

Mozambique: Taking forward action on Human Resources for Health (HRH) with DFID/OGAC and other partners.

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Abbreviations and Acronyms

ART	Anti Retroviral Therapy
CoAg	Cooperation Agreement
CAP	Country Assistance Plan (<i>for DFID</i>)
COP	Country Operational Plan (<i>for PEPFAR</i>)
COPRS	Country Operational Plan Reporting System
CDC	Centres for Disease Control and Prevention
DBS	Dried Blood Spots
DFID	Department for International Development
GAP	Global Aids Program (<i>for CDC</i>)
GHAP	Global HIV/AIDS Programme (<i>for WB</i>)
GHWA	Global Health Workforce Alliance
GoM	Government of Mozambique
HRH- AF	Human Resources for Health Action Framework
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IHP	International Health Partnership
INGO	International Non-Governmental Organisation
MISAU	Ministry of Health
MoU	Memorandum of Understanding
NASA	National AIDS Spending Assessment
NGOs	Non-Governmental Organisations
OGAC	Office of the US Global Aids Coordinator
PEPFAR	President's Emergency Programme for AIDS Relief
PESS	Health Sector Strategic Plan
PHC	Primary Health Care
SBS	Sector Budget Support
SWAp	Sector Wide Approach
TOR	Terms of Reference
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

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Executive Summary

- 1. Background.** In response to the critical Human Resources for Health (HRH) shortages in Africa, the UK Department for International Development (DFID) and Office of the US Global Aids Coordinator (OGAC) responsible for the President's Emergency Programme for AIDS Relief (PEPFAR) have been in discussion with a number of African countries (Ethiopia, Kenya, Mozambique and Zambia) to develop strategies and country level actions. There is high level political support for this process in the UK and US, highlighted by the announcements of President George Bush and Prime Minister Gordon Brown on 17 April, 2008
- 2.** To take this work forward DFID and OGAC agreed to field a team of two consultants to work with their respective leads in Mozambique in the period 02-13 April, 2008. Jim Campbell (INTEGRARE, Spain) was engaged by DFID and Barbara Stilwell (Capacity Project, USA) was made available under existing arrangements with PEPFAR/United States Agency for International Development (USAID). The main objective of the assignment was to facilitate agreement and document current flexibilities of funding streams for HRH (building on existing work and within national frameworks for health reform specific priority actions on HRH)
- 3. HRH.** The concern with HRH development reflects the absolute shortage of health workers in Mozambique, and the effects of the shortage on the absorptive capacity of the health system to scale up programmes. This is a longstanding national concern and there is much evidence of the strategic thought around issues relating to HRH in the resulting national development and management plans. The latest HRH development plan is for 2008-2015. It lays out strategies that can be used to strengthen the workforce and this may be deliberate to encourage practical implementation rather than theoretical frameworks. However, the consultants noted some concerns among development partners and implementing agencies about the way the plan is constructed. The document contains some excellent analysis and the accompanying paper on costings appears comprehensive, but the key messages and priorities resulting are not, as yet, extracted for ease of reference.
- 4.** Clearly delineated areas for workforce development that are mapped in a way that shows how they will contribute to overall workforce development will make the HRH plan a tool for advocacy. Development partners will then be able to see how their support can best be directed and implementing agencies can map their contributions against each component. In addition, managers will be able to better coordinate inputs across the whole system of workforce development
- 5. Capacity Development.** From a review of current interventions in HRH 'capacity development' the vast majority (about 75%) involve training activities and are therefore targeting performance and skills. About one third of interventions are designed to have an impact on facilities, staffing and infrastructure – these include payment of salaries and provision of library resources for example. Only a handful of interventions target the system as a whole – for example, the ability of the health system to manage inputs, to monitor and evaluate its work, or to plan for the future. As with the HRH plan, if there is no management or effective coordination of activities, then changes will be piecemeal, will not be adequately monitored or reported, and if the health system is not strengthened to support changes, then they will not be sustainable.
- 6. Day Hospitals.** Minister Garrido has launched an initiative to build overall system capacity and integrate the current Day Hospitals into Primary Health Care services. For this proposed system to be viable, an appraisal of the potential use of the day hospital is required. The burden of chronic disease needs to be set against the time and availability of staff to estimate the impact

on time and the required skills. It is by no means certain that the same staff that are in the day hospitals are qualified to manage another range of clinical conditions.

7. The assignment requested that particular consideration be given to exploring the funding modalities of the respective health and HIV/AIDS expenditure in light of the emerging need to meet the Ministry's strategy of integrated PHC and the scaling-up of the health workforce.
8. **PEPFAR.** Conceptually PEPFAR can be viewed as a financing modality which is 'on-plan' but 'off-budget'. However, analysis in Mozambique requires due consideration to the activities of each implementing partner, whether they are working at national, provincial or district levels and the planning and interaction each has with its government partners.
9. The consultants noted positive examples of PEPFAR implementing partners and the CDC/USAID representatives working with government counterparts. Moreover the process of in-year monitoring and performance review enables regular assessment of the emerging needs of the MISAU. However, the annual planning process is considered, by some, to be extremely time-consuming and a major burden on national and provincial government counterparts. Whilst ensuring activities are 'on-plan' it appears to have significant transaction costs.
10. Within the working definition for 'on budget' for this review a mixed picture emerges. MISAU is an implementing partner under two Cooperation Agreements (CoAGs). The direct contribution to the MISAU (\$3.95m) is comparable with a number of bilateral partners and the planned funding is clearly 'available to the government for financial management and planning purposes'. The 'on budget' funding is available for the MISAU to draw upon to deliver a broad range of HRH and HSS activities. Similarly, an implementing partner working at national and provincial level in support of HRH/HSS activities provided an excellent example of how PEPFAR funds are 'on budget' at the provincial level (often referred to as a 'pass-through' in PEPFAR-speak). Despite suggestions to the contrary it became evident that significant sums of PEPFAR money are also 'on budget' in some of the provinces. Further work would however, be required to map all implementing partner activities and provide a comprehensive overview of actual funds available to MISAU. This could be combined with a mapping of the level of capacity development that partners are targeting to assess the likely impact of the funds on capacity building in the country.
11. **Disbursement.** In respect to disbursement of PEPFAR funds in Mozambique, this has been acknowledged in a cross-country, cross-funding agency study by the Centre for Global Development as being highly efficient. This was confirmed by interviewees as part of this assignment. However, a concern arising is the financial management capacity within the MISAU to manage resources. There is undoubtedly an additional management and reporting requirement with PEPFAR funds directly available to MISAU, but technical and absorption capacity appears to be a recurring theme that is not isolated to PEPFAR support. Similar examples were provided for management of the Global Fund resources and the Ministry itself is suggested in one-study as disbursing less than 84% of its total health budget for the last 6 consecutive years (being particularly weak on investment spending).
12. **Reporting.** Minister Garrido's recent statements on an absence of NGO reporting (partially directed to PEPFAR partners) either suggests that he is not benefitting from the 'transparency and accountability' that the PEPFAR reporting process intends to provide and/or a weakness in the current system of knowledge management and information sharing across the 'PEPFAR' Mozambique programme. A further explanation is that the capacity of the provincial health departments needs strengthening so that there is enough personnel to both receive reports

from implementing partners and to pass them upward to central level. The deleterious effects of weakness in MISAU management were frequently mentioned to the consultants.

13. The assignment calculated that \$89m of PEPFAR funding (FY 2008) in Mozambique have activities which can be deemed to be supporting 'capacity development'. This figure for Mozambique appears to reinforce the statement of Ambassador Mark Dybul that "*at least one quarter of PEPFAR's total resources are [sic] devoted to capacity-building*". Further work would be required to analyse the level of capacity support in greater detail, but Mozambique is clearly benefitting from a significant investment in health systems strengthening from PEPFAR funds.
14. **Comparative Advantage.** The comparative advantage of PEPFAR programming appears to be in pre-service and in-service education, the temporary support for salaries and incentives to engage a growing workforce and expand services, and in the rapid strengthening of health and health education facilities (renovation, equipment, materials and supplies). Additional work in technical assistance, monitoring and evaluation also features. All of this will be necessary for the scaling-up of the health workforce and corresponding health services envisaged in the HRH plan and an integrated PHC service.
15. In addition, the overall flexibility and the speed of funding disbursement suggests a unique, catalytic position to be supporting immediate HRH and HSS activities or capital investment that can subsequently be absorbed by government as part of recurrent expenditure (supported by pooled-funds). In this respect, examples of PEPFAR Mozambique activities which are 'on plan' and 'on budget' should be promoted. Further work can subsequently be taken forward to formalise the budget reporting between PEPFAR, MISAU and government.
16. **DFID and other partners.** DFID and other development partners participating in the pooled funding are all 'on plan' and 'on budget'. There are a number of mechanisms for channelling sector support to the MISAU, including the Mozambican Sector Wide Approach (SWAp) known as PROSAUDE. The tracking sheets for PROSAUDE and the other pooled-funding arrangements suggest an increasing volume of funds (2007 to 2008) are being channelled through these mechanisms – an additional \$24m in 2008 representing a 22% increase.
17. **Disbursement.** Similarly, an encouraging picture emerges when comparing 2008 to 2007 performance. Only 8% of partner contributions were disbursed in the first quarter of 2007 and nearly half of the funding arrived in the last four months of the year. This was heavily influenced by the late disbursement from the Global Fund (funds from Round 2 and Round 6 accounting for \$41.3m). In 2008 partners are making prompt disbursements of their annual commitment in the first quarter of the government's financial year and nearly \$60m has already been provided. This is in accordance with the 'timely fashion' to respect the Ministry's needs as agreed in the PROSAUDE II Memorandum of Understanding (MoU).
18. The difficulties associated with disbursement of the Global Fund contribution is one of local concern. The late arrival of 2007 funds caused considerable disruption to planning and expenditure and the transaction costs associated with securing the release also appear to be inordinately high. Work is ongoing to improve the situation in 2008. Given that this represents 35% of the overall pooled-funding (as currently indicated) for 2008 there needs to be a focus on securing these funds.
19. **Comparative Advantage** The comparative advantage of DFID is its role as 'partner of first contact' for the health and HIV/AIDS sectors, complemented by its role in the IHP+ initiative, its wider interest in public sector reforms and the promotion of aid effectiveness and

harmonisation. These various elements provide DFID staff with a unique position to assist HRH development and HSS at cross-government, cross-agency levels and potentially mobilise financial resources (through efficiency and new funds) that reflect the ambitions and needs of the MISAU and GoM.

20. **Findings and recommendations.** An initial presentation of findings and possible recommendations was held on Friday 11th April with representatives of CDC, USAID and DFID. It was noted that new guidance from PEPFAR II was imminent and could lead to revisions to the PEPFAR processes at country level, and that work on the key messages from the HRH plan was ongoing (i.e. priority, costed actions for implementation in the next 3 years).

21. Section 4 of this report provides the detailed discussion on the findings and recommendations. The table below is a summary of these.

Recommendation	Lead	Target date	Means of Verification
HRH1: DFID to continue its review of the way in which the HRH plan is currently organized so that it sets out strong objectives to be achieved by clearly articulated and particular strategies that partners can support. 'PEPFAR' Mozambique could provide support to this process through available technical expertise, in consultation with the HR working group and with Dr Mussa and the MISAU.	DFID + CDC/USAID	June 2008	Summary of key messages from the HRH plan
HRH2: Build a Human Resources Information System (HRIS) to support planning, management and monitoring of workforce development	USAID	End 2009	HRIS in use
HRH 3: MISAU to articulate its priority actions for the short, medium and long term in scaling-up the health workforce. DFID to assist in the dissemination of these priorities to all Development Partners and promote alignment with their respective financing mechanisms.	DFID	September 2008	Priorities disseminated to partners Forum for harmonization of funding established.
HRH 4: Strategic management functions to be strengthened through coaching and mentoring activity, especially at Ministry level.	CDC/USAID	End 2008	Benchmarking of good practice in management functions against which MISAU can be measured and seen to improve
CAP 1: A joint planning exercise between MISAU and all partners to be held at which the contribution of all activities to the overall picture of capacity building is mapped, so that gaps are identified and all levels are targeted.	DFID/CDC	September 2008	Capacity development framework available

Recommendation	Lead	Target date	Means of Verification
<p>Pay1: the financial management capacity of the MISAU is strengthened so that there is an ongoing monitoring of the effects of salary changes and the extent to which the fiscal framework will allow workforce expansion and salary increases. This process has already begun with the costing of the HRH plan, but it should not be a one-time exercise, but rather a constant process of monitoring and adjusting plans. Technical support could be given in financial management.</p>	<p>DFID / PROSAUDE</p>	<p>June 2009</p>	<p>Ministry exhibit stronger financial management</p>
<p>Pay2: MISAU and DFID to explore the possibilities of MISAU staff with financial management responsibilities to be offered the same salary package and incentives as their counterparts in other Ministries.</p>	<p>MISAU</p>	<p>September 2008</p>	<p>MISAU proposal for salary parity available for discussion with appropriate Government body.</p>
<p>Pay3: HRH Working Group to promote standard operating procedures for NGOs in Mozambique to set out best practice in terms of supporting national salary policies.</p>	<p>HRH Working Group</p>	<p>December 2008</p>	<p>Standard operating procedures available</p>
<p>KM1: CDC/USAID to review and encourage knowledge management across implementing partners' activities. Available best practice to be documented and shared in Mozambique. Time permitting, examples of best-practice to be prepared for the Implementers Meeting in June 2008</p>	<p>CDC/USAID</p>	<p>In advance of COP preparation for 2009. In time for June 08 Implementers Meeting</p>	<p>x examples of pro-HRH/HSS activities available in the public domain. x examples of 'on-budget' activities available in the public domain.</p>
<p>IM1: CDC/USAID to map provincial activities and link to WHO mapping. DFID to encourage mapping of all other project activities. A country-wide review to be available for further discussion and planning and feed into the ongoing work of the DNAM.</p>	<p>CDC/USAID DFID DFID</p>	<p>June 2008 June 2008 July 2008</p>	<p>Activities by geo-referenced codes shared with DNAM</p>
<p>IM2: DFID and CDC/USAID to provide ODAMOZ with accurate figures on their respective funding for 2008.</p>	<p>DFID CDC/USAID</p>	<p>June 2008</p>	<p>Updated ODAMOZ figures available online.</p>

