP provides expenditure projections in the medium term, taking into account the planned resources package - the projections for each level of activity and budget line. CFDMP clarifies priorities in basic health care (levels I and II), priority programmes and pharmaceutical and human resources, controlling the expenditure of the referral and investment systems. Efforts made at levels I and II and by the priority programmes represent the sector's global contribution to the fight against poverty.
Until now, the annual preparation of CFDMP has been a laborious process using extremely heterogeneous information. There are many shortfalls in information about the present cost of services.
The CFDMP presents an analysis of the public sector. In the context of SWAP, MISAU needs to monitor developments in the whole sector (including the private sector) via National Health Sector Accounts.

Policy

With CFDMP, MISAU intends to:

- Make planning more coherent, by integrating financing and expenditure in its totality;
- Impose financial discipline: prioritising realistic projections of resource availability;
- Avoid unexpected adjustments: ensure greater sustainability, balancing current and capital expenditure, using a medium term perspective;
- Transfer from incrementally-based planning: to planning per activity, programme and lastly by objective and impact.

Strategies

- Institutionalise CFDMP and national accounts;
- Institutionalise cost analysis.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

There is insufficient capacity to continue the work that has been done in the DPC Health Financing Unit.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Reinforce the Health Financing Unit	X	X				DPC
Annual updating of CFDMP	X	X	X	X	X	DPC
Institutionalise cost analysis	X	X				DPC
National Accounts for the Health Sector		X				DPC
Resources required:	Technical Assistance, working funds including research					

D.2. The Common Funds and the Common 'On Budget' Financing Mechanism (FobC)

Analysis of the situation and definition of the problem

External partners do not often commit themselves to long-term financing. In the area of recurrent expenditure in particular, there are many different financing mechanisms for a variety of projects. The basic problem is MISAU's difficulty in influencing resource allocation in keeping with national priorities within a fragmented sector that has no long term horizons.

The existing Common Funds are building blocks for developing an 'on budget' common financing mechanism for MISAU's external donors. These include common funds for the following areas:

- Pharmaceutical area;
- Technical Assistance (PATA);
- Budgetary support for the provinces;
- Common Fund for the Health Sector Strategic Plan (FC-PESS).

MISAU is responsible for managing these funds, with the exception of Budgetary Support for the Provinces which is still managed by Swiss Development Co-operation (SDC). There are a variety of different procedures for each of the common funds which were developed according to individual requirements.

In January 2001 the SWAP MISAU-Donor's Working Group (GT-SWAP) was set up to provide an operational co-ordinating forum between MISAU and external partners. The forum aims to improve monitoring of PESS and Code of Conduct development and implementation. The objectives of GT-SWAP are as follows:[60]

1. Acquire a sectoral vision of the financing and resource distribution network for and within the health sector, with the aim of increasing efficiency. This sectoral vision should also help to define the way in which MISAU and its partners can move forward, starting with the existing funding mechanisms, and develop the concept of uniting resources to support PESS implementation.
2. Discuss and agree on policies concerning the mechanisms for uniting both on and off budget funds.

Policy

Continue the institutionalisation of Common Fund management within MISAU. From the year 2002 create a mechanism for common on-budget financing via MPF, in order to include contributions in the State Budget using such a mechanism.

Strategies

- In close collaboration with external partners and the MPF establish the necessary conditions to implement a mechanism for common on-budget financing via MPF for current, non-salary expenditure. The initial approach could include funds from Budgetary Support to the Provinces and PATA. Other external support funds could be included gradually.
- Create common funds in the provinces to support the implementation of their respective Strategic Plans. These common funds should be considered temporary until the on-budget and the State Budget mechanisms are fully integrated.

Indicator(s)

A reduction in the percentage of off-budget funds.

Conditions for success and constraints to implementation

The implementation of a common on-budget financing mechanism depends fundamentally on the successful implementation of planning, monitoring and evaluation. PESS itself is a condition for the success of implementing the common on-budget financing mechanism. Existing experience in applying the fund allocation key (goods and services: State Budget and Budgetary Support to the provinces) could serve as a basis for developing a common key.
A continuing constraint is the poor capacity of national systems and permanent dependence on external support. In the final analysis, MISAU depends on the willingness of external partners and their commitment to a common financing mechanism. MISAU is also dependent on the various different MPF procedures and on the conditions that influence fund disbursement. For example, there is a lack of liquidity in some provinces.
The planned Public Expenditure Tracking Survey (PETS) is an important opportunity for understanding the losses of funds in financial management and adjusting the system to improve efficiency and equity in the sector's public expenditure.

Steps to be followed

	2001	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Create sufficient institutional capacity within MISAU and MPF to implement and monitor provision and financial accountability (see: Financial System)	X	⇒	⇒	⇒	⇒	DAG & MPF
Create Interim Common Funds in the provinces as a financing mechanism to unite external funding in the provinces (see: Provincial Strategic Planning System).	X	X	X			DPC & DAG
Agree on the application of the fund allocation key for the provinces.	X	X				DPC, DAG & external partners
Prepare a list of indicators to revise the Sectoral Programme (see: Monitoring and Evaluation System)	X	⇒	⇒	⇒	⇒	DPC & external partners
Evaluate the existing Common Funds with the aim of including them in the future FobC.	X					DAG & parc. ext.
Evaluate the existing financial system and PERMAS with the aim of adapting them for FobC.	X					DAG & external partners
Public Expenditure Tracking Survey (PETS)	X	X				DAG & MPF
Prepare guidelines for financial procedures (see: Financial System)	X	X				DAG
Prepare Supply Guidelines and set up a Purchasing Unit.	X	X				DAG
Nominate an external, independent auditor		X				DPC & external partners
Create a Joint Committee (MISAU, MPF and donors) for Financial Management, responsible for general financial management including disbursement and international purchasing.		X				DAG & external partners
Resources required:	Technical Assistance, working funds including research.					

D.3. Allocating Funds.

Analysis of the situation and definition of the problem

MISAU already has a funding allocation system for goods and services for the provinces. The criteria are as follows:

- Health requirements: population (25%) and number of poor (10%).
- Capacity: number of beds (25%).
- Provision: number of Health Units (35%).
- Local conditions: inverse of population density (5%).

For equitable fund allocation, it should be sufficient to apply the criteria of health requirements to local conditions. The inequalities in the distribution of capacity and the absorption of funds implies the inclusion of capacity and provision criteria in the system.

There is still no Health Sector Investment Plan which should establish investment criteria with the aim of reducing existing inequalities in the capacity to provide health care. The Three-Yearly Public Investment Plan (PTIP) does not only focus on investment: it includes current expenditure such as Technical Assistance, medicines and working expenditure. The Investment Plan should include projects in the areas of construction/rehabilitation, training, investigation/research and equipment, including transport.

Mozambique is vulnerable to disasters, and the sector should be better prepared to react to emergency situations. It is important to recognise that the Health Sector should play a dynamic role in preventing and reacting to emergencies. There are still no Intersectional Emergency Plans for the provinces.

A great challenge for the health sector is to optimise access to health care with insufficient resources to guarantee universal access. Particularly in areas of low population density, it is necessary to experiment with innovative approaches to improve access. Mobile clinics could be considered, as well as health posts with community pharmacies and Community Agents, micro-financing for private clinics in rural areas managed by retired health professionals, etc. It is important to create opportunities for the provinces to investigate and exploit these types of innovations.

Policy

Diversify the allocation of funds for current expenditure to better respond to the sector's needs. Create greater transparency and rationality in the application of investment funds.

Strategies

- Continue to apply the fund allocation system for goods and services for the sector.
- Develop the Health Sector Investment Plan based on the following guidelines:
  - Build new health units only to improve equity of access to health care;
  - Only rehabilitate health centres that are in a poor state of repair;
  - Only promote health units based on access criteria, for example, for the population in the catchment area;
  - In the case of Maputo city, the functioning of levels I, II and III needs to be modernised, with 24-hour access, to reduce the pressure on the Maputo Central Hospital for this kind of health care (see: Provincial Strategic Planning).
  - The development of a health network in Matola city should be considered because of the city's rapid growth.
- Create an Emergency Fund for the central level and provinces.
- Create an Innovation Fund to promote actions which improve access to health care, community participation and intersectoral collaboration with the aim of promoting

health advocacy and strengthening collectives and individuals under the ambit of PESS.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

Experience of using the fund allocation system indicates that MISAU favours the more rational allocation of funds to its priority areas. The possibilities of making this approach intra-provincial need to be explored with provincial and district authorities. MISAU depends on the MPF Household Survey of 1997 for information about the poor. This information should be updated and provided in detail down to the district level.

The health network classification document[61] should serve as a basic document for classifying health units and drawing up an inventory of the health network. A constraint to implementing the Investment Plan may be the lack of sustained political commitment in an environment which demands constant change.

The creation of the Preparation and Readiness for Emergencies Fund depends on MPF's co-operation and on the Intersectional Emergency Response Plans being prepared in the provinces. During the consultations in the provinces, participants were very enthusiastic about this initiative. The Innovations Fund will depend on initiatives that are yet to be proposed.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Apply the funding allocation system for goods & services to the district level	X	X+d	⇒	⇒	⇒	DAG
Inventorise and categorise the existing health network (also see EHTP)	X					DNS/DAM
Develop fund attribution criteria for Investment Plan funds.	X					DPC & DNS
Formulate the Investment Plan	X					DPC & DNS
Negotiate MPF procedures to create a Preparation and Readiness for Emergencies Fund	X	X				DAG & DPC
Create methodology and capacity to assist the provinces in developing Emergency Plans		X				DPC & DNS
Develop an Emergency Plan for every province		X	X	X		DPC & DNS
Create an Innovations Fund using MPF guidelines and procedures			X	X	X	DPC & DAG
Resources required:	Technical Assistance, working funds including research					

D.4. Income

Analysis of the situation and definition of the problem

Health Sector Financing Studies clearly indicate that substantial and urgent action is needed to modify the user's price system. Households contribute 2.5 million USD which represented a mere 2.4% of SNS financing in 1997.[62] It is known that high prices are charged illegally, while higher rates are charged for special clinical services.
It is important to understand that users' payments, from an economic point of view, are equivalent to taxes. In the case of consigned income, these 'taxes' are re-used only for health sector expenses.
The exemption list is not applied effectively, so nearly all users pay for their treatment. MISAU still has little information about household expenditure on health and also knows very little about people's willingness to pay and the amounts that households are able to contribute. This information should be made available about rural and urban areas and according to the age and sex of users. Informal information seems to indicate that even people living below the poverty line are willing to increase their expenditure on health care provided it is of good quality. Good quality signifies health care provided by health professionals whose behaviour satisfies the user; the availability of medicines and clean, hygienic hospitals. Apparently there are periodic liquidity problems, particularly in rural areas. In the traditional sector, payments in kind and credit are accepted which facilitate access to these services.
The situation is complicated by illicit payments which SNS is still unable to control. This custom of illegal payments contributes to people's negative opinion of the SNS health centres and health professionals, affecting the reputation of the many dedicated health workers. When applying the income policy, the livelihoods of health personnel who work under very basic conditions also needs to be considered.