Recommendation	Lead	Target date	Means of Verification
CCPM1: CDC/USAID to provide MISAU with confirmed projected expenditure in the first quarter of year n+1 (extracted from existing PEPFAR financial year) as per the MISAU calendar.	CDC/USAID	May and July 2008	First quarter n+1 expenditures available to MISAU (minus implementing partner overheads)
CCPM2: CDC/USAID to endeavour to provide estimates (and MISAU to fully recognise caveats) of additional n+1 funding (extracted from country vision and existing CoAGs) as per the MISAU calendar.	CDC/USAID	May and July 2008	Projected n+1 expenditures (for Q2, 3 and 4) available to MISAU (minus implementing partner overheads)
CCPM3: PEPFAR/OGAC to explore the feasibility of adapting the current planning and forward financing of country activities in the four focus countries of the US/UK initiative, with the option of moving to a two-year cycle of planning and financing projections duly considered.	PEPFAR/OGAC	Initial discussions at Implementers Meeting in June 08.	Meeting notes
RMM1: DFID to liaise with the IHP secretariat on the 'zero draft guidance', seeking additional reference to HRH.	DFID	immediate	Next version of guidance incorporates further reference to HRH
RMM2: MISAU and partners to ensure the national IHP discussions result in a pro HRH/HSS country compact that highlights the resource mobilisation requirements and links to long-term sustainable financing.	MISAU	Ongoing as per schedule of meetings.	Country Compact and proposal to the IHP relates to HRH plan and costings.
RMM3: The GF to ensure timely disbursement of its 2008 funds. In parallel development partners to support MISAU's internal capacity to manage the GF reporting and disbursement processes and hold the GF accountable to its signatory of the IHP and its own operating principles.	GF DFID + partners		Date of receipt of GF monies.
RMM4: All partners to liaise with the CCM secretariat and ensure the HRH plan and resource needs are integrated into the Round 8 application for HSS funding.	MISAU	By end of June	Round 8 application includes specific priority actions extracted from the HRH plan
RMM5: MISAU and HRH Working Group to liaise with GHWA on the potential for Mozambique to receive 'catalytic funding' for HRH.	MISAU	By end of June	Correspondence and updates in HRH Working Group meetings
RMM6: All partners should review PEPFAR II guidance and seek to maximise the potential resources that can be allocated to HRH programming as part of the development of the 2009	CDC/USAID	Within 4 weeks of receipt	Review of guidance and HRH opportunities resulting available to partners.

Recommendation	Lead	Target date	Means of Verification
COP.			

HRH – Human Resources for Health; KM – Knowledge Management; IM – Information Management; CAP – Capacity Development; CCPM – Cycles/Calendars/ Planning Management; RMM – Resource Mobilisation and Management.

1 Background / Introduction

1. In response to the critical Human Resources for Health (HRH) shortages in Africa, the UK Department for International Development (DFID) and Office of the US Global Aids Coordinator (OGAC) responsible for the President's Emergency Programme for AIDS Relief (PEPFAR) have been in discussion with a number of African countries (Ethiopia, Kenya, Mozambique and Zambia) to develop strategies and country level actions. The aim is to demonstrate the maximum flexibility of disease specific programmes to support broad based primary care in line with countries' health plans.
2. There is high level political support for this process in the UK and US. This was highlighted by the announcements of President George Bush and Prime Minister Gordon Brown on 17 April, 2008¹ committing to actions in the four countries (see Annex 1). Further, their call on the G8 and others *'to support partner countries to increase health workforce coverage levels, with a view to work towards the World Health Organization goal of at least 2.3 health workers per 1,000 people'* may potentially influence the content of the next G8 meeting in July 2008.
3. An initial operational meeting was held in Ethiopia in January 2008 convened by the Global Health Workforce Alliance (GHWA), DFID and PEPFAR. Over 40 participants attended this initial meeting including government and partner representatives from Ethiopia, Kenya, Mozambique and Zambia and senior personnel from DFID and OGAC headquarters. Some initial progress was made and a matrix was produced for each country highlighting key short to mid-term priorities that could potentially be funded.
4. A follow-up meeting was held at the Global Forum for Human Resources for Health in Kampala, Uganda (March 2008). Following discussions in Kampala, it was decided that Mozambique would benefit from a country visit to further develop the focus of this work.
5. DFID and OGAC agreed to field a team of two consultants to work with their respective leads (Neil Squires, DFID and Cate McKinney, PEPFAR/Centres for Disease Control and Prevention [CDC]) in Mozambique in the period 02-13 April, 2008. Jim Campbell (INTEGRARE, Spain) was engaged by DFID and Barbara Stilwell (Capacity Project, USA) was made available under existing arrangements with PEPFAR/United States Agency for International Development (USAID). Both consultants had participated in the initial meeting in Addis Ababa and Jim Campbell was also present in Kampala in his role with the GHWA (seconded by the DFID as part of their two-year programme of support).
6. The main objective of the assignment was to facilitate agreement and document current flexibilities of funding streams for HRH (building on existing work and within national frameworks for health reform specific priority actions on HRH). Activities were to take full account of existing country processes and engage the Ministry of Health (MISAU) and other development partners. In keeping with the earlier meetings in Ethiopia and Uganda the process was to encourage dialogue amongst partners and build mutual understanding of the comparative advantages each partner can offer at country level to maximise the impact of their respective funding modalities. The Terms of Reference (TOR) for the assignment is available as Annex 2.

¹ The press release from the White House is available online at:

<http://www.whitehouse.gov/news/releases/2008/04/20080417-5.html>

The full text of their respective announcements is available at: <http://www.washingtonpost.com/wp-dyn/content/article/2008/04/17/AR2008041702641.html>

7. Noting the momentum of high-level political support and the need for country actions to be developed the country visit was put together at relatively short notice. Unfortunately the Ministry's Director of HRH, Dr. Antonio Mussa (who had participated in both the Ethiopia and Uganda meetings) was absent for most of the period and unable to attend the final debriefing session. Separate arrangements have subsequently been made to provide a full brief to him of the visit outcomes.
8. This report presents a summary of the main findings from the country visit. Section 2 details the context of HRH in Mozambique, progress on the HRH plan and costings and an analysis of capacity development activities in HRH. Section 3 reviews the respective activities of the main development partners in support of the MISAU and section 4 offers some initial suggestions for consideration.
9. Method of working
 - a. Relevant documents were reviewed as an initial step to understanding context, as well as revealing gaps in information. A full list of the documents reviewed is appended as Annex 3.
 - b. Initial briefing meetings were held with the Senior Health Advisor, DFID and the Senior Training Specialist, Global Aids Program (GAP), CDC, Mozambique, and these generated a list of key informants. A list of people interviewed is appended as Annex 4.
 - c. Almost all the interviews were carried out by both consultants and the results recorded in note form. Some notes were later transcribed to be used to illustrate key points raised.
 - d. Neither consultant is fluent in Portuguese. This had an impact on their ability to rapidly review and assess a number of the background documents that were made available during their visit. Where required, clarifications of particular terminology and vocabulary were sought from a number of sources. All meetings convened with key stakeholders and partners as part of the assignment were conducted in English so did not present any limitations.

2 National plans and strategies to strengthen HRH

10. The scope of work had particular requests relating to the country HRH plans and key priorities. In relation to HRH the TOR specified that;
- ❖ the HRH plan be reviewed and ways identified in which it can be made a stronger advocacy tool;
 - ❖ specific recommendations be made on how PEPFAR and DFID can increase the impact of their support on HR capacity building;
 - ❖ PEPFAR programme elements be identified which directly contribute to government directed or managed HRH focused programmes, quantifying the extent to which PEPFAR funds are already being used for health system strengthening;
 - ❖ the decision of the MISAU to integrate Day Hospitals into Primary Health Care (PHC) be reviewed, and how this policy decision might impact on plans for supporting HIV/AIDS care at the PHC level. In particular we were asked to consider whether an increased investment in general PHC strengthening will be a consequence of this policy decision, if possible identifying likely resource implications.
11. The concern with HRH development reflects the absolute shortage of health workers in Mozambique, and the effects of the shortage on the absorptive capacity of the health system to scale up programmes. This is a longstanding national concern and there is much evidence of the strategic thought around issues relating to HRH in the resulting national development and management plans. In recent years HRH development has been guided by the HRH Development Plan 1992–2002, updated by the HRH Development Plan 2001–2010. The latest HRH development plan is for 2008-2015. Table 1 shows the number of health workers per thousand population, and shows clearly that Mozambique compares poorly with other countries in sub-Saharan Africa, and falls well short of the 2.3 health workers per thousand population estimated by WHO in the 2006 World Health Report as the minimum required for a country to meet its basic health needs.

Table 1: HRH indicators for Mozambique in comparison to other regional indicators.

	Physicians/ 1000 pop	Nurses/ 1000 pop	Obstetricians/ 1000 pop	Pharmacists/ 1000 pop
Mozambique	0,03	0,21	0,12	0,03
Malawi	0,02	0,59	-	-
Zambia	0,12	1,74	0,27	0,10
Zimbabwe	0,16	0,72	-	0,07
Botswana	0,40	2,65	-	0,19
South Africa	0,77	4,08	-	0,28

Source: World Health Report, 2006

12. The HRH plan specifically addresses the eight general and 51 specific objectives of the Health Sector Strategic Plan (*Política Nacional de Saúde*), and in this way is well aligned with the health sector development vision for the country.
13. Strategies are set out in the HRH plan that can be used to strengthen the workforce and this may be deliberate to encourage practical implementation rather than theoretical frameworks. This

appears to be consistent with the brief the consultants received from senior personnel in MISAU. However, the assignment noted some concerns among development partners and implementing agencies about the way the plan is constructed (perhaps as a result of its original brief?). The document contains some excellent analysis and the accompanying paper on costings appears comprehensive, but the key messages and priorities resulting are not, as yet, extracted for ease of reference. Comments included:

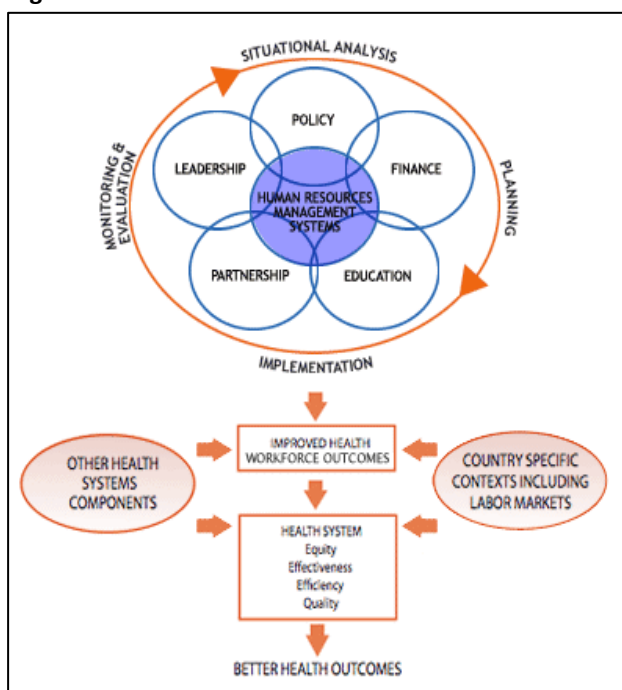
'The HR plan is not operational enough. After every chapter you ask 'what shall we do now?' (Employee of INGO)

'If donors are to be aligned with the HR plan it needs to be more operational' (HR specialist, INGO)

14. **Strengthening the plan:** Analysing the plan against an established framework for HRH development² promoted by the GHWA and the World Health Organisation (WHO) reveals some weaknesses that may be part of the expressed dissatisfaction with the plan as it is currently constructed. Many of the strategies in the plan will have to be supported by national frameworks for policy, legislation and management and there is little mention of how these can be developed. One example given to us is in the field of education. There are recommended strategies to scale up education and training, but there is no mention of strengthening the management system for education that can ensure that these strategies are implemented and coordinated. This may be why it seems to some readers that there is no operational plan.

Figure 1. HRH Action Framework

15. The HRH Action Framework (Figure 1) (HRH-AF) takes a systemic approach to health workforce development and shows six areas that require attention for robust HRH systems strengthening. Applying this to the Mozambique situation, in the light of comments we heard, reveals that all the areas need support, but that the HRH plan does not set them out systematically in a way that donors could yet buy into.



16. We heard comments that the MISAU required support in strengthening its management processes, for example, and that at Provincial level there were too few managers to ensure that reporting by local programmes was passed to central level. Policy support is also considered to be weak.