Policy

MISAU's income policy aims to formalise the relationship between the users and health care providers and create a consigned fund for the health sector. This fund can be used for improving the salaries of health professionals and as an additional fund at health centre level. The fund will be jointly managed with community representatives from the catchment area for each health centre. The policy should be implemented ensuring that access to basic health care for disadvantaged users and those unable to pay should be protected.
The Funding Strategy (1999) discussed the possibility of creating a Health Insurance System for SNS users. At that time, conditions for this type of insurance did not exist, although contributions were made by public employees (2% of salaries) to the Medical and Medicines Assistance Fund. The fund is presently managed by the Ministry of Planning and Finances. Conditions do not exist for increasing the value of the fund for the following reasons:

- Lack of a high cost, good quality health service to interest potential users of the National Health Service;
- Lack of sufficient potential users with the capacity to pay;
- The management costs of health insurance do not justify the coverage of the type of services provided by SNS at present prices. These conditions will probably alter in the private health sector in coming years.

Strategies

- It is necessary to investigate in greater depth and detail household expenditure patterns and people's willingness to pay for health care, including options for paying in kind or pre-payment.
- The policy being developed on income regulation should be clear, transforming normal income in order to eliminate the practice of special treatment. It is important that all health personnel benefit, in a fair and transparent manner, from

a proportion of this income. It is essential that the rules for guaranteeing access for people unable to pay are clear and universally applied. It is also essential that all Mozambicans are aware of their rights and obligations in relation to the income policy. A reduction in payment points is proposed as a way of reducing illegal payments.

- It is necessary to regulate/licence the SNS Special Clinics to ensure that they do not benefit from the actual low prices of resources supplied by the public sector.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

An important constraint is the difficulty in identifying individual cases of disadvantaged people who are unable to pay. The Health Sector depends on the co-operation of the Ministry for Women and Co-ordination and Social Action, and the communities and community leaders.
To apply the policy in a clear, transparent manner, MISAU needs to strengthen its capacity for communication, supervision and professional discipline to eliminate illegal payments in the sector. As long as basic conditions for survival do not exist for health personnel it is difficult to demand this professional discipline.
MISAU needs the co-operation of every player, including doctors, to ensure that income is used fairly.
The policy should be responsive to local conditions: Mozambique is a large country with great socio-economic diversity.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Include estimates of household contributions in the National Accounts (see CFDMP)		X				DPC
Investigate the capacity to pay, including aspects of periodical liquidity		X				DPC
Pilot pre-payment systems			X			DAG
Establish an income policy, revising exemptions, and launch a public information campaign			X			DAG
Regarding the large hospitals, include in the service provision agreements clear rules on the functioning of special clinics.		X	X			DNS/DAM
Encourage the use of income consigned to levels I & II and priority programmes with an additional contribution from the State Budget, equal in value to the income that provinces allocate to these priorities.			X	X	X	DAG
Resources required:	TA, working funds, including research.					

D.5. The Private Sector, profitmaking and non-profitmaking

Analysis of the situation and definition of the problem [63]

The Non Governmental Organisations (NGOs) mobilised 26.4 million US dollars (21.7% of the total financing of the health sector) in 1997. Of this expenditure, 91% was from international NGOs and 92.4% of this expenditure was directed into the SNS. The NGOs provide significant support for SNS, although the support is not always well regulated and sometimes the contributions are not in line with sector priorities. It should be emphasised that fragmentation within the public sector contributed to the difficulties in communication between the public sector and the NGOs. MISAU cannot guarantee that it will support a health centre that has recently been built by an NGO if this building was not recognised as a MISAU priority.

Employers financed at least 7.6% of health sector expenditure in 1997, to a value of 9 million USD in the following areas:
- Services provided by employers: 24.4% of this expenditure in at least 100 health posts financed by employers. Only 38 of these health posts are registered by MISAU;
- Services provided by the public sector: 42.2% of expenditure;
- Services provided by the private sector: 33.3% of expenditure.

Employers want to promote and preserve the health of their employees and their families and also aim to minimise the loss of working hours due to visits to health institutions. Private sector health care is seen as expensive, and public sector care of poor quality. Employers seem to be interested in co-financing public health care, including care in rural areas, in order to improve quality.

Private health providers still represent a limited proportion of total health sector expenditure: 6.2% with a value of 7.5% million USD. Of this total, 3 million USD are financed by employers. These profit-making providers are concentrated in urban areas, particularly in large cities. In 1997, 23 of the profit-making medical and dental services out of a total of 30 were located in Maputo province and city. Private pharmacies (41 in 1997) are also concentrated in urban areas. In Maputo, it is said that private providers' prices are, to a great extent, determined by the prices charged in the Special Clinic of the Central Hospital. This happens because the private clinics feel that they should continue to compete with Special Clinic prices if they want to maintain their level of business. It seems that the private clinic owners resent the Special Clinic's market power, feeling that its prices are heavily subsidised.'[64]
The slow expansion rate of the middle classes in the country hinders the development of private national health insurance. In the medium term, the private health sector will mainly continue to serve the relatively rich in urban centres, particularly in Maputo.

Policy

MISAU intends to improve its collaboration with the private profitmaking and non-profitmaking sector, through a clear explanation of its policies and regulation to ensure that public interests are protected.

Strategies

- Establish clear relations between MISAU and the NGOs, through contractual agreements which clarify their respective roles, responsibilities and objectives.
- Facilitate the co-financing of the public sector by employers, with the option of employers participating in the management of respective health centres.
- Facilitate the expansion of the private profitmaking network, avoiding unfair competition between the private and public sectors.
- Licence and enforce licensing control via a Health Professionals Council in close collaboration with MISAU's General Inspector, the highest authority in applying

laws and rules relating to health care provision. The same Council should function as a tribunal for resolving cases of bad practice.

- Help public sector management entities to contract non-clinical services from the private sector to improve the efficiency of the public sector and liberate human resources that can be employed in other priority areas.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

The majority of the private sector is interested in seeing improvements to the public sector. An improvement in the quality of public health care and the fight against HIV/AIDS, for example, are of great interest to employers. The public sector could take advantage of employers' contributions, either in co-managing or co-financing health units.
MISAU needs the co-operation of every player, including doctors, to establish and apply norms and regulations.
The juridical system's lack of capacity and the absence of resolutions concerning bad medical practices in criminal law hinder fair treatment in this area.

Steps to be followed

	2001	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Organise an annual meting between NGOs and MISAU at the national level, including, among other things, the preparation of a Code of Conduct using rules already established by the Ministry of Foreign Affairs, and promote similar meetings at provincial level.	X	X	X	X	X	DPC
Draw up clear rules on: - contracting for specific activities; - Co-financing and the management of a public health institution; - Contracting for managing a health institution.		X	⇒	⇒	⇒	DAG
Utilise the Innovation Fund to contract NGOs who explore options included in the fund's ToR.			X	X	X	DPC & DAG
Establish a Professionals' Health Council represented by MISAU, lawyers, civil society and health professionals.			X	X	X	GdM
Resources required:	Technical Assistance, working funds, including research.					

E. Institutional Development

MISAU's organisational development is aimed at improving effectiveness in attaining targets, and in improving sustainability. MISAU's present institutional capacity is poor. This weakness is evident in the inadequacy of the organisational structure and its functions. Roles and responsibilities are unclear, and processes are complex and extremely hierarchical and centralised. Relationships are individualised, formal and often mechanised leading to the low morale and technical capacity of personnel, particularly in management areas.
MISAU intends to improve organisational performance through a gradual, integrated process of decentralising functions. The structure and processes will be adjusted and human resources will be developed.
MISAU has prepared an Institutional Development Plan (PDI) annexed to PESS. PDI is inclusive in its approach to implementing the institutional development aspects of PESS, and focuses on six clearly inter-related areas:

1. Decentralisation;
2. Responsibilities, management and organisation of MISAU headquarters;
3. External links;
4. Accountability;
5. Continual integration of Priority Programmes;
6. Separation of the provision function.

In the context of PESS, areas 1, 2, 4 and 6 will be incorporated in the decentralisation policy. Area 3 is linked to the chapters on intersectoral collaboration and the communication strategy. Area 5, concerning the continual integration of priority programmes is discussed in the chapter on priority programmes.
Institutional development involves other important issues which are treated separately, namely institutional capacity in the areas of Human Resources, Communication Strategies and Modernising the Management Systems.

E.1. Decentralisation

Analysis of the situation and definition of the problem

MISAU's statute, created by ministerial decree no. 94/97[65] established the structure and functions of MISAU's central bodies to the level of National Directorates. According to the decree, each department should prepare its own list of personnel for approval, and propose functions for achieving its objectives and specific responsibilities. Except for the personnel list, none of these proposals have been approved to date. This has resulted in a lack of clarity about the mandates of the various bodies comprising the departments of MISAU's central body. This includes mandates related to inter-sectoral collaboration and the promotion of community participation. In addition, the SNS, created by Law no. 25/91[66] is confused with MISAU. SNS employees are part of the state apparatus. MISAU's accumulation of health provision functions weakens its performance of principle tasks: formulating policies, setting standards and regulating, financing and supervising health services.

The following factors weaken MISAU's leadership and authority, particularly at the most peripheral levels: lack of qualified personnel at every level, but particularly at district and provincial levels; organisational fragmentation; centralised top-down management; poor horizontal communication between bodies/units and excessive verticalisation of Directorates and central departments, reinforced by vertical projects.

Although there is some evidence that some functions have been delegated to the provincial level, (i.e. basic and elementary level human resources management and the transfer of some decision-making power over resources) there has been no concurrent decentralisation of similar institutions. This has reduced the effectiveness of the

decentralised functions. The role of the municipal government in the health sector in their area of jurisdiction is not clear, with the local health structures continuing to be directly subordinate to MISAU.

Policy

MISAU intends to improve the efficiency of sector management and promote users' participation in health services and intersectoral collaboration. It will do this through implementing a decentralisation programme involving the gradual transfer of resources and decision-making power and planning and management functions within MISAU. This process will take into account the principles of equity and economies of scale and preserve the positive gains made by the sector.

Strategies

Prepare a 'Health Sector Decentralisation Programme' based on the sector's experience and other evidence. The Programme should clarify the following aspects: the operational objectives of decentralisation; the resources, functions and authority that are to be transferred, and to which levels; the authority relationships between the various levels; adapting the organisational structure to the changes; strengthening the decentralised units; intersectoral collaboration and community participation.

Various types of decentralisation are anticipated, considering the nature of the country. These forms will include:

- Progressive and gradual deconcentration of functions to provincial and district levels;
- The delegation of management and planning responsibilities to the level III and IV hospitals, whose forms of authority and relationship with MISAU need to be clearly defined in contractual agreements. These agreements will allow MISAU to implement a policy of 'Strategic Services Purchasing'.
- The devolution of the Municipalities refers to the transfer of responsibilities for primary health care services to locally elected bodies.
- Develop SNS as a semi-autonomous service structure with specific functions for providing health care.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

- The success of the Institutional Development Plan will depend on the implementation of Integrated Means of Change which covers areas such as organisational structure (authority relationships), management systems (working processes), personnel training (motivation and development) and organisational values (supportive relationships, team work, positive attitudes to change), contributing to a balanced and integrated transition process.
- The creation of a Committee for Institutional Development to direct and monitor the process is equally important.
- Effective, inclusive communication within the sector about the process of decentralisation, clarifying the 'why', 'what' and 'how' would facilitate the process and reduce the fear of change.
- Creating a professional management career structure is an important condition for success. This will create conditions for stabilising management, particularly in the decentralised units.
- MISAU's present institutional capacity may hamper the success of the process.
- The lack of confidence due to earlier unsuccessful processes may also be an obstacle.
- The non-implementation of an integrated decentralisation process of state apparatus could be a significant obstacle.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Revision of MISAU's statute	X					DPC
Analyses of decentralisation policies, external links and accountability.	X	X				DPC
Consultation with MISAU's central and peripheral bodies/units, the Municipalities and communities.	X	X				DPC
Studies on decentralisation and inter-related areas.	X	X				DPC
Revision of health sector legislation	X	X				Legal Assessor
Analysis of training institutions	X					DRH
Formulation and implementation of a programme of courses related to the decentralisation process		X	X			DRH
Preparation and implementation of the Effective Decentralisation of the Health Sector Programme		X	X	X	X	DPC
Resources required:	Working funds, personnel & Technical Assistance, materials and equipment.					

E.2. Institutional Capacity-Building

E.2.a. Human Resources [67]

Analysis of the situation and definition of the problem

According to data from the Personnel Information System (SIP), on 31/12/2000 the National Health Service employed 15,926 people who received salaries from the State Budget (see table 1).
The work force pyramid at the beginning of the decade was characterised by an excessive number of elementary, basic auxiliary staff and a relative shortage of staff at middle and senior levels. The implementation of PDRH helped to correct this situation to a great extent: the proportion of senior level staff rose from 1.3% to 3.7% and the proportion of middle level staff rose from 5.4% to 15.6%. Personnel without technical qualifications decreased from 50.8% to 41.1% (annex, table 2).
There is still a shortage of specialised doctors at the third and fourth levels of the system. Expatriate technical assistance has been recruited to resolve this problem, normally organised through bilateral contracts, partnership and co-operation.
The distribution of personnel between the different regions of the country is unequal, prejudicing the northern provinces. The situation is improving slowly, as shown in Table 3 in the annex. The proportion of the work force in Maputo province and city fell from 25.3% to 18.6% while in Niassa, Cabo Delgado, Nampula and Zambezia the proportion rose from 31.1% to 34.2% (see annex: Table 3).
In terms of gender, 55.1% of employees are male and 44.9% female. Women doctors represent 47% of the total, and in the 26-35 age group (mostly trained in the last decade) women outnumber men by 5%. This is an example of MISAU's commitment to gender equality (annex: Graph 3).
Personnel numbers have not kept pace with the growth in the health network over recent years. There are various reasons for this, for example, the excessively bureaucratic recruitment process and poor co-ordination with participants which have reduced MISAU's capacity to absorb recently-qualified personnel. Another problem is the excessive concentration of personnel in the large cities and the difficulty in placing people in more peripheral areas. This situation contrasts with the capacity to train technicians whose numbers have risen since the implementation of PDRH. Between 1992 and 2000, 2055 basic level and 1238 middle level technicians graduated. In 2001,

it is estimated that there will be approximately 918 elementary, basic and middle level graduates.
From 1996, the training sector has benefited from PRSS funds to finance the courses included in PDRH (1992-2002). Multilateral and bilateral co-operation have supported training courses in specific categories and/or in training institutions in particular provinces. However, as funding linked to PRSS terminates in 2000 the sector could face funding problems in the short term.
Post-graduate training of national doctors increased significantly in recent years. From 1995 to 2000, 40 specialists graduated, and between 2002 and 2004 it is predicted that about 100 doctors will graduate in specialist areas including medicine, paediatrics, surgery and gynaecology-obstetrics.
In terms of the work force structure, there is an excessive number of levels (6: elementary, basic, medium, medium specialised, bachelor and masters) and categories. At the same time, the curricula for the various career paths tend to be similar and need to be better differentiated. The composition of the essential teams for each level of attendance has not been recently defined, and human resources management is carried out without rational, standardised criteria. Continuous training activities have generally been implemented sector by sector, depending on the availability of funding for the vertical programmes. Training has mainly benefited particular professional groups and categories. There is no systematic supervision of health activities and no integration between supervision and continuous training.
Employees are de-motivated owing to difficult living and working conditions (lack of equipment, insufficient skills) and generally unsatisfactory salary levels. The HIV/AIDS epidemic has also contributed, causing excessive staff losses and reducing the number of candidates for health courses.

Policy

The Health Sector provides essentially human services. It is necessary to invest and maintain investment to ensure that there is sufficient capacity to serve the population and fulfil the Sector's Mission objectives in both the public and private sectors.

To improve the quality of provision by health personnel, instruments must be created to encourage good performance. It is important to modernise the human management systems.
Up-to-date initial and continuous training that is appropriate for the needs of the sector is essential and should be a priority.

Strategies

Planning and management area

- Personnel management mechanisms that permit horizontal and vertical career progression for the employee, linked to continual improvements in professional performance;
- Find ways of making public health careers more autonomous, allowing the flexibility needed by the human resources management system.
- Integrate and adapt information systems, ensuring that SIP becomes an effective, standardised instrument for both central planning and sector personnel;
- Strengthen and professionalise the personnel management area, through re-qualifying staff and by contracting medium and superior level personnel;
- Implement a policy of improving living standards, including salary increases;
- Use placement criteria for personnel based on principles of equity, using flexible indicators which consider volume of work and development plans for the health network;
- Rationalise Human Resources, reducing categories and levels, clearly differentiating professional profiles using information given by users and in team performance surveys;
- Create mechanisms (salary subsidies, rotation, scholarships, in-service training etc.) which facilitate the placement of personnel in rural areas;

- Co-ordinate and integrate the various DRH funding mechanisms, particularly for training.

Continuous Training

- Investment in continuous professional development training for personnel, without resorting to formal courses that lead to promotion.
- Improve the integration of tasks and functions of health team members through integrated and sustained supervision.

Initial Training

- Consolidate the system (moderate increases in the numbers of health professionals, particularly at medium and superior levels. However, the increase should not be so large that it reduces the likelihood of salary increases for existing personnel, or aggravates the poor distribution and management of personnel).
- Promote primary health care personnel training.

Indicator(s)

Planning and Management

- Updated information about human resource characteristics (who they are, how many, what they do, how they work, where they are).
- Strengthened provincial human resource teams with middle level technical staff and at least one at senior level, with adequate equipment and a suitable communications network.
- Coverage of the health network by technical and administrative staff according to defined criteria (essential teams, activity indicators).

Continuous Training

- Functional Provincial Continuous Training Sectors, with equipment to produce educational material and for distance learning, competent technical and teaching staff and tutors for in-service professionals.
- At least 90% of personnel participating in continuous activities leading to vertical career progression.

Initial Training

- Estimates of the basic, middle and specialised technicians to be trained by 2010 (=5400 recent graduates).
- Global pass rate above 85%.
- 100% of courses completed by the agreed date.

Conditions for success and constraints to implementation, including necessary resources

Planning and Management

- The quantity and quality of central and provincial teams at middle and senior levels need to be improved.
- In-service human resource management training is required for existing personnel.
- Reinforce equipment, working instruments and means of communication among the provinces and between the provinces and the central level.

Insert 8: Human Resources, conditions and standard of living

Without improving the standard of living for health personnel and creating career prospects in the sector, it may be impossible to realise the ambitious objectives of the Strategic Plan.

Continuous Training

- Technical (personnel) and financial aspects of the sector need to be strengthened at central and provincial levels, leading to the gradual integration of responsibilities, the circulation of relevant information, the integration of

Continuous Training programmes, activity planning and implementation and the dissemination of results.