17. The existence of data about the health workforce was not confirmed. Some data exists in the finance sector for payment of salaries, but this is not linked to the planning department in the MISAU, with the result that some health workers continue to receive payment after they have left the sector. There is a Training Information Management System (TIMS), though whether this is current is also speculative. The workforce planning department is separate from the Human

² The HRH Action Framework www.hrresourcecenter.org

Resources unit. This highlights the potential for lack of coordination and the difficulties in planning and costing for workforce development.

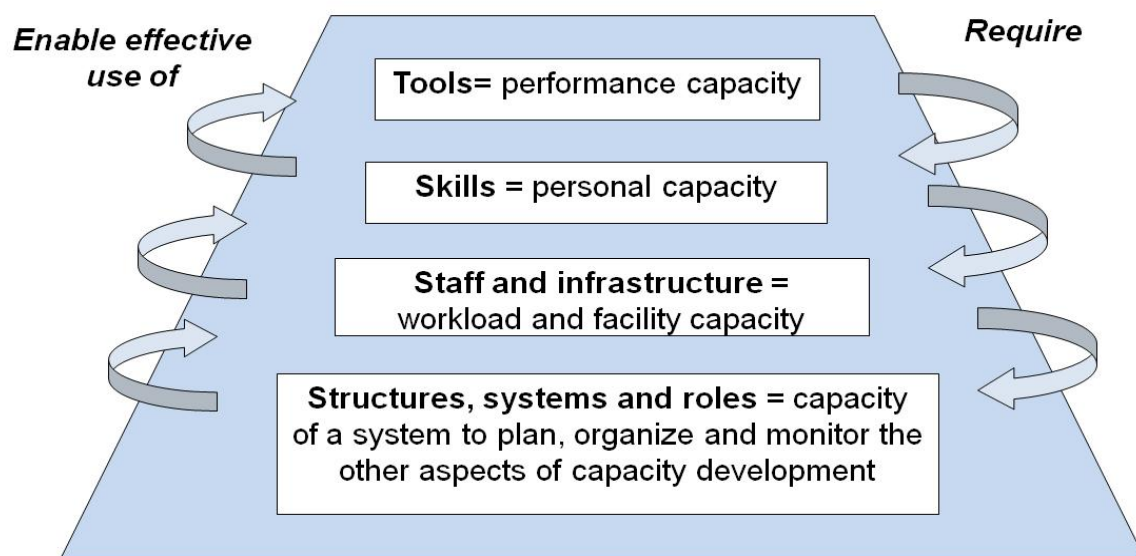
18. Issues of salary are currently being considered within the larger public sector reform strategy. In terms of the health workforce one concern is that development partner contributions to salaries in the health sector (for 'contract workers') are not included in the budget. In the longer term the government will have to take these over, thus pushing up the predicted wage bill. Issues of salary remain crucial to recruitment of additional staff and the retention of all staff.
19. A strong human resources management system is at the heart of the HRH-AF, and is not apparent in Mozambique. Notably, the management system overlaps with all other systems in workforce planning and it is essential for sustainable and systemic development to take place.
20. The HRH Plan was also described as a 'data free zone'. This is not entirely true, as ratios of health workers to population are given. Nevertheless, it would be useful to have some specific figures that provide a baseline for the planned activities and for estimating outcomes against which monitoring and evaluation can take place. The World Bank HRH assessment of 2006 gives some of these data³ but it is clear that much data is secondary and estimated. This is yet another imperative for developing an accurate Human Resources Information System (HRIS) for planning and managing the workforce, as well as for monitoring change.
21. Clearly delineated areas that are mapped in a way that shows how they will contribute to overall workforce development will make the HRH plan a tool for advocacy. Development partners will then be able to see how their support can best be directed and implementing agencies can map their contributions against each component. In addition, managers will be able to better coordinate inputs across the whole system of workforce development.
22. **Capacity Development:** 'Capacity building' is a component of most programmes implemented by partners and supported by development partners, but it has been criticised as too broad a concept to be useful, and is often operationalised as training⁴. Nevertheless experience suggests that achieving better health outcomes requires financial resources and adequate local capacity to use the resources effectively, which means institutions, systems and individuals, though often this is not specified. In general, capacity building is a process or series of activities that improve the ability of an institution, system or individual to 'carry out stated objectives'.⁵
23. A simple model (Figure 2) showing a hierarchy of capacity building was used to review a list of the current inputs of implementing agencies provided by the HRH Working Group.

³ The Human Resources for Health Situation in Mozambique, Paulo Ferrino and Caroline Omar Africa Region Human Development. Working Paper Series No. 91, 2006

⁴ Potter C., Brough R., (2004) Systematic Capacity Building: a hierarchy of needs. Health Policy and Planning 19(5)

⁵ LaFond A., Brown L., Macintyre K., (2002) Mapping Capacity in the health sector: a conceptual framework. International Journal of Health Planning and Management, 17: 3-22

Figure 2: Capacity Building model, (Potter and Brough 2004)



24. The vast majority of the interventions (about 75%) involved training activities and in the model used are therefore targeting performance and skills. About one third of interventions are designed to have an impact on facilities, staffing and infrastructure – these include payment of salaries and provision of library resources for example. Only a handful of interventions target the system as a whole – for example, the ability of the health system to manage inputs, to monitor and evaluate its work, or to plan for the future.
25. To improve the impact on capacity building, a joint planning exercise between the MISAU, donors and implementing partners, that maps capacity building efforts against a simple framework such as we used, can ensure that all levels are targeted. As with the HRH plan, if there is no management or effective coordination of activities, then changes will be piecemeal, will not be adequately monitored or reported, and if the health system is not strengthened to support changes, then they will not be sustainable.
26. **Day Hospitals.** The proposal to integrate Day Hospitals into PHC comes from the MISAU and it seems that the aim of the integration is to strengthen the capacity of the *health system* to provide care of the same level to all people with chronic diseases, and at the same time, ensure that people living with HIV/AIDS are not separated from people with other chronic diseases. In many ways this is laudable, and represents an attempt by Minister Garrido to build overall system capacity. Day hospitals are providing 40% of all Anti Retroviral Therapy (ART) services provided to a total of 90,000 patients in Mozambique. The remaining sixty percent of services are provided in health centres.
27. For this proposed system to be viable, an appraisal of the potential use of the day hospital is required. The burden of chronic disease needs to be set against the time and availability of staff to estimate the impact on time and the required skills. It is by no means certain that the same staff that are in the day hospitals are qualified to manage another range of clinical conditions.
28. There are currently 24 larger day hospitals, and these facilities may be overburdened by greater patient usage. Similarly, for people to be given ART at facility level has logistical and training implications. The time constraints of this consultancy made it impossible to carry out such an appraisal, but it is suggested as a next step to quantify the impact of the policy decision.

3 Development partners - supporting activities

29. Dialogue and understanding of how development partners provide support to the MISAU in Mozambique in achieving its Health Sector Strategic Plan (PESS) and the HRH plan is a highly relevant topic for partners. The assignment ran in parallel to a number of other coordination activities in this area, including:

- ❖ Receipt of the Joint briefing for the Annual Joint Evaluation of the Performance of the Health Sector (ACA) 2008 HIV and Annual Review Meeting (03 April)
- ❖ Ongoing work and dialogue on the development of the national HRH plan + costings (HR costing report received on 04 April; HRH plan - mission report received on 07 April)
- ❖ DFID's introductory meeting with the Minister of Health as the 'partner of first contact' (06 April)
- ❖ Receipt of guidance by the International Health Partnership (IHP+) on the development of Mozambique's 'Country Compact' (08 April)

30. The examples demonstrate -on an almost daily basis - the evolving and fluid nature of dynamics within Mozambique. Staff from both DFID and 'PEPFAR' Mozambique are intimately involved in the processes. Extracts from the cited examples highlight the issues at hand:

- ❖ 'During the completion of the [National AIDS Spending Assessment (NASA) exercise undertaken in 2006/2007], it was recognised that full collaboration of stakeholders (donors and implementing agencies) is difficult to achieve and highlights the difficulties inherent in coordinating and monitoring a national response without the 'full picture' in terms of available funding and expenditures. Given the huge rise in vertical funding for HIV and AIDS in recent years, e.g. PEPFAR, never has a greater need existed to try to capture all relevant financial information on a 'routine' basis to assist with planning and budgeting processes, and to also inform future resource allocation, MTEF exercises, etc. to improve predictability of funding'. **Briefing for the Annual Review Meeting**
- ❖ 'On predictability of financing, [Minister Garrido] indicated that he recognises the challenges of improving donor predictability and does not expect miracles. However he wishes to see continued progress in this area. He is accountable for health sector performance and if his control over resources is limited, through not being able to control when large amounts of funding arrive in any given year, then it is difficult for him to manage the sectors performance. He stated that given the significant level of funding flowing through NGOs, which "control nearly 60% of the total resources for health and HIV/AIDS in the country", if he is to be held accountable for sector performance there need to be stronger mechanisms for NGO accountability. He does not expect to control the funding going to NGOs, but he does expect, increasingly, to have good quality reporting on NGO activities and for NGOs to be working more closely at district and provincial levels to build the capacity of government services. He sees NGOs as having an increasingly important role in quality assurance'. **Neil Squires, Report back from focal partner meeting with Minister Garrido**
- ❖ 'The purpose of a country Compact to achieve the health-related MDGs is to improve aid effectiveness and provide a framework for increasing aid for health, which addresses fragmentation, volatility and reduces transaction costs of aid. [it will establish] clear benchmarks for development partners' and government performance against their commitment to fund one national health plan. Commitments are aligned to country planning and budgeting, and consolidated into one budget planning process. Financing gaps are addressed per scenario, through multi-year commitments, with a disbursement calendar

to reduce volatility, integrated in country macro-frameworks, with joint schedules, clear donor mapping, financing gaps, joint matrices of policy milestones and results, a planning and budgeting calendar and a joint validation process. The benchmarks will be monitored and evaluated in an open and transparent way'. **IHP (2008b) 'Development of a Country Compact. Guidance for Action – Roadmap to a Country Compact'**

31. The picture painted above is represented in the table below. The suggestion is that 'PEPFAR' and 'Project' funding, potentially representing 55% of projected health and HIV/AIDS expenditure, are currently outside of government planning and reporting processes.

Table 1: Projected* health and HIV/AIDS expenditure (US \$) for 2008.

Source of funds	2008 (US \$ m)	As % of total
Ministry of Health	138	23
Pooled funding (PROSAUDE + other mechanisms)	135	22
'PEPFAR'	228	38
'Projects'	100	17
totals	601	

Source: various documents.

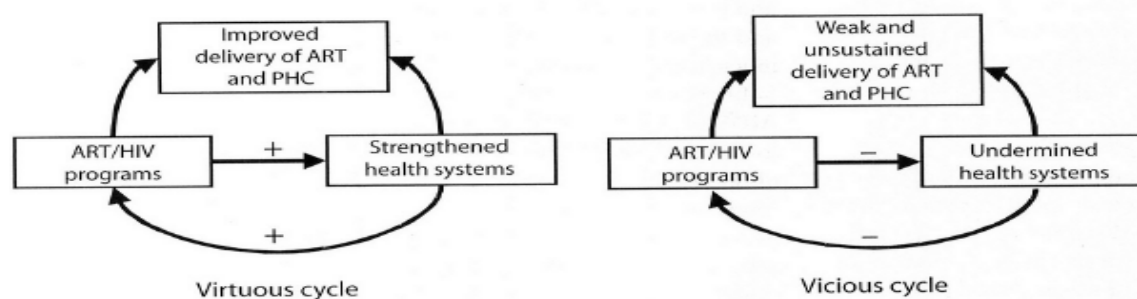
Note *: Figures do not necessarily include all available funds and may not reflect the net amount of US\$ received by the GoM once true exchange rates (rather than estimated) are confirmed. The GoM may consequently report higher net receipts

PEPFAR: PEPFAR 08 spending is April 08 – Mar 09 and so the above figure is indicative only. A true figure would need to include PEPFAR 07 spending in the first quarter of 2008 and deduct PEPFAR 08 spending in the first quarter of 09. In the absence of these calculations, this document considers the 08 spending as \$228m.

'Projects': Is calculated on the basis of vertical funds made available via development partners (excluding PEPFAR). This figure does not include activities funded by international NGOs with their own sources of funding.

The TOR requested that particular consideration be given to exploring the funding modalities of the respective health and HIV/AIDS expenditure in light of the emerging need to meet the Ministry's strategy of integrated PHC and the scaling-up of the health workforce. It is increasingly clear that the manner in which HIV/AIDS initiatives are developed and implemented can have an impact on the wider health system - the virtuous or vicious cycles described by McCoy et al (2005)⁶. Hence a complementary approach where each partner could maximise the impact of its funding for HRH and capacity support is preferred.

Figure 3: Virtuous and vicious cycles of HIV/AIDS and HSS.



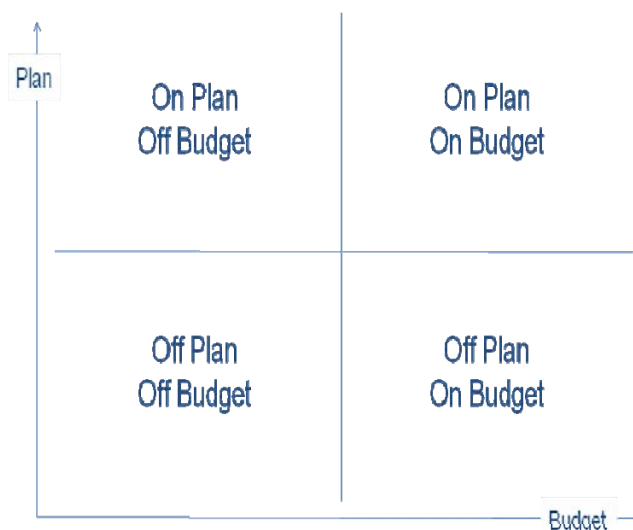
Note. ART = antiretroviral therapy; PHC = primary health care.