- It is essential that the Quality Assurance group and the Continuous Training Department co-ordinate their efforts, rather than working as 'vertical autonomous programmes'.
- Continuous Training activities should be co-ordinated with integrated supervision that is carried out in a systematic, inclusive manner. The CT strategy should focus on the actual situation of the working team and not on the responsibility areas of the centralised programmes. The responsibilities of the integrated supervisory teams in the provinces should be defined.
- Continuous Training activities should be formally accredited to permit career progression.
- The costs of Continuous Training will increase progressively as the organisation of the sector improves at the central level and training begins in the provinces. The sector may need 3 million USD globally per year to cover the volume of planned training activities. As the training programme expands, costs similar to those for initial training may be required.

Initial Training

- The sector already possesses the minimum conditions for implementing initial training activities. Foreign competent and qualified Technical Assistance is recommended where possible to improve the quality of training and assist with essential resources. The main problems are financial ones. The average cost of training basic and medium level technicians, excluding the use of infrastructure, was calculated in 1997 at approximately 8000 USD per trainee.
- Taking the training plan to 2010 as a reference, we may conclude that the annual global cost of Initial Training for the sector will reach 5 million USD.

Insert 9: Human Resources – training needs assessment

Technician training needs were assessed in the following way:

- Predicted demographic growth and its characteristics;
- Probable expansion in the health sector;
- Development of activities (based on the development registered in the 1990s , and considering the objectives of the Action Plan for the Reduction of Absolute Poverty (2000-2004);
- Estimated losses in the work force, particularly due to the impact of AIDS;
- The calculation for essential teams in the primary and secondary level health units, considering the documents by A R Noormahomed - M Segall (1992), and particularly H Martins (1998) and the characteristics of the existing network;
- The present and predicted capacity of the training system (Training Institutions);

The final estimate is based on the requirement for training about 5,400 new technicians (about 200 initial courses) by 2010 to meet the needs of the system. The priority areas continue to be nursing, obstetrics (SMI), medicine and preventative medicine. However, the system should not underestimate the serious lack of technicians in other categories such as dental health.

A significant effort is required (the average number of graduates should increase substantially compared with the 1990s). In response to the strategic plan's flexibility, planning should be revised annually and should be responsive to quantitative data about the work force. Variables and users' indications should be better defined.

Steps to be followed

Management Area	2001	2002	2003	2004	2005	Entity responsible
1. Isolation subsidies for every category		X				DRH/DAG
2. Definition of essential teams per level	X					MISAU
3. User/Trainer Communication		X	⇒	⇒	⇒	DNS/DRH
4. Adapting assessment instruments to the performance of health personnel	X	⇒	⇒	⇒	⇒	DRH/DNS/MAE
5. Improving the integration of health team members' tasks	X	X				DNS/DRH
6. Rationalising categories and levels of personnel	X	X				DRH/DNS
7. Institutional strengthening with personnel qualified in non-medical areas (including OC, DPS, DDS managers)	X	⇒	⇒	⇒	⇒	DRH/DNS/DAG
8. Improving links between MISAU and other participants in the appointment/placement process	X	X				DRH/DAP, MFP, MAE, DPAC, TA
9. Appointing/Placing recent graduates	X	⇒	⇒	⇒	⇒	DRH/DAP
10. Appointing/Placing technicians from outside the system	X	X				DRH/DAP
Planning Area	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
1. Integrate information systems (IS, SIS, health network)	X	X				DRH/DPG DPC/SIS
2. Economic and social incentive system		X	X			MISAU/MAE/ MPF
3. Personnel rotation system		X	⇒	⇒	⇒	DRH/DPG
4. Budget allocation for absorption of personnel		X	⇒	⇒	⇒	DRH/DPG, DAG
5. Improve information of funds availability	X					DRH/DAG/DPC & ext. partner
6. Administrative and financial mechanisms for managing external funds (pooling)		X				DRH/DAG/DPC and ext. partner
7. Select criteria for placing personnel	X	X				DRH/DPG DNS
Continuous Training Area	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
1. In-service training for personnel in rural areas		X	X	X	X	DRH/DFC
2. Increasing the capacity of the HCB, HCN and HPQ for post-graduate medicine		X	X	X	X	DRH/DNS
3. Creating a Continuous Training dept. and organisation of provincial sectors	X	X	X			DRH
4. Systematic implementation of Continuous Training activities as planned			X	⇒	⇒	DFC
5. Training managers for central, provincial and district levels	X	⇒	⇒	⇒	⇒	DRH/DAG and partners
6. Train trainers and build the capacity of others involved in training	X	X	⇒	⇒	⇒	DRH and other partners
Initial Training Area	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
1. Personnel for rural areas recruited and trained in the districts		X				DRH/DF DPS/IdFs
2. Revision of professional profiles based on health team assessment		X	X			DRH/DF DNS
3. Develop training plan (see annex)	⇒	⇒	⇒	⇒	⇒	DRH/DF
Resources required:						

E.2.b. Communications

Analysis of the situation and definition of the problem

The present lack of co-ordination causes significant communication problems between the Ministry of Health and its key partners. MISAU's different departments and sectors do not make full use of information which hampers communication about activities and links between the different bodies.

The various flows of information do not circulate efficiently within MISAU. Internal communication is extremely poor between the different directorates (horizontally through its structure as well as vertically).

The sector does not make good use of the media to broadcast information about health and fundamental sector issues. The media is only occasionally approached to cover important MISAU meetings. At the moment, only RESP[68] produces some publications to promote health care for all and organises radio and television publicity. There is no centralised communication body which MISAU could use to develop a productive relationship with the media and distribute regular publications within the Ministry and to external partners.

The lack of training in areas of communication, media, publications and marketing hinders the internal development of communication capacity. Formal and informal canvassing within MISAU and between MISAU and its partners needs to be improved and transformed into a co-ordinated dissemination process. At present, results of surveys are not widely shared within the sector. Indicators are not used to measure or evaluate levels of participation and stakeholders' opinions.

Policy

Communicate the vision, objectives and priorities for health in Mozambique to interested parties while building alliances with key partners to improve performance in the health sector.
Understand the needs and perspectives of the population concerning health issues and enable health personnel to improve health service provision.

Strategies

- Prepare and use key messages to support all communication activities;
- Develop canvassing processes to help meet the needs and aspirations of the population;
- Plan communication to improve co-ordination, guidance, monitoring and evaluation, while guaranteeing continuous improvement;
- Build personnel capacity through basic communication training to improve MISAU's internal communication;
- Adopt a proactive and co-ordinated approach to health information and relationships with the media;
- Improve the dissemination of information through regular publications;
- Use information technologies to develop and plan communication to improve and develop communication within MISAU and the health sector as a whole;
- Promote health through general communication activities.

Indicator(s)

- Level of employees' participation and knowledge;
- Population coverage;
- Quantity and quality of publications;
- Quantity and quality of news about health and its coverage in the media;
- Attitude of population and employees.

Conditions for success and constraints to implementation

- Commitment from the highest level of MISAU to support communication;
- Selection of a communications adviser and press attaché; training a communications group;
- Personnel training in aspects of communication.

Steps to be followed

Strategy:	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Contract a communications adviser and a Ministry press attaché / adviser	X					DPC
Create and appoint a communications group	X					DPC
Ensure that a sector resource centre is created for the principal actors		X	⇒	⇒	⇒	DPC
Prepare and produce a monthly diary		X	⇒	⇒	⇒	DPC
Produce and publish regular internal bulletins and other publications		X	⇒	⇒	⇒	DPC
Establish the function of the media within MISAU		X	⇒	⇒	⇒	DPC
Develop a database on journalists and publications	X	⇒	⇒	⇒	⇒	DPC
Collect information for the MISAU and SNS web page.		X	⇒	⇒	⇒	DPC
Promote continuous training courses in communication	X	⇒	⇒	⇒	⇒	DPC
Establish monitoring and evaluation processes for basic activities	X	⇒	⇒	⇒	⇒	DPC
Resources required:	Human, Material and Financial Resources - Communications Adviser - Ministry Adviser / Press Attaché - Communications group with diverse members					

E.2.c. Maintenance/Management of Health Technology

Analysis of the situation and definition of the problem

The National Health Service has always received significant support from a variety of partners. The diversity of this support has resulted in a great diversity of technologies. Sometimes these technologies are not appropriate for the country and are very difficult to maintain. The absence of clear guidelines for the acquisition of durable goods has contributed to the present situation of poor preventative maintenance.
There are no training courses in the country in biomedical technology which is reflected in the shortage of adequately trained maintenance service personnel.
This situation is further aggravated by the low professional status of biomedical technicians who manage specialised equipment such as X-ray machinery.
Users have been negligent in conserving durable goods; new technologies have been introduced without any user training and donations have been made without assessing the beneficiaries' real needs, their technical maintenance capacity and their financial capacity for operating the technology.

Policy

Develop norms and standards to rationalise the acquisition of technology and ensure that it is used effectively, promoting a culture of preventative maintenance. Sufficient capacity should be established at every level to manage technology by SNS staff or specialised contracted maintenance services.

Strategies

- Develop an multi-annual Action Plan to define and reinforce the norms and standards for technology acquisition and maintenance (see EHTP);
- Adapt the information system for technology management;
- Create opportunities for contracting management services for specialised equipment;
- Upgrade the qualifications of existing personnel to enable them to maintain basic, non-specialised technology, particularly at levels I and II (continuous training);
- Provide training to improve the academic level of personnel working in MISAU's technology maintenance and management bodies.

Indicator(s)

Planning:
- No. of Peripheral Operative Plans introduced.

Information System for Health Technology Management (SI_GeTS)
- No. of maintenance units using SI_GeTS Computer Programmes;
- Sectors using SI_GeTS Computer Programmes to manage SNS property;
- Volume of computerised information flow;
- Percentage of goods inventorised.

Management Support:
- No. of maintenance contracts for high technology equipment;
- % of apparatus in working order in relation to the total available at each level of attention;
- % of technology available in relation to the minimum necessary per level of attention.