Source: McCoy et al, 2005

⁶ McCoy D, Chopra M, Loewenson R, et al. (2005) Expanding access to antiretroviral therapy in sub-Saharan Africa: avoiding the pitfalls and dangers, capitalizing on the opportunities. *Am J Public Health* 2005,95:18-22.

32. This is in line with conclusions from a DAC-World Bank meeting in 2006 which called for a “mutually reinforcing approach” between global programs and the country-based aid delivery model, focusing on complementarities and strengthening the alignment of “vertical” aid with country programs⁷. More importantly this is complementary to the ongoing work across the Government of Mozambique (GoM) to improve its framework for planning, budget formulation and public financial management⁸ and for development partners ‘to systematically compile, report and publish information on the ODA projects they operate or support in Mozambique and to report these on a regular basis in the ODAMOZ web-based database’⁹.

Figure 4: Model for ‘On Plan’ / ‘On budget’



33. The funding modalities were compared against a simple model of whether they were “on –plan” (i.e. jointly agreed and aligned with Ministry priorities) and “on- budget” (i.e. whether planned and projected aid flows are made available to the government for financial management and planning purposes¹⁰). An appreciation of the effectiveness of disbursement was also undertaken, albeit limited by the time and information constraints, and where possible activities were assessed as to their level of ‘capacity support’ to HRH (building on the model described earlier)

3.1 ‘PEPFAR’ Mozambique

34. It is worth noting that the PEPFAR is a global initiative with particular guidelines and reporting mechanisms. However, implementation of PEPFAR activities at country level adopts differing organisational and delivery models and results in a country-specific structure. In the case of Mozambique the \$228m of PEPFAR funding for 2008 is routed through 7 different streams: \$214m (94%) of which is channelled through USAID and CDC. There are subsequently 42 partners implementing activities under USAID and CDC oversight, accounting for \$203m (89%) of the funding (see Table 2 below).

35. The Ministry of Health is one of the 42 partners working with CDC with \$3.95m of PEPFAR funding available for specific activities. In this instance the MISAU is an implementing partner as well as a beneficiary of PEPFAR funds. Labelling the many activities financed with PEPFAR resources in Mozambique as a single ‘PEPFAR’ programme is, to an extent, a misleading representation of the complexity of the country-specific context and the added value. It also fails to take account of the separate guidelines, funding possibilities and reporting procedures if an implementing partner is contracted by USAID or CDC: an example being that renovation of health facilities is feasible under USAID but not under CDC.

⁷ IDA (2007) Aid architecture: An overview of the main trends in Official Development Assistance flows

⁸ see Alex Warren-Rodriguez (2007) for a detailed overview of this work.

⁹ *Ibid*, para.3.13, p.17

¹⁰ The interpretation of ‘on budget’ is acknowledged as being less stringent than other interpretations but was seen as a workable definition for the purpose of this review.

Table 2: PEPFAR financing in Mozambique (US \$m) for 2008.

Financing stream	US\$ m (rounded)	% of total	Implemented by
USAID	133.63	58.45%	31 partners
HHS_CDC	81.25	35.54%	11 partners
HHS_HRSA	7.67	3.35%	*
State	2.37	1.04%	*
Peace Corps	1.77	0.77%	*
HHS_OS	1.18	0.52%	*
DoD	0.75	0.33%	*
total	228.62		

Source: Country Operational Plan Reporting System (COPRS)¹¹.

*- information not retrieved.

36. Conceptually PEPFAR can be viewed as a financing modality which is 'on-plan'¹² but 'off-budget'. However, analysis in Mozambique requires due consideration to the activities of each implementing partner, whether they are working at national, provincial or district levels and the planning and interaction each has with its government partners. This detailed exercise was beyond the scope of available time on this assignment and hence only a few partners were consulted.
37. **On-plan:** It is evident that the development of an annual Country Operational Plan (COP) involves the Ministry of Health and takes account of country priorities. Interviews with key stakeholders confirmed that the annual planning process creates many opportunities for interaction between national/provincial representatives, CDC/USAID and implementing partners over an intensive planning and development period of 3-4 months. This is concentrated at the programmatic level where implementation will subsequently be coordinated. However it was acknowledged by CDC staff that the plan is not consistently vetted back to MISAU at the leadership level.
38. There were positive examples of implementing partners and the CDC/USAID representatives working with government counterparts and detailing specific activities and objectives that would be incorporated into the annual programme. Moreover the process of in-year monitoring and performance review enables regular assessment of the emerging needs of the MISAU and new initiatives (i.e. those not originally planned) can be incorporated into the activity cycle with relative ease.
- 'Things don't stay on plan because new situations arise. We need to be flexible.'*(CDC staff member)
39. However, the annual planning process is considered, by some, to be extremely time-consuming on a yearly basis and a major burden on national and provincial government counterparts. Whilst ensuring activities are 'on-plan' it appears to have significant transaction costs (and bargaining costs) in achieving this.

¹¹ The COPRS data system is a web-based system for USG country planning and results reporting for the President's Emergency Plan.

¹² PEPFAR guidance on 'Relationship to Host Country Strategies' is explicit that programmes should be "developed and implemented within the context of multisectoral national HIV/AIDS strategies under the national authority". <http://www.pepfar.gov/pepfar/guidance/76820.htm>

“it is very difficult to function on an annual planning cycle...it’s almost impossible for Provincial Directors” (implementing partner)

“We receive a lot of documents from PEPFAR and USAID...they are experts in sending paper” (government official)

40. Irrespective of the perceived burden of annual planning, the resulting COP is a comprehensive overview of programmatic areas, activities, expected results and indicative funding levels. The 2008 COP for Mozambique is in excess of 700 pages. This information is available electronically in the Country Operational Plan Reporting System (COPRS) and in CDC Mozambique has been extracted into a user-friendly excel workbook that can be interrogated using pivot tables.
41. **On budget:** Within the working definition for this review a mixed picture emerges.
42. As highlighted earlier the MISAU is an implementing partner under two Cooperation Agreements (CoAGs) with CDC totalling \$3.95million (\$3.75m + \$200k). The main CoAG of \$3.75m is available for the MISAU to draw upon to deliver a broad range of HRH and HSS activities. This includes: extensive in-service education programmes for health workers at national and provincial levels; the development of pre-service curriculum; the development of training materials and programme guidelines; training of trainers; procurement of vehicles and IT infrastructure; the payment of staff salaries in the Ministry, and; programme supplies and support (i.e. for DBS samples and treatment sites).
43. This direct contribution to the MISAU is comparable with a number of bilateral partners (Flemish government, Denmark, France, Spain and Switzerland all contribute in a range of \$2.8m-\$4.3m) and the planned funding is clearly ‘available to the government for financial management and planning purposes’. Unlike pooled funding, there is an additional reporting requirement for the Ministry to access and utilise these funds. CDC provides assistance or ‘know-how’ to the MISAU to complete this reporting (this has also been described as ‘active vigilance’¹³), but it does raise questions on the capacity and efficiency of the Ministry’s management which will be considered in the next section on ‘disbursement’.
44. With implementing partners who were interviewed there are varying models of interaction with government. One partner with central funding (outside of CDC/USAID streams) has no interaction with the government on the available funding, only the planning of technical activities. Subsequent discussions on the resources to meet the Ministry’s requirements and needs are solely within the PEPFAR process.
45. Conversely, an implementing partner working at national and provincial level provided an excellent example of how PEPFAR funds are ‘on budget’ at the provincial level (often referred to as a ‘pass-through’ in PEPFAR-speak). A guiding ethos of this partner’s activities is to ‘build capacity from within, to increase service efficiency’. Within a comprehensive programme to scale-up ART, including renovating and equipping testing and treatment facilities, it was suggested that ‘in excess of 50%’ of the financial resources are available for the Provincial Directorates they are working with.
46. The prominent example is the transfer of funds from the partner to the Provincial Directorate so that the government can pay ‘staff’ salaries. This situation arises from the inability of government to employ and pay health workers without a long, drawn-out process lasting up to 24 months (the ‘nomination’ process). In the interim, Non-Government Organisations (NGOs)

¹³ Oomman et al (2007), p.21

are contracting newly qualified health workers and paying them the equivalent of a government salary as 'contract workers'. In this particular instance the implementing partner has integrated the 'contract workers' (approximately 500 health workers) into the provincial HR system and is supporting the salary payments as part of their systems strengthening approach. Given that this partner's activities in Mozambique are largely funded by PEPFAR (circa 85%-90%), it is evident that significant sums of PEPFAR money are 'on budget' in some of the provinces¹⁴.

47. Further work would however, be required to map all implementing partner activities and provide a comprehensive overview of actual funds available to MISAU.
48. **Disbursement:** The example of provincial level funding above, supported by the implementing partner, has an excellent disbursement process which follows the standard operating procedures of PEPFAR. In this respect the flow of PEPFAR funds in Mozambique has been acknowledged in a cross-country, cross-funding agency study as being highly efficient¹⁵. This was confirmed by interviewees as part of this assignment.
49. In the example of funding to the government itself, the process is the same and so, in theory, is equally efficient. However, the specific example of Mozambique raised a number of issues which highlighted a breakdown in the normal process. Whilst the funding was agreed as part of the extensive process of developing the COP the MISAU has been unable to draw down on it for two main reasons: a) an under-spend (circa \$6m) in a previous financial year which needed to be resolved, and b) due to ongoing delays in resolving the under-spend the untimely end of the award period of their CoAg (normally five years). It transpires that the funding now available in 2008 was initially planned in the development of the COP in 2006, communicated as approved for the financial year of 2007 (FY07)¹⁶ and hence normally available to government from March/April 2007. At the time of the visit, the new CoAg and the corresponding Notice Award had finally been completed (07 April) which will now enable the MISAU access to the funds - some 20+ months after initial discussions and agreements.
50. A concern arising is the financial management capacity within the MISAU to manage resources. There is undoubtedly an additional management and reporting requirement with PEPFAR funds, outside of the government's own public financial management processes, but technical and absorption capacity appears to be a recurring theme that is not isolated to PEPFAR support. Similar examples were provided for management of the Global Fund resources and the Ministry itself is suggested in one-study as disbursing less than 84% of its total health budget for the last 6 consecutive years (being particularly weak on investment spending) – "the financial resources are available but not used"¹⁷.
51. **Reporting:** PEPFAR requires annual reporting on country activities¹⁸ and implementing partners are active in providing inputs to quarterly review meetings which MISAU is invited to attend (though may not always be present). There is a separation between activity and financial

¹⁴ Precise figures were not readily available to support the statements, but a willingness to provide the detailed sums being disbursed at provincial level, available from the partner's internal management system, was expressed.

¹⁵ Oomman et al (2007), p.21

¹⁶ The PEPFAR budget period runs from 01 April – 31 March.

¹⁷ Mozambique background paper for the Oomman et al (2007) report. Personal communication from the authors. A range in absorptive capacity of 0.60-0.83 in the period 2001-2006.

¹⁸ PEPFAR guidance states that "Reporting will be required annually on the relevant programming areas against a minimal set of indicators standardized across the Emergency Plan"

<http://www.pepfar.gov/pepfar/guidance/76811.htm>

reporting which has been documented elsewhere¹⁹. The result is an attention to target performance, but less attention to the utilisation of funds that is actually available in Mozambique (the ‘source to actual use’ discourse which would disaggregate overheads and operating costs from systems inputs) and which the government expresses an interest in for planning purposes.

52. Ambassador Mark Dybul describes PEPFAR as being:

“committed to the strategic collection and use of information for program accountability and improvement” and that *“Reporting is one of the principal means of establishing effective systems for transparency and accountability..... building an ever-increasing body of empirical data from which to develop, evaluate, and improve evidence-based HIV/AIDS interventionsand fostering the establishment of national health information systems in partner countries”*²⁰.

53. Minister Garrido’s statements on an absence of NGO reporting (partially directed to PEPFAR partners) either suggests that he is not benefitting from the ‘transparency and accountability’ that the reporting process provides and/or a weakness in the current system of knowledge management and information sharing across the ‘PEPFAR’ Mozambique programme.

54. It should be noted that this is not necessarily the sole responsibility of the ‘PEPFAR’ Mozambique programme. The process of government decentralisation and the chain of reporting from Provincial Directorates to the Ministry is also a factor. The capacity of the provincial health departments to both receive reports from implementing partners and to pass them upward to central level may need strengthening. The deleterious effects of weakness in MISAU management were frequently mentioned to the consultants. However, there appears to be scope for further improvement. For instance, a recent exercise to provide OGAC (and subsequently the US Congress) with the numbers of Mozambican health workers participating in (PEPFAR-supported) pre-service training has been duly submitted to Washington but has not yet been used to inform country-level stakeholders.

55. Similarly, a review of the online ODAMOZ database highlights an absence of ‘PEPFAR’ Mozambique data. It cannot be gauged if this is due to non-reporting or ODAMOZ not inputting the data received. USAID’s health contributions for 2007 (\$48m) are reported, which confirms some data is being provided. Irrespective of this, the complete picture of PEPFAR funds is not being captured and reported in the same consistency as other development partners and this may be reinforcing some of the Minister’s perceptions. (see Annex 5).