Human Resources:
- No. of engineers entering the system;
- No. of medium level technicians entering the system;
- No. of trained technicians.

Conditions for success and constraints to implementation

It is essential that the beneficiaries contribute to preventative maintenance. The budgets allocated to maintenance should be guaranteed and not diverted for other uses. SNS must have the capacity to mobilise specialised technical support to ensure the efficient functioning of technology, particularly in large hospitals. Attention should be paid to the allocation of internal or external resources (financial or human) for technology maintenance. External partners should respect MISAU's need to manage state property in the health sector.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Formulate a Management Action Plan for Technologies to be presented to the National Health Sector Co-ordinating Council in Maputo, May 2001	X					DAG/DM
Assess existing technology and propose appropriate technology to be acquired (Equipment Commission)	X	⇒	⇒	⇒	⇒	DAG/DM DNS
Develop and maintain the information system to manage health technology	X	X				DAG/DM
Co-ordinate with DPS for management support in supervising and monitoring Hospital Maintenance Services & Provincial Maintenance Sectors	X	⇒	⇒	⇒	⇒	DAG/DM
Admit personnel at medium and superior levels to improve management and the quality of services provided	X	X				DRH
External contracting of maintenance services for high technology equipment	X	⇒	⇒	⇒	⇒	DAG/DM
Continuous training for new and existing equipment management and maintenance personnel	X	⇒	⇒	⇒	⇒	DAG/DM
Raise users' awareness of the need to care for Health equipment	X	⇒	⇒	⇒	⇒	DAG/DM SMH/SPM
Resources Required:	Technical Assistance, working expenses, materials and equipment, scholarships and other training funds.					

E.2.d. Modernising the management systems

An important aspect of institutional capacity-building is adapting management systems to the needs of managers and administrators working in the various health institutions. The management systems should reflect, as far as possible, the key interventions of these institutions and help them to achieve their objectives.

Focusing on the objectives of the respective management units and their required resources will improve the efficiency and practicability of management systems, ensuring that they meet the needs of the respective institutions. MISAU should consolidate planning and budgeting using available resources and prepare accounts in a transparent manner, linking performance and attainment of objectives to funds spent.

E.2.d.1. Planning systems.

Provincial Strategic Planning [69]

Analysis of the situation and definition of the problem

Planning has essentially been a top-down activity and the provinces themselves have no negotiating instruments for implementing their plans and programmes with partners. The Provinces have experience of plan preparation, i.e. the Integrated Plans, although these do not include medium and long term vision. The process of Provincial Strategic Planning has already begun, though it is only in its initial stages in some provinces.

Policy

Every province should develop a process that is in keeping with PESS, involving partners, DDS and civil society. The provinces should diagnose their own problems, improving their capacity to analyse and use modern management instruments. The Provincial Strategic Plan should link identified needs with the resources necessary for implementation. The Strategic Plan should guide annual planning, and the whole planning process should be driven by a capacity-building/action dynamic.

Strategies

Five phases should be followed in each province:

1. Negotiation. The provinces themselves should ask to initiate the PESS process. In this phase, working groups will be selected and responsibilities allocated, particularly at provincial level, with the support of partners;
2. Prepare a diagnostic study at provincial level including management (MOST) and financial (FIMAT) aspects, Information Systems and Expenditure Revision;
3. Canvass civil society to identify principal health needs and alternatives provided by civil society;
4. Logical Framework, preparing a matrix of solutions for the major problems faced using this methodology;
5. Prepare and approve PESS, finalising the plan and presenting it to the DPS consulting council.

Indicator(s)

- No. of strategic plans prepared;
- No. of strategic plans implemented.

Conditions for success and constraints to implementation

Successful implementation depends on the involvement of provincial teams in the process. A clear diagnosis of the present situation in the Provincial Health Sector is also essential. The facility of converting PESS into annual budgeted plans will also contribute to success. PESS is a continuous process of action which still needs to be improved. At present, the MPF budgeting method does not facilitate PESS activities.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Prepare methodologies	X					DPC
Negotiate with the provinces	X	X				DPC-DPS
Develop plans	X	X				DPC-DPS
Develop implementation methodology		X				DPC
Implement methodology		X	X	X	X	DPC
Resources Required:	Technical Assistance and working expenses.					

Strategic Plan in the large urban centres [70]

Analysis of the situation and definition of the problem

The urban health situation is unsatisfactory, particularly in Maputo city and province and in other cities such as Nampula and Beira.

- These cities have a high population density (particularly Maputo) and the population is growing faster than in the rest of the country;
- These cities have the most complex hospital infrastructure and the highest number of health professionals. A larger and faster-growing allocation of resources at national level is required, not always in keeping with the final objectives of equity and poverty reduction;
- The epidemiological profile of these cities' suburbs is comparable to the rest of the country, but there are a greater number of accidents, including road accidents.

The cities have been allocated a large proportion of the national resources available for the National Health Service and are continually exerting pressure for additional resources. For these reasons some special considerations have to be made.

Policy

The process of strategic planning in the large cities needs to be considered as a special case, given the particular problems of urban health. A more functional redistribution of existing resources should be made in return for improved use of these resources. Resources should be used to benefit the most vulnerable communities, particularly in marginal areas, with emphasis on levels I and II and their referral systems.

Strategies

- Prepare health development plans for the large cities following the process used for the Provincial Strategic Plans;
- Clarify, without delay, the municipalities' role in promoting and providing services in the city in the medium and long term, emphasising promotional activities, community participation and processing users' complaints;
- Adjust cost recovery to the socio-economic levels of the different social strata of urban populations;
- Encourage national and international non-profit-making NGO participation in managing existing or new health units. These units should remain open beyond normal working hours and prices should be accessible. The units should be self-supporting in the short term;
- Encourage the private sector to operate in high-density areas not covered by the public sector;
- Determine the epidemiological profile of the large cities, particularly trauma caused by road accidents and its impact on service provision in the cities. Study the viability of accident insurance as a means of guaranteeing financial resources for emergencies.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

- When preparing Strategic Plans in participation with representatives of health institutions, the future development of the cities should be taken into account,;
- Implement an effective medicines management and monitoring system;
- Create mechanisms and means for mass communication on the use of the city's health services and the tariffs charged;
- Strengthen the role of DPS in monitoring the norms and criteria for redistributing national and Municipal resources.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Analysis and/or study of accidents	X		X			DPS/Cid.
Study of accident insurance		X				MISAU
Accident insurance (implementation)		X	X	X	X	MISAU/DPS
Analyse the health network		X				DPS/Cid.
Implement recommendations on the health network			X	X	X	DPS/Cid.
Co-operation or co-management with NGOs or other partners		X				MISAU/ DPS/Cid.
Co-operation or co-management with NGOs		X	X	X	X	DPS/Cid.
Study of costs and tariffs		X	X			MISAU/ DPS
Implement recommendations			X	X	X	DPS/Cid.
Design PESS		X				DPS/Cid.
Implement PESS			X			DPS/Cid.
Follow-up to PESS			X	X	X	MISAU
Resources Required:	Technical Assistance, working expenses, research etc.					

Annual Planning[71,72]

Analysis of the situation and definition of the problem

Planning, at present, is an annual exercise of little importance. The planning system is complex and has no set implementation mechanisms. It does not help to prioritise the needs of the districts and provinces and tends to be a routine activity carried out with little serious analysis. It is not linked to Institutional Development nor used as a reference document to guide normal work. The provinces see few advantages in the annual planning process except as a means of obtaining financial approval.

Policy

Annual Planning and the operative part of PESS are basic tools for guiding SNS management. All employees should use this plan as a point of reference in their respective areas of responsibility to plan their personal working agendas for the year.

Strategies

Annual planning should take PESS into consideration. PESS should be revised by the National Health Co-ordinating Council to provide more specific guidelines to direct the complimentary cycles of annual planning at both provincial and central levels.
Annual planning should be carried out according to a calendar cycle:

1. Diagnosis or assessment of the previous cycle that includes the following phases;
2. Policy guidelines established by the National Health Co-ordinating Council;
3. Annual programming;
4. Resource allocation;
5. Dissemination of programming, adjusted to DPS and DDS levels;
6. Execution, based on the programme;
7. Quarterly monitoring linked to programming aspects (health, financial, supervision, other activities, investment);
8. Annual evaluation.

The implementation and monitoring phases should be emphasised in this cycle, developing methodology, administrative processes and financial aspects to facilitate the programmed activities.

The potential implementers of the annual plans should be closely and actively involved in the PESS formulation phase in order to better facilitate implementation. The first annual plan will be fully based on PESS. In the following year, it is hoped that the national plan will be based on the evaluation of the previous year's annual plan and on the recommendations and observations about PESS made by the National Health Co-ordinating Council.

The central level and DPS should have an operative annual plan which should be reflected in the operative plans of all the Ministry Directorates and in the DPS.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

Annual planning should follow a calendar cycle, approved by MISAU and the various partners. Responsibilities should be divided between MISAU, partners, DPS and DDS as follows:

- MISAU prepares policies and defines criteria for allocating resources;
- MISAU, in collaboration with partners, allocates resources and carries out quarterly monitoring and annual evaluation;
- Partners agree with resource allocation for the provinces and manage the delivery of these resources. They may collaborate in monitoring and evaluation;
- DPS efficiently implements the programmed activities to obtain new resources, which are directed to the DDS. DPS carry out quarterly monitoring and annual evaluation of the DDS;
- DDS follow their own annual programming and are responsible for quarterly monitoring and annual evaluation of the health units.

The National Health Co-ordinating Council should reinforce its role as director of policies and resources. It should select an appropriate date for its annual meeting and encourage positive competition between the DPS.

For the success of PESS, annual planning should be part of the various sectors' normal work. To ensure compliance with the annual planning cycle, the different directorates should present a quarterly report to the Ministry of Health Consultative Council. The provincial level should also receive progress and quarterly reports from the DPS Collectives. Budget distribution, both from the State budget and donor funds, should be based on these reports. Previously-agreed criteria should be applied as well as bonuses for good results. In this way, a double dynamic will be created between the Ministry and DPS, in which PESS acts as a guiding document.
The work plans of the various departments are guided by their respective PESS at the national and DPS levels. At DPS level, this work is facilitated by existing Integrated plan methodology.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Defining Policies	X					DPC
Adopting an annual planning calendar		X				DPC/Partners
Institutionalising present integrated planning	X					DPC/Partners
Software	X	X				DPC
Implementing the annual planning cycle at all levels, including central.		X	⇒	⇒	⇒	DPC, DPS, DDS
Resources Required:	Technical Assistance, software and equipment.					

E.2.d.2. Financial management system[73,74]

Analysis of the situation and definition of the problem

The present planning and budget system fails to link sector policies and priorities with resource allocation. Information is poorly used and disseminated making it difficult to base planning on earlier experience. The planning/budget systems for state and external funds (i.e. Budgetary support to the provinces) are still incompatible and the fiscal and planning calendars are out of sequence. Some of the inefficiency in budget execution is caused by bureaucratic procedures (poor co-ordination between DPPF and DPS), a lack of liquidity in the provinces and other reasons such as an inadequate market for purchases. Managers spend a great deal of time travelling to deal with accountancy or salary issues.

The implementers often fail to present documents justifying expenditure (transport tickets, signed travel authorisations and work reports). There is still a lack of institutional administrative and financial capacity, despite the efforts made under the ambit of PERMAS.

Policy

Under the ambit of SWAP and decentralisation, the financial system should be adjusted to permit integrated management directed towards the sector's priorities, improved efficiency, transparency and accountability.

Strategies

- Develop the financial system as a continuation of PERMAS[75], focusing on building the capacity of the Provincial and District Health Directorates;
- Computerise the financial system in the short term;
- Introduce uniform planning/budgeting programmes and mechanisms in line with MISAU's mission;
- Appoint qualified financial management personnel in the short term;
- Develop instruments to codify budget and fund execution, considering the levels of attention and specific objectives of SWAP and CDFMP, in negotiation with MPF and external donors.

Indicator(s)

Aggregated rate of execution in the provinces.

Insert 10: PriceWaterhouseCoopers: the Financial Management System.[76]

"The 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 plan 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""(PWC)

Conditions for success and constraints to implementation

"The accounting and financial management laws and regulations of the 'State Systems' in the Ministries are well-organised and inclusive. They focus principally on the complex procedures relating to bank accounts and expense reimbursement which practically guarantee that the Ministry does not overspend its budget." [77]

The difficulty in retaining qualified personnel is an important constraint which hampers the sustainability of Technical Assistance contributions.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
DPAGs capacity building	X	⇒	⇒	⇒	⇒	DAG
Developing a computerised Financial System (pilot in Niassa and Inhambane) to codify budgets, expenditure and income, whether on or off budget, in collaboration with MPF.	X	⇒	⇒	⇒	⇒	DAG & DPC
Implement Phase II of PERMAS	X	⇒	⇒	⇒	⇒	DAG
Produce a manual for financial management and accountancy procedures in collaboration with MPF.	X	X				DAG
Regular self-evaluation of financial management capacity, using instruments such as MOST, FIMAT and integrated supervision.	X	⇒	⇒	⇒	⇒	DAG
Resources Required:	Recruiting Superior and Medium Technicians and equipment for all DPSs. Training DAG and DPAG staff, including scholarships. Technical Assistance. Working funds.					

E.2.d.3. Monitoring/Assessment System [78,79,80,81]

Analysis of the situation and definition of the problem

MISAU has a variety of uncoordinated information subsystems which result in fragmented processing and partial analysis of data. However, there have been notable successes in the SIS components, particularly at levels I and II. A certain degree of institutional capacity for collecting and analysing information for management has already been established. HIS is effectively a nuclear system of information management, systematically collecting concrete data for decision-making at every level. However, the system's employees lack motivation and adequate training and supervision.

The indicators produced by the different subsystems are not validated objectively and are not used often enough to monitor the health service's performance and to evaluate options for health policies and strategies.
For various reasons, the dominant management culture in the sector does not encourage the use of information in decision-making processes. HIS is limited to levels I and II, although it has valuable information which should be used in decision-making processes. HIS is still not developed and institutionalised at levels III and IV, although these levels consume most of the health sector's budget.
In numerical terms, there are very few qualified personnel in this area at central, provincial and district level. Personnel in the districts work part time and have other responsibilities. There has been no continuous training in information system management and health statistics and information are not included in pre-graduate training programmes.

Legal mechanisms have not been implemented for regulating data collection in the private sector. There are no clear guidelines on adopting and developing information technologies. It is necessary to identify specific areas for intervention with their own characteristics and needs, and update and strengthen applications in the sector, gradually integrating them into a more general health sector information system.

Policy

An integrated information system is essential for monitoring and assessing performance in the entire health sector. The system should be integrated to combine information from the different subsections. It will be used for monitoring performance and evaluating health care and resource management.

Adapting HIS is a priority in the sector for monitoring and strengthening the decentralisation process. To create an integrated information system, a central data base will be set up and shared by the different decision-making authorities at this level.

The existing systems will be updated, strengthened and extended (including the private sector) to obtain wide-ranging information on the country's health activities. The systems will be progressively computerised, aiming to create uniform and compatible applications. Synergy will be created between the manual and computerised systems and communication will be improved both inside and outside the sector. This issue will be discussed in more detail in the following section.

Health personnel must be familiarised and trained in the basic concepts and skills of data processing and interpretation to encourage a result-oriented work attitude. Personnel in the executive, clinical, support and preventative areas will be given in-service training. Service managers at all levels should be specifically trained in using information for decision-making (as part of their general management training). Personnel directly involved in data processing should receive specific, multi-disciplinary formal and in-service training with the aim of professionalising this area of work.

Strategies

1. Adapt the present routine information system, gradually integrating the departments' information subsystems and the human resources and financial management systems.
2. Consolidate the existing subsystems for departmental micro-management, ensuring the necessary co-operation with HIS;
3. Introduce data on quality monitoring, emphasising the user;
4. Create performance assessment mechanisms for the health system as a whole, in the context of PESS - SWAP;
5. Develop co-ordination mechanisms with other institutions such as the National Statistics Institute (INE), with other Ministries and other sectors which generate and collect relevant health information (Civil Register);
6. Strengthen HIS's operations at levels I and II and expand HIS to levels III and IV. Design a system which supplies gender-sensitive information, and which supports managers' decision-making. Assure that the principles, strategies and technologies promoted at district level are in line with those defined by MISAU and reinforce SNS management systems;
7. Promote the establishment of a service or centre (for 'intelligence') for processing data and analysing, presenting and disseminating information.;
8. Encourage managers to use information more effectively. As information influences managers' actions and contributes to action research, training should be linked to the present processes of management system revision. These processes are being implemented as part of decentralisation and public sector reform, particularly in the health sector under the ambit of SWAP. HIS should also be used for managers' self-evaluation of information, focusing on the relevance of data and the usefulness of periodical summaries and publications.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

In 1997, the category of Statistics and Planning Group was raised to Provincial Planning and Co-operation Department, by Ministerial Decree. This created a window of opportunity which should be used to raise the profile of this area and improve the dissemination of information to other departments.

The increase in use of computer equipment may bring about changes and a new culture. The SNS computerisation process is essential for the success of the

monitoring/evaluation system, and an opportunity for increasing the capacity to analyse, interpret and use information at the level at which the data was produced. This should promote autonomy and rational, appropriate decision-making at each level while safeguarding national leadership of the process at all times.

A constraint within HIS is the shortage of full-time staff to process data at the different levels. This is aggravated by the fact that staff are appointed inappropriately and follow up of staff in work processes is inadequate.

The implementation of the law regulating data collection in the private sector (Law no. 26/91, BR no. 52 - I Series, *of 31 December, which authorises health care provision by profitmaking or non-profitmaking private individuals or groups*) is an area which needs attention. A more complete picture of the country's health profile is needed.

Steps to be followed

Strategy I	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Analyse and reach a consensus on uniform HIS principles, contents and procedures to be used in MISAU and the provinces	X					MISAU
Analyse the viability of expanding the management approach and instruments of district programmes and services in neighbouring districts and at DPS level.	X	⇒	⇒			DPC, DPS, UEM
Create a data base.		X				MISAU
Ensure that the computerisation plan is in line with other sectors' plans, such as MPF and MAE.		X				DPC
Pilot the HIS proposal in one or two provinces		X	⇒			DPC
Implement HIS in the provinces			X	X	X	DPC
Prepare HIS management / use manuals				X	X	DPC
Integrate HIS into personnel training.					X	
Identify and test instruments for monitoring quality. Collaborate in Quality Assurance development				X	X	DNS, DPC
Strategy 2	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Prepare a list and reach a consensus over the type of information to use in monitoring PESS in the context of SWAP	X					MISAU, external partners.
Approve monitoring indicators and mechanisms for PESS	X					MISAU, INE, ext. partners
Approve indicators and instruments for assessing SNS performance	X					MISAU, INE, ext. partners
Monitor PESS		X	⇒	⇒	⇒	MISAU, parc. Ext.
Monitor SNS performance			X	⇒	⇒	MISAU, parc. Ext.
Strategy 3	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Encourage the adoption of criteria and an explicit process to select new data and new indicators for HIS	X	⇒	⇒			DPC, DNS
Implement organisational and training measures based on evaluations of HIS.	X					DPC, DNS, OMS
Carry out surveys and test modified registers		X	⇒			DPC,INS

and forms to register gender (in representative health units)						
Inventorise existing information systems at levels III and IV.		X				DPC
Pilot the system prepared for levels III and IV.			X			DPC
Reach a consensus to approve HIS at levels III and IV.			X			DNS, DPC, DRH, DAG
Implement HIS in provincial and central hospitals				X	X	DPC
Analyse the private sector systems and reach a consensus over integrating them.		X	⇒			DPC, INE, Private Inst.
Strategy 4	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Strengthen DIS capacity	X	⇒	⇒	⇒	⇒	DPC, DRH
Introduce HIS in the training curricula for health personnel		X	⇒	⇒	⇒	DPC, DRH, CRDS
Define the profile and career for health data and statistics management personnel			X	⇒	⇒	DPC, DRH, INE, MAE
Train personnel to analyse and process data		X	⇒	⇒	⇒	DPC, DRH
Define and approve the functions of units responsible for HIS management						DPC, DRH
Strategy 5	**2001**	**2002**	**2003**	**2004**	**2005**	**Entity responsible**
Contribute to the design and implementation of modernised management systems						DRH, DPC, others
Build the capacity of managers at all levels on the use of information for decision-making		X	⇒	⇒	⇒	DPC, DRH
Resources Required:	Working and personnel funds: 137 medium level professionals (Distr.) & Central: 1 economist, 1 epidemiologist, 1 bio-statistician, 1 preventative medicine specialist, 1 computer specialist, 2 administrators, 1 archivist; materials and equipment.					