56. CDC and USAID staff are aware of the gaps and have already taken action to address this. The pending arrival of dedicated communications personnel will improve internal capacity and future communications.

57. **Capacity Support:** Our understanding of ‘capacity support’ was described earlier. A similar interpretation of this model was echoed by two of the implementing partners interviewed. An analysis of the COPRS was also undertaken using specific filters in the database which identify programme activities that have ‘Emphasis Areas’ of capacity support²¹. A sensitivity analysis was not possible but it was confirmed that the ‘Emphasis Areas’ are reviewed during the

¹⁹ Oomman et al (2007),

²⁰ Ambassador Mark Dybul, U.S. Global AIDS Coordinator. Testimony before the House Committee on Foreign Affairs Washington, DC April 24, 2007 <http://www.pepfar.gov/press/83436.htm>

²¹ ‘Human Capacity Development’ + ‘Local Organisation Capacity Building’ + ‘Wraparound Programmes’.

development of the COP and that was therefore a consistency in attributing activities to 'capacity support'.

58. From this exercise it was calculated that \$89m of PEPFAR funding (FY 2008) in Mozambique have activities which can be deemed to be supporting 'capacity development'. This figure for Mozambique appears to reinforce the statement of Ambassador Mark Dybul that "*at least one quarter of PEPFAR's total resources are [sic] devoted to capacity-building*"²². Further work would be required to analyse the level of capacity support in greater detail, but Mozambique is clearly benefitting from a significant investment in health systems strengthening from PEPFAR funds.
59. **Comparative advantages:** The comparative advantage of PEPFAR programming appears to be in pre-service and in-service education, the temporary support for salaries and incentives to engage a growing workforce and expand services, and in the rapid strengthening of health and health education facilities (renovation, equipment, materials and supplies). Additional work in technical assistance, monitoring and evaluation also features. All of which will be necessary for the scaling-up of the health workforce and corresponding health services envisaged in the HRH plan and an integrated PHC service.
60. In addition, the overall flexibility and the speed of funding disbursement suggests a unique, catalytic position to be supporting immediate HRH and HSS activities or capital investment that can subsequently be absorbed by government as part of recurrent expenditure (supported by pooled-funds). In this respect, examples of PEPFAR Mozambique activities which are 'on plan' and 'on budget' (within this document's working definition) should be promoted. Further work can subsequently be taken forward to formalise the budget reporting between PEPFAR, MISAU and government.

3.2 DFID & other pooled-funding partners

61. DFID is currently the 'partner of first contact' for both the Health and HIV/AIDS sectors. It is also the liaison for the Global Fund. The role combinations, in addition to the implementation of its own Country Assistance Plan (CAP), place the DFID staff in a strong strategic position to support the health sector. There is significant potential to capitalise on their position in support of the joint USA/UK commitments to HRH development.
62. DFID recognises that 'even with recent improvements in harmonisation, donors continue to impose a significant burden' on the GoM. The DFID CAP, agreed by the GoM, therefore has a focus on 'management, service delivery and aid effectiveness reforms at sector level'²³ and seeks to be underpinned by a 10-year development strategy.
63. **On-plan.** DFID funding for health is provided through the Mozambican Sector-Wide Approach (SWAp) for health – PROSAUDE - to support government plans and priorities. The Memorandum of Understanding (MoU) for PROSAUDE II (work is ongoing to finalise the text and secure signatures) sets out the common terms and how DFID and potentially 14 other partners in the SWAp agree to cooperate to achieve, review and finance the plans.

²² Ambassador Mark Dybul, U.S. Global AIDS Coordinator. Testimony before the House Committee on Foreign Affairs Washington, DC April 24, 2007 <http://www.pepfar.gov/press/83436.htm>

²³ DFID – Country Assistance Plan

64. Any additional technical assistance undertaken that is outside of the main sector support (i.e. DFID coordinated TA to develop the HRH plan and costings) is also coordinated with government.
65. **On-budget.** There are a number of mechanisms for channelling sector support to the MISAU, including the SWAp. All of the 2008 SWAp funding is available 'on budget'. The tracking sheets for PROSAUDE and the other pooled-funding arrangements²⁴ suggest an increasing volume of funds (2007 to 2008) are being channelled through these mechanisms – an additional \$24m indicated for 2008 representing a potential 22% increase²⁵.
66. **Disbursement:** The April 2008 report on budget execution data for 2006 and 2007 (*Análise do Relatório de Execução Orçamental (REO IV 2007), do ponto de vista do Pilar de Capital Humano*) was reviewed for trends in ODA contributions. Actual external investment for health rose from 2,683 to 3,678 (milhoes de MT), whilst HIV/AIDS decreased from 425 to 318 (milhoes de MT). The figures suggest a year-on-year increase in total actual contributions of 129% whilst the planned contributions initially suggested an increase of 166%. The trends in internal contributions (planned and actual) show a 280% increase year-on-year.
67. When comparing the totals of actual contributions versus planned commitments there is a decrease from 91% to 72% (though actual investment has increased by 35%). The figures suggest as if there may be a) differences in the data that has been captured (similar trends were not available in the tracking sheets of the PROSAUDE contributions in \$, nor in the Mozambican country study for the Oommen et al report) and b) poor disbursement against commitments (heavily influenced by the external investment not received for health).
68. Neil Squires confirmed that both the difference in performance between 2006 and 2007, and the increase in funding in 2007 are primarily because projects which were previously not captured have now been put 'on budget'. Performance may be low, in part, because many of those budgets have not yet finalised their reporting of expenditure (i.e. they may have different financial years to the government cycle). As a result it is difficult to compare and contrast the disbursement performance in this document year-on-year and make any concluding remarks.
69. Similar confusion on disbursement to health and HIV/AIDS spending appears in other documents. The recent analysis of the National AIDS Spending Assessment (an 18-month study to track funding and disbursement) suggests over \$81m of international assistance for HIV/AIDS in 2006. Bilateral expenditures were calculated as approximately \$25m. No similar figure for bilateral expenditures could be extracted from the report on the budget execution, again suggesting different techniques and categorisation to capture and report on expenditure. The NASA does conclude that "a substantial amount of external assistance for HIV and AIDS is disbursed and reported through vertical projects and is therefore not captured in government accounts", but irrespective of this there appears to be a gap in consistency and the risk of double-counting cannot be discounted.
70. From the pooled-funding tracking sheets, however, an encouraging picture emerges when comparing initial 2008 performance against 2007. Figure 5 presents the data for 2007. Only 8% of partner contributions were disbursed in the first quarter of 2007 and nearly half of the

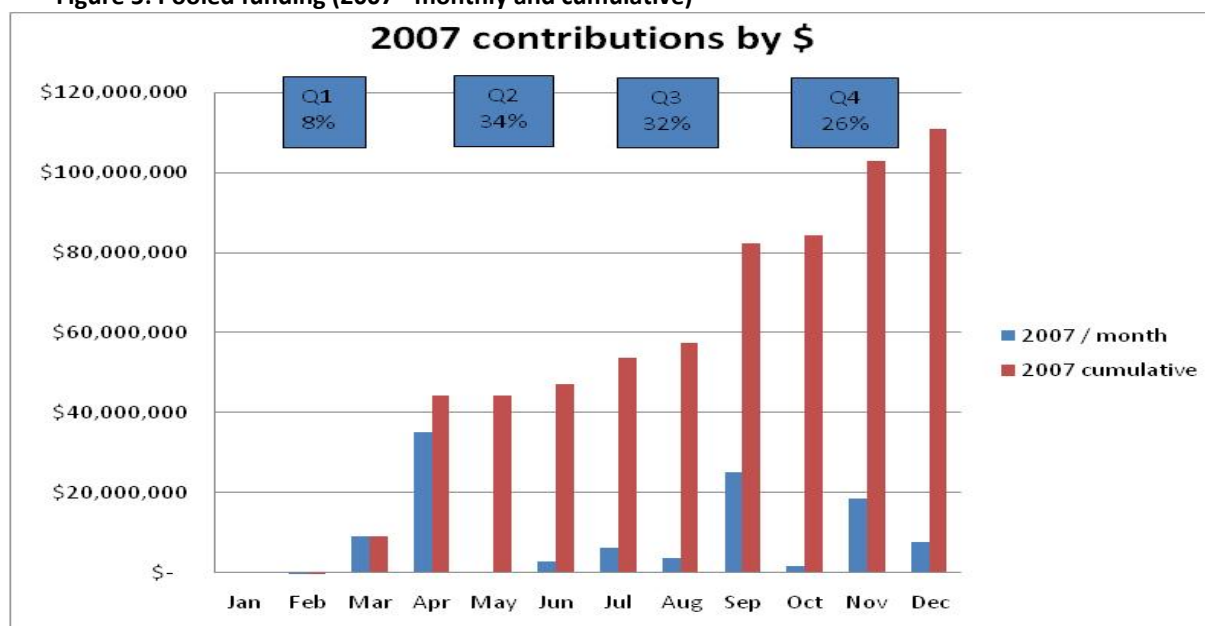
²⁴ FCMSM + FCP

²⁵ Actual net receipt by the GoM/MISAU in 2007 and 2008 may not correspond to the figures in the tracking sheet as a result of currency exchange rates. Hence any comparisons can only be considered indicative or potential.

funding arrived in the last four months of the year. This was heavily influenced by the late disbursement from the Global Fund (funds from Round 2 and Round 6 accounting for \$41.3m)

71. In 2008 (Figure 6) partners have improved their performance and are making prompt disbursements of their annual commitment in the first quarter of the government's financial year. This is in accordance with the 'timely fashion' to respect the Ministry's needs as agreed in the MoU²⁶ - even if none of the partners was able to meet the suggestion of disbursement in January of the financial year²⁷. Nearly \$60m of the planned \$135m has been already been received by April 2008 (the same level of funding was not attained in 2007 until September). The majority of the remaining balance (62 %) is from the Global Fund. Similarly the ODAMOZ database is recording the projected contributions of the vast majority of partners for the years 2009, 2010, 2011 which is also in accordance with the MoU²⁸.

Figure 5: Pooled funding (2007 - monthly and cumulative)



2007 Q (\$)	\$9,113,250	\$38,145,079	\$35,168,473	\$28,349,681
2007 Q (%)	8%	34%	32%	26%

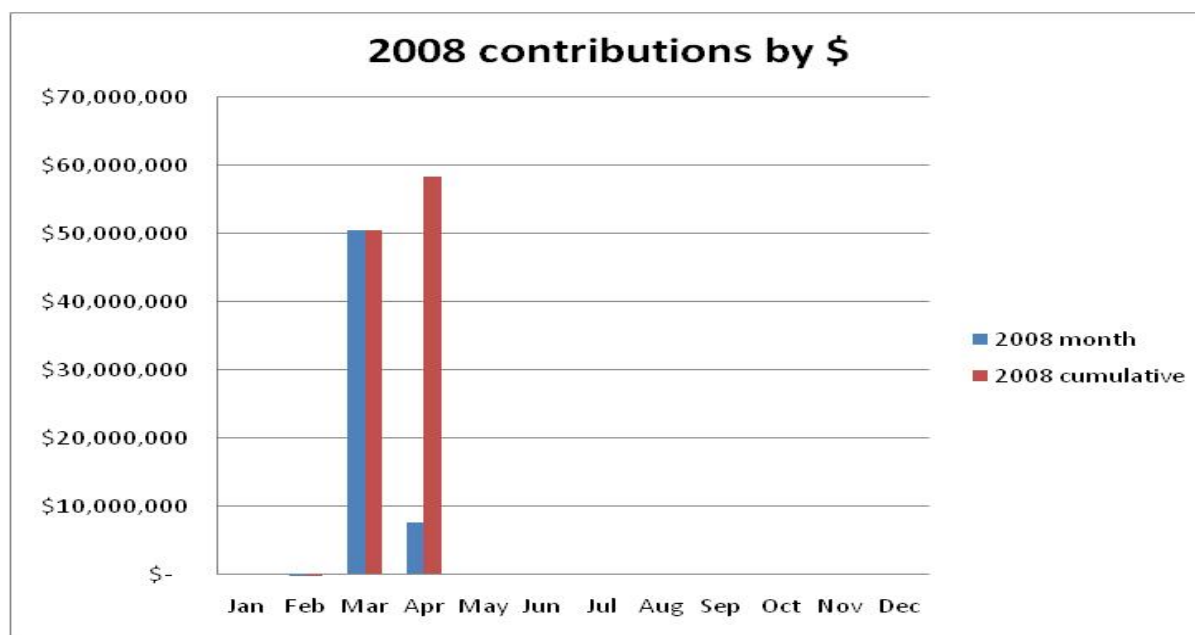
Source: Extracted from PROSAUDE tracking sheets

²⁶ As per Article 5.3 of the MoU

²⁷ See Annex 3 of the MoU

²⁸ As per Article 5.1 of the MoU

Figure 6: Pooled funding (2008 - monthly and cumulative)



Source: Extracted from PROSAUDE tracking sheets

72. The difficulties associated with disbursement of the Global Fund contribution is one of local concern. The arrival of 2007 funds in November and December 2007 caused considerable disruption to planning and expenditure²⁹. The transaction costs associated with securing the release were reported as inordinately high. Whilst the delays in the disbursement of funds related to Round 6 approval may, in part, be linked to the clarification and adjustment process referred back to the CCM by the GF³⁰, the same cannot be said of the late disbursement of the \$19.2m and \$14.3m of Round 2 funds³¹. The GF, both as a signatory to the International Health Partnership and based on its own principles of 'efficient and effective disbursement mechanisms'³² should seek to improve the situation in 2008.
73. Given that the GF monies represent 35% of the pooled-funding for 2008 there needs to be a focus on securing these funds. Whilst \$2.6m has been disbursed to the National AIDS Council (CNCS) (a separate arrangement for HIV/AIDS pooled funding) in February 2008, other Round 2 and all Round6 funding is still pending.
74. Ongoing delay in the finalisation of the MOU, which is a condition for some partners to disburse (EC, France and Spain), has restricted disbursement by some agencies. Others (Ireland, Switzerland) are waiting for the MOU signature before making their disbursements. However, in 2009, all partners operating under the new MOU should be able and should commit to disbursing the bulk of their funding as early as possible and preferably in the first trimester. This would offset any repeat of delays with GF disbursement.