Information Technologies

Analysis of the situation and definition of the problem

Planning, co-ordination and integrated development of infrastructure and technology are still inadequate, although progress has been made in computerising HIS levels I and II.

There are no precise, clear guidelines concerning the adoption of technology, i.e. the acquisition of applications follows separate and sometimes incompatible guidelines. Most of the systems lack an integrated vision, use poor quality basic materials which do not satisfy their specific needs. Some of the projects are not properly monitored by MISAU and are dependent on external entities which endangers continuity.

No inclusive communications infrastructure exists that is shared by the various users and applications. Technical assistance and support for basic packages is carried out by private companies or individuals contracted directly by each directorate or department. This means that MISAU is not able to benefit from economies of scale. The same situation exists for information technology service provision, for example, a variety of companies provide Internet[82], and E-mail[83] and services for MISAU.

In terms of Human Resources, the Computer Department, responsible for MISAU's Information Technology, has been forced by a lack of resources to formally abdicate its functions, delegating the responsibility for IT/IS (Information Technology, Information

Services) maintenance, development and support to each of the Directorates. This has lead to an uncoordinated effort to build the capacity of specialised IT/IS personnel. There are great differences in the emphasis that each MISAU Directorate places on IT/IS.

HIS is not completely automated, and much of its technology is out-of-date.

Expectations have been raised by the introduction of an information management package - DHIS[84]. This is a computerised database which is being introduced in an initial pilot phase in the districts, to be extended for use at provincial and central levels.

Some initiatives have produced positive results, such as the Maintenance Information Systems and various systems developed by the National Health Directorate. Experience gained in these cases will be very valuable as a point of reference.

Tentative attempts have been made to use Telemedicine[85] between the Radiology services of Maputo and Beira Central Hospitals. However, there have been many problems in transferring data making the technology difficult to use from the outset.

Specific areas of intervention need to be identified to define a master plan for developing IS/IT in MISAU. HIS will be the principle focus of action because of its inclusiveness and the type of information it disseminates. Information in other MISAU subsystems may be included in one of the following three groups: Information on Goods and Materials, Financial Information and Personnel Information. In second place is data and communication infrastructure to support all integrated development. The last area is productivity tools to be used individually or in groups, and training in the use of these tools.

Policy

Define a computerisation policy for the Ministry of Health and strategies for the development of computerised IS for MISAU and SNS.
Reach agreements on key issues for ensuring that IS and associated technologies are accepted as indispensable tools for performing quality health sector tasks in a sustainable manner.
Draw up, in the form of a programme, priority tasks and others aimed at achieving established objectives.

Strategies

- Align IS/IT strategies with the needs of MISAU's strategy, prioritising systems which directly contribute to the success of MISAU's strategy, with particular emphasis on HIS;
- Prepare for the global integration of all systems;
- Ensure that development and support capacity is available for strategic, operational IS/IT:
- Complement MISAU's capacity, defining mechanisms for IS/IT service provision by the public/private sector;
- Maximise the reach, availability, quality and security of the systems;
- Centralise the management of the main computer systems, administration of individual computer systems and technological infrastructure;
- Contribute to greater operational autonomy in the provinces, in line with MISAU's strategies and policies;
- Analyse the cost-benefit relationship in all decisions related to IS/IT;
- Ensure that the systems develop according to an open systems policy;
- Select new components (both hardware[h] and software[i]) for MISAU based on market forces;

- Develop and improve the systems in line with technological developments.

Indicator(s)

- Percentage of users relative to the total number of employees with access to computers;
- Average time for training employees;
- Volume of training implemented;
- Rate of trainee satisfaction;
- Employees' attitudes.

Conditions for success and constraints to implementation

- Explicit support from the highest authorities in MISAU;
- Replacing MISAU's computer network and developing staff capacity for working with the new system;
- Awareness that all are responsible for managing information about their activities;
- Creating a technological infrastructure that reaches all users;
- Shared vision of IS/IT's fundamental role in implementing the strategy;
- Create the habit of using computers, promoting intensive capacity-building and training courses in individual and group production tools.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Develop a budgeted action plan	X					DPC
Design a continuous training plan	X	X	X	X	X	DPC
Begin the process of implementing the plan: - Create a data network for MISAU, HCs and DPSs.	X	X	X			DPC
- Internet and E-mail access;	X					DPC
- Develop Intranet for MISAU[j]	X	X				DPC
- Introduce software for integrated systems management in MISAU and HCs;		X	X	X	X	DPC
- Ensure that the basic systems are resilient to hardware, energy and communications failure and provide physical protection for equipment;	X	X	X			DPC
- Promote Telemedicine;	X	X				DPC
- Create more complex computer capacity in the DPS, DDS and Health Units;	X	X				DPC
- Define an outsourcing[k] policy.		X	X	X		DPC
Monitor implementation						DPC
Resources required:	Working funds, equipment and technical assistance					

Research and Investigation[86]

Analysis of the situation and definition of the problem

Health research in the country is in a relatively dormant state with an uncertain agenda. There are no clear, concrete guidelines from MISAU on health research, and no legal framework has been adopted that defines the sector's mandates and priorities in this

[h] The physical part of the computer used for processing information.
[i] Group of programmes necessary for the computer to function, aimed at resolving a given problem or for computer processing.
[j] Internal information network using Internet technology.
[k] External contracting for most internal IS/IT, through specific agreement.

area. Numerous institutions linked to MISAU (INS, CRDS, FUMIS, CISMA, FdM) carry out various types of uncoordinated research into health while following agendas of their own in a context of extreme shortages of resources. Health research is not 'visible' in practice. Contrary to policy declarations, it is a non-priority activity of little importance. As a consequence, there is little decision-making based on the results of research.

Human, financial and material resources allocated to this area are severely limited. For example, the National Health Institute (the institution for health research) has no archive documenting studies carried out in the sector. The training, dedication and experience of health researchers is unknown. Research carried out by INS has focused on laboratory areas, traditional medicine and some illnesses such as resistance to malaria treatment.

Experience in carrying out Epidemiological and Health System studies is extremely limited. INS is experiencing a general management crisis. Corrective measures are being taken, but the effect of these will only be felt in the medium term.

Other institutions which carry out research are the Medical Faculty of Eduardo Mondlane University which has developed an organisational process to support research. Maputo Central Hospital has carried out research in some clinical areas. Other institutions finance research and carry out or contract their own projects, sometimes in co-ordination with the Ministry, e.g. USAID, Swiss Co-operation, UNPF, Save the Children, World Vision and MSF. There are other institutions that do not work exclusively with the health sector but which carry out research in certain health areas, such as FAO and the National Statistics Institute. However, findings are infrequently disseminated to a limited number of recipients. There is little communication between the various institutions and research is generally an isolated activity within the system.

There is still no legal framework defining the ethics, norms and standards for experimentation on human beings.

Policy

Research should be an important and continual activity that should support the objective evaluation of health policy and programme decisions. Collaboration is needed between all the institutions that are involved in clinical, epidemiological, anthropological and health system research. There should be a balance between different types of research according to the country's main health problems. The National Health Institute should play a leading role in developing health research.

Strategies

- Transform INS into an organ with greater autonomy and responsibility for directing research in the country, adopting modern management mechanisms;
- Analyse the relevance of the research and broadcast the results of the major studies;
- Create a forum within the health system, co-ordinated by the Health Institute to facilitate the implementation of the sector's research policies. The forum will also act as a mechanism for disseminating results and sources of information;
- Encourage the creation, and support the training of groups or NGOs that are interested in carrying out research that is in line with MISAU's priorities;
- Develop INS's institutional capacity for facing its new challenges;
- Specialise different research bodies in specific areas of the sector's research agenda, strengthening their comparative advantages.
- Promote and develop methodological capacity, mainly for research at DPS level related to their main problems.

Indicator(s)

To be defined.

Conditions for success and constraints to implementation

- Define the main lines of health research which are needed in the country, taking into consideration existing information and resources;
- Use forums and meetings to emphasise the need to take decisions based on evidence (the results of research) at all levels of SNS. These decisions should be taken according to health directives in management and programme areas;
- An important constraint is the lack of professionals skilled in research methodology. The interruption of training in this area has aggravated the situation.

Steps to be followed

	2001	2002	2003	2004	2005	Entity responsible
Define research policy	X		X			INS
Study and define INS's status in SNS	X					GdM-INS
Define indicators	X					INS-DPC-GTP
Analyse retrospectively research carried out in the country	X	X				INS-DPC-GTP
Study the profile of health researchers		X				INS-DPC-GTP
Establish the training plan for researchers	X	X	X	X	X	INS
Establish mechanisms for co-ordinating with other research institutions	X	X	X	X	X	INS
Develop financing mechanisms	X	X	X	X	X	INS
Manage research projects	X	X	X			INS
Encourage dissemination of results	X	X	X	X	X	INS
Approve a ministerial decree for regulating experimentation on humans, and create a Ministerial Scientific and Ethical Commission to reinforce this.		X	⇒	⇒	⇒	GdM
Required Resources:	Working funds, personnel and equipment					

Glossary

Accessibility: the physical, financial and cultural potential for using health services. Health promotion and preventative health care should be accessible to all Mozambicans. This means that the Ministry is responsible for providing these services as close as possible to the family home. Services should be available (willingness and capacity established to pay for available services).

Accountability: financial accountancy and monitoring service provision.

Advocacy: all activities and interventions with the potential to influence determining health factors that improve the population's state of health, which are not directly under the influence of the health sector. For example, sanitation, access to drinkable water.

Benefits: good quality health care provided equitably (see: efficiency).

Community Participation: involvement of members of the community in health care management and provision. This involvement may be consultative, participatory or executive.

Decentralisation: Decentralising the health sector depends on state administration reform. The Ministry is in favour of decentralisation as it provides for:

- Greater efficiency, making management more appropriate for local circumstances;
- Greater acceptance by the users, particularly if they participate in management;
- The promotion of greater equity in collaboration with other providers;
- Realisation of the potential to increase individuals' control over their own lives from day to day.

Three types of decentralisation have been recognised that are relevant to PESS and the situation in Mozambique:

1. Deconcentration is a form of decentralisation that occurs when resources, authority and responsibility are transferred from the centre to the periphery, linked to the principal line of management authority. Final control is maintained by the centre although important responsibilities and authority over resources may be deconcentrated. This may happen in two ways in Mozambique: a) in the relationship between the central, provincial and district units, and b) in the relationship between central government, the Provincial Governors and District Administration.
2. Delegation to semi-autonomous agencies is another form of decentralisation which occurs when an institution, such as a tertiary level hospital, is given resources, responsibilities and authority from a central institution. When this delegation is allowed, the semi-autonomous institution continues to operate under general strategic direction from the centre. The quantity of authority transferred may vary considerably and may include the power to contract personnel, generate income and draw up service contracts. The institution is directed by a board of directors partially appointed by MISAU while other members are appointed from different professional groups and agencies and community representatives.
3. Devolution is a political form of decentralisation which transfers authority, resources and responsibilities to a separate level of government. In Mozambique, this may be the Municipality. In many countries, this level of separate government is recognised by law, has its own source of income (for example, taxes) and has a series of multi-functional responsibilities. The main characteristic of devolution is that there is no line of management control over the devolved authorities, which are often elected by a local electorate.

Determining Health Factors: these are aspects of society that have the greatest influence on health. Health care has an influence, but there are certainly other factors of equal importance such as access to good quality water and nutrition; opportunities to live a life that is considered 'happy' (constructive human relationships, opportunities to control one's own life from day to day, democracy, particularly local democracy, opportunities to earn a salary, etc.)

Efficiency: to maximise benefits using available resources.

- Technical: minimum combinations of resources to produce benefits x.
- Allocative: the minimum combination of cheapest resources to produce benefits x. A production process cannot have allocative efficiency without technical efficiency.
- Economy of scale: this reflects the capacity of a system, being allocatively and technically efficient, to increase its efficiency even more by producing at optimum scale. Unit costs typically fall in relation to increased volume of production. An economy of scale is efficient whereas a dis-economy of scale is not. An economy of scale cannot be achieved without being technically and allocatively efficient.

Equity: Distributing resources and improving access, particularly for disadvantaged groups. This means that the different needs of potential users need to be identified.

- Horizontal: Everyone with the same needs and the same quantity of resources across regions of the country and social groups.
- Vertical: Resources distributed according to needs: people with greater needs (the poor) receive more resources and services while those with less needs receive fewer resources.

Geographical inequality indexes (concerning horizontal equity): - funds per inhabitant of the most affluent group divided by funds per inhabitant of the most disadvantaged group, or;
Funds per inhabitant of 25% of the most affluent group divided by 25% of funds for the most disadvantaged group.
Unit per inhabitant of the most affluent group divided by the value for the most disadvantaged group; or,
Unit per inhabitant for the most affluent 25% of population divided by the value for the 25% most disadvantaged group of the population.

Health: WHO definition: health is a state of complete physical, mental and social well-being and not only the absence of illness or infirmity (see: state of health).

Health Care: health services of four types:

- Curative: treatment of patients;
- Preventative: preventing illnesses;
- Promotional: promoting a healthy physical and social environment;
- Rehabilitative: maximising psycho-physical capacity.

Health Sector: includes all the components of the health care system.
Functions:

- sources of financing;
- financing agents;
- health care suppliers;
- health care users.

Type of health care supplier:

- Public Sector: supplying services under the government's responsibility. In the public sector, the supplier is accountable to the state which represents Mozambican society in managing services. In this case, the investment resources are the property of the state.
- Private Sector: supplying services under the responsibility of a private entity. In the private sector, the supplier should be accountable to the owner(s) for

managing services. The owner(s) may aim to make a profit but this does not exempt private services from conforming with standards established by the government for supplying health care to society.

Health status: mostly mortality indicators (i.e. peri-natal, infant, maternal and general deaths including life expectancy at birth), but also morbidity indicators (prevalence - conditions existing over a particular period e.g. a year, and incidence - the occurrence of illnesses/incapacity over a particular period e.g. a year). Other measurements exist, such as the World Bank's approach to calculating the 'burden of disease' using DALYs (Disability Adjusted Life Years). This methodology begins with an optimal life expectancy (i.e. life expectancy in Japan) and calculates years lost from illnesses, traumas etc. The difference between the two figures equals the disability adjusted life years.

Health Technology: all goods such as medical and general equipment, infrastructure and circulating goods. These goods should, by definition, be the most appropriate for the conditions in which they are used.

Infant mortality: probability of death during the first year of life (0 to 11 months). Expressed as X/1000 live births.

Infant-child mortality: probability of death during the first five years of life (0 to 59 months). Expressed as X/1000 live births.

Integrated Provincial Planning: related explicitly to activities with allocated resources. There are objective criteria established for determining efficiency, equity, quality, absorption capacity and priorities for planned, budgeted activities.

Investment resources: resources that can be used for more than one year.

Maternal mortality: probability of death due to pregnancy. Expressed as X/100,000 live births.

Off-budget: funds not included in Mozambican State accounts.

Quality: Health care services, which are:
- acceptable: from the users' socio-cultural point of view, particularly women. This also includes non-users' perceptions of the quality of health care;
- appropriate: technical options that are suitable for local conditions, to satisfy needs and attain objectives in the most effective way. This includes services provided by health professionals with respect and compassion for users.

Sustainability: sufficient capacity to ensure the continuity of health care services.

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 co-ordination 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.*

Technology management: ensuring the most efficient way of applying and maintaining health technology.

Unit of Analysis:
Compilation of specific activities in a single indicator:
- Days/beds occupied (including all services - maternity, medicine etc.);

- Deliveries (only institutional deliveries);
- Vaccinations (the sum of all vaccinations given, below and above the targets);
- Mother/Child contacts (sum of all pre- and post-natal, 0-4 year and family planning consultations);
- External Consultations (not including those carried out by APEs)
- Dental Consultations.

"Activities"	**Average time spent**	**"Weight" (10 min. = 1)**
Days/beds occupied	90 min.	9
Deliveries	120 min.	12
Vaccinations	5 min.	0.5
Mother/Child contacts	10 min.	1
External consultations	10 min.	1
Dental consultations [*1]	20 min.	2

[*1]: 1996 and does not include all provinces.

USD/Metical Exchange Rate:

		Source:
1994: 1 USD =	6,039Meticais	Bank of Mozambique
1995: 1 USD =	9,024Meticais	Bank of Mozambique
1996: 1 USD =	11,294Meticais	Bank of Mozambique
1997: 1 USD =	11,544Meticais	Bank of Mozambique
1998: 1 USD =	11,875Meticais	Bank of Mozambique
1999: 1 USD =	12,696Meticais	Bank of Mozambique
2000: 1 USD =	14,000Meticais	Estimate

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Annex 1: Annual Chronogram (d.d. 27-6-'00)

(See: Annual Planning)

January February March	- Disseminate the approved budget limits (state budget) for the current year (DAG & MPF) and adjustments in the respective institutions (including DPSs) - Complete the financial exercise for the previous year (state budget) - Prepare the Co-ordinating Council
April May	- **Co-ordinating Council:** re-examine the previous year and discuss important strategic issues (MISAU and representatives of external partners - at the start of April). - External financial **auditing** and joint **revision** of the previous year's performance (PES), with **field visits** (end of April, beginning of May). - Disseminate budget limits (state budget) for the following year (MPF: end of May). - Distribute guidelines on the preparation of annual plan and budget proposals by the respective institutions, including the DPSs (DAG & DPC; June).
June July	- **Annual Meeting (CCS;** last two weeks in June): • Fulfilment of Annual Work Plan (PAT) and budget execution for the previous year, with emphasis on the second semester: Revision and Joint Auditing (including PIP). • Fix and disseminate verified values to financing agents (Budget Support) for the following year. - Teams from the respective institutions, including the DPSs, take part in programming and annual budgeting exercises for the following year. - Budget proposals and PATs sent by the DPS, analysis by DPS and DAG specialists.
August September	- Monitoring and evaluation of PAT fulfilment, and budget execution for the first semester of the current year: Revision and Joint Auditing (including PIP), presentation in the CCS. - PAT for the following year signed by MISAU and all the partners, in the same CCS. - Budget proposal and justification sent to DNPO of MPF.
October November December	

Annex 2: Medium Term Expenditure and Financing Framework (CFDMP) [!]

Annex 3: Institutional Development Plan [!]

Annex 4: Strategic Programme for Reform and Modernisation of the Administrative Sector (Phase II), MISAU-DAG, April 2001.

Annex 5: Strategic Communication Plan [!]

Annex 6: National Strategic Plan to Combat STD/HIV/AIDS in Mozambique, 2000-2002.

Annex 7: National Integrated Plan (PNI) for Community Health (PNI 1)

Annex 8: National Integrated Plan (PNI) for Communicable Diseases (PNI 2)

Annex 9: Strategic Plan for Pharmaceuticals

Annex 10: General Action Plan 2001-2004 for Health technology/Maintenance Management [!]

Annex 11: Updated Human Resources Development Plan (PDRH +) 2001 – 2010 [!]

[1] Presented to the Health Sector National Co-ordinating Council (May 2001)