²⁹ Noticias, 20 March, 2008. 'MISAU nao recebeu todos fundos prometidos'.

³⁰ The Grants for Round 6 (Malaria and HIV/AIDS) were originally approved in November 2006 as Category 2 and 2B hence requiring clarification and/or adjustment. The Grant signature date was not until September 2007. This delay appears similar to Grants for S. Africa, Tanzania and Uganda whereas Rwanda and Namibia were able to complete their respective Grants in April and May 07.

http://www.theglobalfund.org/en/funds_raised/reports/

³¹ Disbursed in August/ September and November respectively

³² http://www.theglobalfund.org/en/funds_raised/principles/

75. **Reporting.** The reporting framework for those development partners within the pooled-funding arrangements is defined in the MoU. As very few implementation activities are undertaken outside of the pooled-funding there is minimal requirements for separate activity reporting.
76. Reporting and coordination between development partners appears to be functioning well. During the assignment there were numerous examples of inter-agency and agency-government coordination. The efforts to achieve this should not be underestimated.
77. **Comparative advantages:** The comparative advantage of DFID is its role as 'partner of first contact' for the health and HIV/AIDS sectors, complemented by its role in the IHP+ initiative, its wider interest in public sector reforms and the promotion of aid effectiveness and harmonisation. These various elements provide DFID staff with a unique position to assist HRH development and HSS at cross-government, cross-agency levels and potentially mobilise financial resources (through efficiency and new funds) that reflect the ambitions and needs of the MISAU and GoM

4 Discussion and recommendations

78. An initial presentation of findings and possible recommendations was held on Friday 11th April with representatives of CDC (Cate McKinney), USAID (Polly Dunford) and DFID (Neil Squires and Katie Bigmore). As stated earlier, Antonio Mussa from the MISAU was unable to attend. The slides presented are available as Annex 6
79. Whilst there was general agreement on the ideas and suggestions put forward, it was noted that new guidance from PEPFAR II was imminent and could lead to revisions to the PEPFAR processes at country level; that work on the key messages from the HRH plan was ongoing (i.e. priority, costed actions for implementation in the next 3 years) and; that the consultants had not had the opportunity to interact with Dr. Mussa as originally anticipated. Recommendations should be read in the spirit of promoting dialogue, which the assignment was intended to do.

4.1 Strengthening HRH activities (HRH)

80. We noted that there is much interest and activity around HRH development, though currently it tends not to be strongly coordinated by the MISAU and not supported by policy and legislation development. While it is not as easy to address the institutional strengthening that will result in strong national frameworks for HRH development, it is worth considering to ensure that the workforce develops in a coherent and sustainable way. Supporting the MISAU management staff at national and provincial levels in acquiring strategic management skills will be one way of doing this. In addition, strengthening the professional associations to contribute to workforce development and to monitor quality of practice, will result in longer term and lasting change.

Recommendation HRH1: *DFID to continue its review of the way in which the HRH plan is currently organized so that it sets out strong objectives to be achieved by clearly articulated and particular strategies that partners can support. 'PEPFAR' Mozambique could provide support to this process through available technical expertise, in consultation with the HR working group and with Dr Mussa and the MISAU.*

Recommendation HRH2: *A Human Resources Information System (HRIS) is essential for meaningful planning, management and monitoring of workforce development. This is a discreet activity that can be supported by a donor with the required technical assistance.*

Recommendation HRH 3: *MISAU to articulate its priority actions for the short, medium and long term in scaling-up the health workforce. DFID to assist in the dissemination of these priorities to all Development Partners and promote alignment with their respective financing mechanisms.*

Recommendation HRH 4: *Ministry level of management to be strengthened through coaching and mentoring activity. Technical expertise should be identified and funded by partners to undertake this as a matter of urgency. Strong management is the foundation for coordinating partner activity in workforce development and will be essential for planning in the longer term, as the MISAU takes over salaries, education and training.*

81. **Capacity development:** The many development partners involved in Mozambique result in a complex system of funding, implementation and reporting. Mapping interventions against a simple model of capacity development shows where the major efforts are directed and how far they can be said to be building the capacity of the health sector – or one of its systems – and are

therefore more likely to result in long term and sustainable capacity development. We have suggested one possible model that shows 4 levels of capacity development against which activities could be compared.

82. We have noted that more than a quarter of PEPFAR funding is directed to capacity building, especially education, training, salaries and technical assistance. Much of this is at provincial level. This is a significant asset to the country and should be complemented by activity at the central level to build systems and procedures as well as management.

Recommendation CAP1: *A joint planning exercise between MISAU and all partners to be held, perhaps under the auspices of the HR working group, at which the contribution of all activities to the overall picture of capacity building can be discussed and mapped, so that gaps are identified and all levels are targeted. The result should be a capacity development framework to guide donors, implementing partners and MISAU.*

83. **Pay issues** are currently being considered within the larger public sector reform strategy. In terms of the health workforce one concern is that development partner contributions to salaries in the health sector (for 'contract workers') are not included in the budget. In the longer term the government will have to take these over, thus pushing up the predicted wage bill. Issues of salary remain crucial to recruitment of additional staff and the retention of all staff. This is so at all levels, including staff at Ministry level who do not have parity between ministries. We heard, for example, that finance staff in the MISAU are being recruited to the Ministry of Finance because the salaries there are higher. Losing key finance personnel will almost certainly weaken the MISAU at a time when the coordination and monitoring of all funds is vital to workforce expansion.

Recommendation Pay1: *the financial management capacity of the MISAU is strengthened so that there is an ongoing monitoring of the effects of salary changes and the extent to which the fiscal framework will allow workforce expansion and salary increases. This process has already begun with the costing of the HRH plan, but it should not be a one-time exercise, but rather a constant process of monitoring and adjusting plans. Technical support could be given in financial management.*

Recommendation Pay2: *MISAU and DFID to explore the possibilities of MISAU staff with financial management responsibilities to be offered the same salary package and incentives as their counterparts in other Ministries.*

84. There are potential distortions in the health labour market between the public and private sectors. This is partially being addressed through a code of conduct for NGOs employing health workers. CDC/USAID could create added value by ensuring all implementing partners are co-signatories to the Code of Conduct and adhere to a pro-HRH/HSS policy on salary policies that could be developed by the HRH Working Group. The Working Group may wish to take account of an international initiative developing an NGO Code of Conduct for Health Systems Strengthening that will be launched on 29 May, 2008 (www.ngocodeofconduct.org)

Recommendation Pay3: *HRH Working Group to promote standard operating procedures for NGOs in Mozambique to set out best practice in terms of supporting national salary policies.*

85. DFID is in a strong position to coordinate overall input to HRH strengthening, including pay, with its history of involvement in public sector reform, its promotion of aid harmonization and experience of creative funding for salaries in other countries. Now, as partner of first contact for

health and HIV/AIDS in Mozambique, DFID can take a lead on convening other partners to address the HRH, capacity and pay issues outlined in this report. PEPFAR is contributing significantly to many aspects of capacity building in the country, and their contribution can be complemented by other donors or pooled funding financing to ensure that there is institutional capacity development, especially through strengthening strategic and financial management arrangements throughout the health system.

4.2 Knowledge & Information Management (KM + IM)

86. This visit noted some excellent examples of pro-HRH/HSS and 'on budget' activities currently within the PEPFAR-funded programme in Mozambique. What became clear is that these are not necessarily being systematically captured or reported as knowledge or information and shared with the MISAU or GoM. The 'PEPFAR' Mozambique programme is subsequently doing itself an injustice, is unable to refute perceptions or statements that may arise locally, and in part contributing to some of the inaccurate perceptions that have become entrenched in the political discourse emanating from MISAU and/or between partners.

87. **Knowledge Management (KM):** Chopry et al (2005) have highlighted the concern that 'there are few examples of documented good practice approaches which use HIV prevention, care and treatment to purposefully strengthen the wider health sector or of systematic studies of poor HIV care and treatment practices undermining the wider health sector'.

88. A number of current initiatives are addressing this.

- ❖ The Global HIV/AIDS Programme (GHAP) of the World Bank (WB) is currently working with UNAIDS and the World Health Organisation (WHO) on a comprehensive study on 'Health Systems and HIV/AIDS', which includes a focus on HRH.
- ❖ The WB is also working with OGAC/PEPFAR in preparation for the Implementers Meeting in Uganda in June 2008.
- ❖ Tom Kenyon and Michel Sidibe from OGAC and UNAIDS respectively are co-chairing a GHWA Task Force on the HRH implications of scaling-up towards Universal Access (which will potentially include Mozambique as a partner in its country work).
- ❖ UNAIDS is separately conducting a study on AIDS and HSS.
- ❖ DFID has recently commissioned work which examines the role and potential for Global Health Partnerships in the international health architecture, especially in HSS; and how the existing vertically financed programmes affect health systems and wider service delivery capacity in different country contexts, with a view to promoting a more balanced approach to health and HIV/AIDS financing through 'diagonal funding' strategies.
- ❖ The US and UK governments have committed to joint work in Mozambique.

Synergies and similar objectives therefore exist between respective partners and can be developed.

89. CDC and USAID are in a prime position to improve the evidence base within Mozambique and to share this nationally, regionally and globally (feeding into some of the above examples). Some of the implementing partners have association with academic institutions and, of those interviewed, would welcome an opportunity to incorporate knowledge management within their activities. Partners should be encouraged (and potentially resourced) to develop 'lessons learnt' and write-up examples (ideally with MISAU staff at national and provincial levels) of the current innovative and successful initiatives which are a) pro-HRH/HSS (institutional capacity

development included) and b)'on budget'. Short 'briefing papers' or similar could be shared amongst all partners in Mozambique as examples of best practice that are to be encouraged. This is distinct from 'guidance' from PEPFAR (which some partners have expressly called for – '[PEPFAR should] encourage if not mandate certain actions') and could be seen as a lighter touch to steer the development of pro-HRH/HSS activities in the 2009 COP. Sharing available best practice at the Implementers Meeting would have additional benefits for other country operations.

Recommendation KM1: *CDC/USAID to review and encourage knowledge management across implementing partners' activities. Available best practice to be documented and shared in Mozambique. Time permitting, examples of best-practice to be prepared for the Implementers Meeting in June 2008.*

90. The scope of KM activities in the 2009 COP could be further developed. There is the potential to analyse in greater depth the performance of activities. Each implementing partner maintains detailed financial accounts (financial reports are currently submitted separately to activity reports) and could apply an agreed methodology to calculate the efficiency of their activities, the percentage of funds available in Mozambique etc, etc. The potential benefit for the MISAU and the GoM, improving the data available to them for public financial management and planning purposes is considerable. Further internal debate is probably required and encouraged, including addressing concerns that there could consequently be reductions in government funding in some provinces; hence no specific recommendation is made at this stage.

91. **Information Management:** Minister Garrido's initiative to strengthen integrated PHC and involve NGOs to structure their support activities on a Province by Province basis provides a clear opportunity for CDC/USAID leadership with their implementing partners. WHO Mozambique has recently updated their Service Availability Mapping (SAM) across the country. PEPFAR funded activities could be reviewed by Province³³ and matched to the SAM using geo-referenced information codes. DFID in its coordinating role could encourage other project activities to complete a similar exercise. This would result in a clear overview of Provincial support and provide clear information to the Medical Assistance Directorate (DAM) which is currently reviewing, with partners, how the Minister's initiative can be developed.

Recommendation IM1: *CDC/USAID to map provincial activities and link to WHO mapping. DFID to encourage mapping of all other project activities. A country-wide review to be available for further discussion and planning and feed into the ongoing work of the DAM.*

92. The results of subsequent discussions with DAM could provide greater clarity on the priority actions/activities and where 'PEPFAR' Mozambique may apply its comparative advantages in 2009.

93. The consultants are unsure how integral the ODAMAZ database is to the GoM for planning and financial management, but both 'PEPFAR' Mozambique and DFID appear to be under-reporting their contributions to the health sector. DFID, as focal partner for the health and HIV/AIDS sector and with its focus on aid harmonisation should strive to ensure that all partners are providing timely and updated information to the GoM for public financial management. This can be addressed almost immediately.

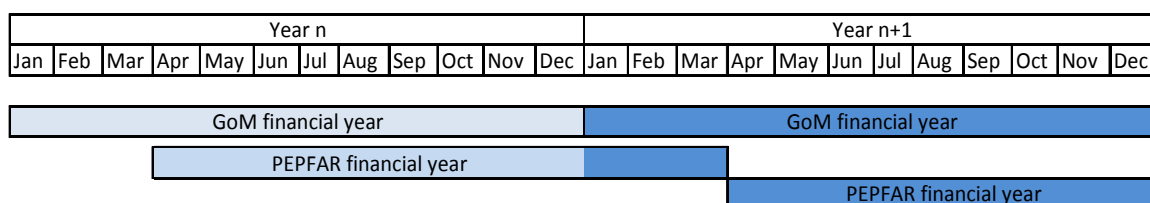
³³ Similar exercises to review Provincial activities were completed in 2007, and available in the CDC datasheets. The precedent and the increasing capacity of USAID/CDC offices in Mozambique suggest the exercise is feasible.

Recommendation IM2: *DFID and CDC/USAID to provide ODAMOZ with accurate figures on their respective funding for 2008.*

4.3 Cycles/Calendars/Planning Management (CCPM)

94. MISAU has a clear calendar of activities for its public financial management and planning processes (see Annex 7). These are linked to the wider GoM processes and financial planning (Medium Term Expenditure Framework, Poverty Reduction Strategy etc). Development partners are increasingly aligning themselves to this calendar as evident in the disbursement of pooled-funds and the notification of future funding intentions discussed earlier.
95. Whilst it is evident that some of the PEPFAR funding to Mozambique is ‘on budget’ within the working definition (whether planned and projected aid flows are made available to the government for financial management and planning purposes), it is nonetheless on a different calendar/cycle and critically does not allow for forward planning beyond the immediate one-year cycle. Any changes to this process will clearly require OGAC interventions and may yet be part of the new guidance for PEPFAR II. A move to two-year planning would be beneficial given the expressed concerns.
96. It was noted however that there is a five-year vision associated with country activities, both from the official PEPFAR guidance and in the CoAgs that are signed with implementing partners. Whilst the consultants recognise the many caveats that prevent PEPFAR from committing funding beyond their current financial year, there is potential scope for the four focus countries of the US/UK initiative to work on improving the projected funding levels that will be part of PEPFAR II.

Figure 7: MISAU / PEPFAR – financial years



97. MISAU asks development partners to communicate projected funding levels for the following year (n+1) in May and confirm this in July. PEPFAR already has data on spending projections for the first 3 months of n+1 as a result of its financial year covering two annual calendars of MISAU. If implementing partners are tasked to present a calendar of financial disbursement plans there is therefore an opportunity to indicate and confirm this spending in May and July respectively.
98. Added value would be gained by estimates of the remaining 9 months of n+1 spending also being indicated in May. The caveats may prevent confirmation in July, but MISAU planning could be enhanced if they are aware of the intentions.

Recommendation CCPM1: *CDC/USAID to provide MISAU with confirmed projected expenditure in the first quarter of year n+1 (extracted from existing PEPFAR financial year) as per the MISAU calendar.*

Recommendation CCPM2: *CDC/USAID to endeavour to provide estimates (and MISAU to fully recognise caveats) of additional n+1 funding (extracted from country vision and existing CoAGs) as per the MISAU calendar.*

Recommendation CCPM3: *PEPFAR/OGAC to explore the feasibility of adapting the current planning and forward financing of country activities in the four focus countries of the US/UK initiative, with the option of moving to a two-year cycle of planning and financing projections duly considered.*

4.4 Resource mobilisation and management (RMM)

99. The current financial management capacity within MISAU and the difficulties in the disbursement of current internal and external resources have been described earlier. Recommendations to strengthen the capacity of MISAU and retain the staff responsible for these functions have also been presented. A minimum foundation to manage existing resources effectively is required before development partners will have the confidence to scale-up their financial commitments and be reassured that efficiency is also to be addressed.

100. Further work is required on understanding the real volume of funds available to MISAU for health and HIV/AIDS expenditure, including the actual sums from PEPFAR after overheads ('source to actual use'). Additional work on all other sources of project funding, resulting in a clear analysis of incoming funds and disbursement would also be beneficial. As discussed earlier it is currently difficult to compare year-on-year performance, or to confidently provide an accurate figure of resources and subsequent resource gaps, based on the current information available. Developing a single reference that all partners will be confident in, and eliminating any risk for double-counting, will be a measurable success. DFID is well placed to support MISAU in addressing these issues as part of a comprehensive programme of resource mobilisation and management that engages all development partners and builds on the comparative advantage of each.

101. The recent receipt of the 'zero draft guidance' for the International Health Partnership (IHP+) country compact provides a timely opportunity to develop a resource mobilisation and management strategy around the concept of 'one country plan'. The draft guidance presents an opportunity for comments. In the current text there is only the one reference to HRH in the results section. This is a potential gap and it would be good to see more reference in the IHP literature to one country HRH plan with costings. This will serve to reinforce the HRH development work that is needed across all IHP countries, but specifically in Mozambique. If amended it will provide development partners with a further reference to encourage alignment to the implementation work that is needed. DFID and development partners are encouraged to respond.

Recommendation RMM1: *DFID to liaise with the IHP secretariat on the 'zero draft guidance', seeking additional reference to HRH.*

102. Taking the IHP Country Compact forward will be aided by the earlier activities on extracting the key messages from the HRH plan and costings and agreeing the priority actions. In parallel, the mobilisation of resources should seek to promote the sustainable financing of the health workforce.

Recommendation RMM2: *MISAU and partners to ensure the national IHP discussions result in a pro HRH/HSS country compact that highlights the resource mobilisation requirements and links to long-term sustainable financing.*

103. The GF, as a signatory to the IHP and in keeping with its own operational principles needs to ensure timely disbursement of its funding. A repeat of late in-year disbursement, as in 2007, will

undermine the MISAU activities which in turn affect performance-based results and the confidence of development partners to further increase investment. The GF is encouraged to meet timely disbursement in the next few months. DFID and other development partners are encouraged to support MISAU in addressing any internal bottlenecks that may be contributing to poor management of GF funds and to hold the GF accountable for timely disbursement.

Recommendation RMM3: *The GF to ensure timely disbursement of its 2008 funds. In parallel development partners to support MISAU's internal capacity to manage the GF reporting and disbursement processes and hold the GF accountable to its signatory of the IHP and its own operating principles.*

104. Round 8 of the Global Fund (GF) launched on 01 March and permits applications for health systems strengthening, including the health workforce. Proposals are due to the GF by 01 July. There is therefore a short window of opportunity to link the momentum within Mozambique to this. In previous Rounds, the GF has approved HRH/HSS funding for curriculum development, training, recruitment, salaries and incentives, retention incentives, facility renovation, equipment, monitoring and evaluation (including HRIS). Many of the priority actions in the HRH plan will fall within these categories. Participants in Mozambique's Country Coordination Mechanism (CCM) should therefore seek to capitalise on the HRH plan, articulate the 'cross-cutting' elements that will improve disease outcomes and maximise the potential funding from Round 8.

Recommendation RMM4: *All partners to liaise with the CCM secretariat and ensure the HRH plan and resource needs are integrated into the Round 8 application for HSS funding.*

105. Given the considerable coordination underway in Mozambique, there is potential for the country to become a recipient of 'catalytic funding' from the GHWA. This funding is currently \$300k per country for the purposes of country coordination, removing bottlenecks, the implementation of the HRH-AF and the response to the Kampala Declaration and Agenda for Global Action. Work identified above, that may not quite fit the flexibilities of existing development partners could feasibly be supported by GHWA. MISAU, with the HRH Working Group, should therefore seek to engage with the GHWA.

Recommendation RMM5: *MISAU and HRH Working Group to liaise with GHWA on the potential for Mozambique to receive 'catalytic funding' for HRH.*

106. The announcement of the US/UK initiative on HRH adds further imperative to ensure a coordinated approach, building on the excellent partnership between DFID and 'PEPFAR' staff that was visible in this assignment. Many of the earlier recommendations will facilitate the development of an extremely positive, pro-HRH/HSS, COP for 2009. The comparative advantage of PEPFAR funding needs to be compared against the priority actions resulting from the HRH plan and activities developed accordingly. Existing initiatives that already demonstrate added value should be strengthened alongside new initiatives addressing gaps in provision. PEPFAR II guidance should be reviewed on receipt to ascertain the maximum advantage that can be incorporated into future activities.

Recommendation RMM6: *All partners should review PEPFAR II guidance and seek to maximise the potential resources that can be allocated to HRH programming as part of the development of the 2009 COP.*

4.5 Matrix of recommendations resulting.

107. The following table presents the above recommendations, by lead, target date and means of verification.

Recommendation	Lead	Target date	Means of Verification
HRH1: DFID to continue its review of the way in which the HRH plan is currently organized so that it sets out strong objectives to be achieved by clearly articulated and particular strategies that partners can support. 'PEPFAR' Mozambique could provide support to this process through available technical expertise, in consultation with the HR working group and with Dr Mussa and the MISAU.	DFID + CDC/USAID	June 2008	Summary of key messages from the HRH plan
HRH2: Build a Human Resources Information System (HRIS) to support planning, management and monitoring of workforce development	USAID	End 2009	HRIS in use
HRH 3: MISAU to articulate its priority actions for the short, medium and long term in scaling-up the health workforce. DFID to assist in the dissemination of these priorities to all Development Partners and promote alignment with their respective financing mechanisms.	DFID	September 2008	Priorities disseminated to partners Forum for harmonization of funding established.
HRH 4: Strategic management functions to be strengthened through coaching and mentoring activity, especially at Ministry level.	CDC/USAID	End 2008	Benchmarking of good practice in management functions against which MISAU can be measured and seen to improve
CAP 1: A joint planning exercise between MISAU and all partners to be held at which the contribution of all activities to the overall picture of capacity building is mapped, so that gaps are identified and all levels are targeted.	DFID/CDC	September 2008	Capacity development framework available
Pay1: the financial management capacity of the MISAU is strengthened so that there is an ongoing monitoring of the effects of salary changes and the extent to which the fiscal framework will allow workforce expansion and salary increases. This process has already begun with the costing of the HRH plan, but it should not be a one-time exercise, but rather a constant process of monitoring and adjusting plans.	DFID / PROSAUDE	June 2009	Ministry exhibit stronger financial management

Recommendation	Lead	Target date	Means of Verification
Technical support could be given in financial management.			
Pay2: MISAU and DFID to explore the possibilities of MISAU staff with financial management responsibilities to be offered the same salary package and incentives as their counterparts in other Ministries.	MISAU	September 2008	MISAU proposal for salary parity available for discussion with appropriate Government body.
Pay3: HRH Working Group to promote standard operating procedures for NGOs in Mozambique to set out best practice in terms of supporting national salary policies.	HRH Working Group	December 2008	Standard operating procedures available
KM1: CDC/USAID to review and encourage knowledge management across implementing partners' activities. Available best practice to be documented and shared in Mozambique. Time permitting, examples of best-practice to be prepared for the Implementers Meeting in June 2008	CDC/USAID	In advance of COP preparation for 2009. In time for June 08 Implementers Meeting	x examples of pro-HRH/HSS activities available in the public domain. x examples of 'on-budget' activities available in the public domain.
IM1: CDC/USAID to map provincial activities and link to WHO mapping. DFID to encourage mapping of all other project activities. A country-wide review to be available for further discussion and planning and feed into the ongoing work of the DNAM.	CDC/USAID DFID DFID	June 2008 June 2008 July 2008	Activities by geo-referenced codes shared with DNAM
IM2: DFID and CDC/USAID to provide ODAMOZ with accurate figures on their respective funding for 2008.	DFID CDC/USAID	June 2008	Updated ODAMOZ figures available online.
CCPM1: CDC/USAID to provide MISAU with confirmed projected expenditure in the first quarter of year n+1 (extracted from existing PEPFAR financial year) as per the MISAU calendar.	CDC/USAID	May and July 2008	First quarter n+1 expenditures available to MISAU (minus implementing partner overheads)
CCPM2: CDC/USAID to endeavour to provide estimates (and MISAU to fully recognise caveats) of additional n+1 funding (extracted from country vision and existing CoAGs) as per the MISAU	CDC/USAID	May and July 2008	Projected n+1 expenditures (for Q2, 3 and 4) available to MISAU (minus implementing partner overheads)

Recommendation	Lead	Target date	Means of Verification
calendar.			
CCPM3: PEPFAR/OGAC to explore the feasibility of adapting the current planning and forward financing of country activities in the four focus countries of the US/UK initiative, with the option of moving to a two-year cycle of planning and financing projections duly considered.	PEPFAR/OGAC	Initial discussions at Implementers Meeting in June 08.	Meeting notes
RMM1: DFID to liaise with the IHP secretariat on the 'zero draft guidance', seeking additional reference to HRH.	DFID	immediate	Next version of guidance incorporates further reference to HRH
RMM2: MISAU and partners to ensure the national IHP discussions result in a pro HRH/HSS country compact that highlights the resource mobilisation requirements and links to long-term sustainable financing.	MISAU	Ongoing as per schedule of meetings.	Country Compact and proposal to the IHP relates to HRH plan and costings.
RMM3: The GF to ensure timely disbursement of its 2008 funds. In parallel development partners to support MISAU's internal capacity to manage the GF reporting and disbursement processes and hold the GF accountable to its signatory of the IHP and its own operating principles.	GF DFID + partners		Date of receipt of GF monies.
RMM4: All partners to liaise with the CCM secretariat and ensure the HRH plan and resource needs are integrated into the Round 8 application for HSS funding.	MISAU	By end of June	Round 8 application includes specific priority actions extracted from the HRH plan
RMM5: MISAU and HRH Working Group to liaise with GHWA on the potential for Mozambique to receive 'catalytic funding' for HRH.	MISAU	By end of June	Correspondence and updates in HRH Working Group meetings
RMM6: All partners should review PEPFAR II guidance and seek to maximise the potential resources that can be allocated to HRH programming as part of the development of the 2009 COP.	CDC/USAID	Within 4 weeks of receipt	Review of guidance and HRH opportunities resulting available to partners.

HRH – Human Resources for Health; KM – Knowledge Management; IM – Information Management; CAP – Capacity Development; CCPM – Cycles/Calendars/ Planning Management; RMM – Resource Mobilisation and Management

108. As discussed earlier, these recommendations are for ongoing dialogue and discussion between partners. Many are complementary to each other and require continuing commitment to working in partnership, applying complementary strengths to take these forward.

Annexes

Annex 1 - US/UK Announcement on Health and Health Workers (April 17)

For Immediate Release - Office of the Press Secretary April 17, 2008

US/UK Announcement on Health and Health Workers

In July 2007 we joined together with leaders from 14 countries to revisit our commitment to meet the goals of the 2000 Millennium Declaration. Both developing and developed nations need to mobilize our individual and collective efforts toward the 2015 goals. We are committed to reducing maternal mortality by three quarters, and under-five child mortality by two thirds, of their rates in 1990. But we know that to save more lives we need stronger health care and institutions in developing countries. And for that, a sustainable health workforce is critical.

In this regard, the United States and United Kingdom have committed to work together, alongside other partners, to fight diseases and support stronger health systems, public and private-sector health institutions, and health workers. Today, we are demonstrating this commitment in Ethiopia, Kenya, Mozambique, and Zambia -- four countries that the United Kingdom is supporting through the International Health Partnership and the United States is supporting through the President's Emergency Plan for AIDS Relief and other activities. In these four countries, the United Kingdom is planning to spend at least \$420 million on health, including the health workforce, over the next three years, and the United States is planning to invest at least \$1.2 billion over five years on health workforce development.

It is also why we call on the G8 and others to support partner countries to increase health workforce coverage levels, with a view to work towards the World Health Organization goal of at least 2.3 health workers per 1,000 people. This will allow a substantially higher percentage of women to give birth with a skilled attendant present and will also allow a greater number of health workers to provide essential health care, including for HIV/AIDS.

By putting in place this foundation for stronger health, we also build upon existing initiatives, including to address the issue of neglected tropical diseases (NTDs). Approximately one billion people, mostly in the developing world, suffer from one or more NTDs. Building upon the President's announcement in February, the United Kingdom will support this effort to control or eliminate seven major NTDs. We will challenge other donors, including our G8 partners, foundations, and public, private, and voluntary organizations to meet the balance of this need to have a positive affect on the lives of hundreds of millions people in Africa, Asia, and Latin America.

Since before the 2005 G8 Summit in Gleneagles, the United States and United Kingdom have been scaling up their aid for health. The international community as a whole must do more, including by meeting the commitment made by the G8 at Heiligendamm to provide \$60 billion in aid for health. We can only achieve our goals by working together more effectively, and by providing more, and more effective resources for health.

<http://www.whitehouse.gov/news/releases/2008/04/20080417-5.html>

Annex 2 – Terms of Reference

Taking forward Action on Human Resources for Health (HRH) in selected African Countries with DFID/OGAC and other partners. (*Mozambique Draft: 20/03/08*)

Background:

1. In response to the critical HRH shortages in Africa, DFID and Office of the US Global Aids Coordinator (OGAC) responsible for PEPFAR have been in discussion with a number of African countries to develop strategies and country level actions. The aim is to demonstrate the maximum flexibility of disease specific programmes to support broad based primary care in line with countries' health plans.
2. An initial operational meeting was held in Ethiopia in January 2008 with US, UK and country representatives from Ethiopia, Zambia, Mozambique and Kenya (PEPFAR, DFID overlap countries). Some initial progress was made and a matrix was produced for each country highlighting key short to mid term priorities that could be potentially funded. However, these required further work and details on priority areas for each country.
3. There is high level political support for this process in the UK and US, provided that the efforts result in specific actions and commitments in each country. However, there is a short political window to demonstrate success. The outcomes may also influence the content of the 2008 G8. Support is therefore required to work up costed options of priority short to mid-term actions for these countries. There are risks that this activity runs counter to existing country processes and every effort should be made to ensure that this work does not bypass country systems and HRH working groups. This should be undertaken in low key manner, with support from DFID and US country teams and focus on operational level activities. Discussions should include WB, WHO, Foundations and other bilateral and multilateral agencies working in country.
4. Following discussions with OGAC at the Global Health Workforce Forum in Uganda, it was decided that Mozambique would be the initial focus of this work, before expanding this to Ethiopia and Zambia.

Purpose:

5. To facilitate agreement and document current flexibilities of funding streams for HRH, specific priority actions on HRH in selected African countries (initially Mozambique followed by Ethiopia, Zambia) with PEPFAR, DFID, MISAU and other partners, building on existing work and within national frameworks for health reform.

Scope of Work for Mozambique visit

6. The consultant (s) will:
 - a. Review country HRH plans and key priorities
 - A draft HRH plan with financing options has been presented to the Ministry of Health on 20 March, which includes detailed costing work. The consultants should discuss the costed options with the HR working group and identify with development partners whether mobilisation of resources for the higher case scenario is realistic and identify any additional work that may be needed in order to make the HR plan a useful advocacy tool for mobilising additional funding for the health sector – both in terms of dialogue with Ministry of Finance and mobilisation of additional donor support.

- Current support for HRH by PEPFAR and DFID should be reviewed and specific recommendations made on how both organisations might increase the impact of their support on HR capacity building.
- b. Review DFID and PEPFAR country assistance plans & identify relevant areas of support,
- The consultants should make recommendations on how DFID sector and general budget support modalities and DFID's role as focal donor for health and HIV/AIDS might be used to complement PEPFAR financing, in order to maximise the impact of both funding modalities. The consultants should focus on the extent to which donor funding is provided 'on plan' and assess how predictable funding is from different donors and the impact of different funding patterns has on the government's ability to plan for timely implementation of plans.
- c. Review results of the initial PEPFAR-DFID HRH meeting in Addis Ababa and consider progress made in the following areas:

Documenting the extent of current PEPFAR support to health system strengthening: This will require use of information extracted from the PEPFAR Country Operation Plan (COP) and should cover the following areas :

- i) Identify programme elements which are directly contributing to government directed or managed programmes, such as financing of pre-service training and scholarships, and investments in curriculum development, identifying the level of investment where possible - the purpose is to quantify to extent to which PEPFAR funds are already being used for health system strengthening;
 - ii) Develop an overview of PEPFAR funding through Partner agencies (INGOs), identifying any existing policy guidelines from PEPFAR which are shaping NGO interaction with government services, but also highlighting any variations in the interpretation of these guidelines. The consultants should meet with Key partners, such as Columbia, and HAI and consider whether there are any key difference in the way these agencies work with and respond to government, identifying where possible best practice for joint working. The Health Minister has recently complained that provincial directors have insufficient information on the activities undertaken by NGOs, and recommendations on how to improve NGO reporting at the district and provincial level should be made. Therefore the consultants should identify the extent to which PEPFAR partners agencies work with central and provincial leadership and whether they report to them regularly.
 - iii) Identify challenges to the predictability of PEPFAR financing – documenting the timeframe between budget submission, budget approval and financial disbursement, and assessing the implications of any delays for joint planning with government. Identify whether clearer specifications of dates and milestones for this process could be used to give a more reliable indication of when funds will arrive, in order to facilitate planning on the basis of a realistic and predictable indication of key dates. This information should be contrasted with pooled funding partner commitments, also noting reasons for delays in pooled funding donor disbursements, and making recommendations for increasing the predictability through all funding channels.
- d. The consultants should hold discussions with the PROSAUDE focal donor (current DFID and outgoing EC) and chairs of key working groups – such as the financing working group and NGO working group – to identify how existing investments are captured and reflected in recording and reporting on health sector investment and health sector performance.

- e. Identify government planning process and mechanisms for ensuring that programme donor investments are 'on-plan'. Discussions should be help with MISAU and with partners to identify how programmes are currently developed in order to respond to nationally defined priorities – identifying strengths and weaknesses of the existing systems with both MISAU and with technical advisers placed within MISAU.
- f. Review the decision of MISAU to integrate Day Hospitals into Primary Health Care, and to discuss with both PEPFAR and other donor financed NGOs, whether and how this policy decision will impact on plans for supporting HIV/AIDS care at the PHC level. Identify in particular whether there an increased investment in general PHC strengthening will be a consequence of this policy decision, if possible identifying likely resource implications.
- g. Through dialogue with development partners, the main barrier to increasing the proportion of pooled financing to the health sector should be identified, giving a prioritised list of actions that would be necessary to give non pool donors greater confidence to channel funds through PROSAUDE.
- h. Present outputs to country governments, US, UK and other partners

Timeframe:

- 7. Interim Mozambique report to be completed by the first week of April 2008, Final report for 3 countries by end of May 2008

Output:

- 8. Interim report highlighting current investments and flexibilities for supporting HRH and key options for action and funding in Mozambique, including agreed country matrix outlining costed priorities. (Ethiopia and Zambia to follow depending on outcome)

Inputs:

- 9. Up to 30 days shared between two consultants with a background in health systems, targeted disease programming, and human resources for health, with strong facilitation skills and experience of working in Africa.

Annex 3 - Documents consulted / referenced materials.

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Dybul, M. (2007). Testimony before the House Committee on Foreign Affairs Washington, DC April 24, 2007 <http://www.pepfar.gov/press/83436.htm>

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MISAU (undated) Plano Nacional de Desenvolvimento dos Recursos Humanos Da Saude 2008-2015 Ministerio da Saude, Dreccao de Recursos Humanos

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- No author (undated) Summary of main results and recommendations of ACA VII to be included in the ACA AM. PowerPoint presentation, undated.
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- No author (undated) Matriz de Desempenho Saude. Excel spreadsheet.
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- Potter C., Brough R., (2004) Systematic Capacity Building: a hierarchy of needs. Health Policy and Planning 19(5)
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- White House (2008) US/UK Announcement on Health and Health Workers, Office of the Press Secretary April 17, 2008
- WHO (2005) Country Cooperation Strategy Mozambique 2004-2008, WHO Regional Office for Africa 2005

Annex 4 – Itinerary and persons met

DFID: Neil Squires (NS)
PEPFAR: Cate McKinney (CM)
Consultants: Barbara Stillwell (BS), Jim Campbell (JC)
Dates: 02 April – 13 April, 2008

Date	Time	Barbara Stilwell	Jim Campbell
Wed 2 nd	am	Travel from S.Africa	-
	pm	14.55. Arrive Maputo	-
Thur 3 rd	am	10.00-12.00. Meeting with NS and CM	-
	pm		-
Fri 4 th	pm	13.00– Dr. El Hadi Benzerroug, WR + Dr. Hilde de Graeve, Health Systems Officer, WHO	Travel from BCN
Sat 5 th	am		10.45. Arrive Maputo
	pm	13.00 Meeting BS/JC	
Sun 6 th	am/pm	Document review	
Mon 7 th	am	10.00 CM	
	pm	11.20 -13.00 Lucy Ramirez, Training Technical Advisor, CDC. 15.00 Marla Smith. Country Director, I-TECH 17.30 CM	
Tue 8 th	am		
	pm	13.30 NS	
		14.30 Sabine Rens (Clinton)	
		16.00 Chris Pupp, I-TECH	
		16.00 NS 17.30 CM	
Wed 9 th	am	08.00 Rui Vieira de Silva, Program Support Specialist, CDC 10.00 Kenny Sherr, Country Director, HAI	
	pm	14.00 Nadia van Camp (MSF) 16.00 Dirce Costa + Eleasara Antunes, Austral Cowi Consulting Eve: Polly Dunford, USAID + CM	
Thur 10 th	am	10.00 Melanie Luick-Martins, HIV Advisor, USAID (BS)	08.30 IHP+ TF meeting (JC)
		11.00 Dr. Gertrudes, MISAU	
	pm	15.30 Katie Bigmore, DFID	
Fri 11 th	am	09.00 Rui Vieira de Silva, Program Support Specialist, CDC 11.30-14.00 Debriefing CM, NS, PD, KB	
	pm		14.30– Dr. El Hadi Benzerroug + Dr. Hilde de Graeve (WHO)
Sat 12 th	am/pm	16.00 Edgar Necochea & Deborah Bossemeyer (JHPIEGO)	
	pm		19.50 Depart Maputo
Sun 13 th	am	Depart Maputo	

Annex 5 - Extracts from ODAMOZ

Table 1. Projects by Donor / UN Agency by Year (in US \$)

1725 current projects								
Donor	2005	2006	2007	2008	2009	2010	2011	Total
ADB	168.058.209	125.765.509	79.519.403	74.509.272	208.002.985	112.582.090	0	768.437.467
AUSTRIA	3.993.806	6.975.931	3.110.247	6.686.679	3.474.830	3.153.160	0	27.394.653
BELGIUM	11.277.916	14.893.246	16.160.729	12.866.059	10.907.847	6.092.857	0	72.198.653
CANADA	38.100.514	43.538.299	42.345.983	64.526.524	54.436.223	55.040.450	47.575.258	345.563.250
DENMARK	45.469.339	44.266.356	65.886.172	36.122.813	68.783.069	69.664.903	69.664.903	399.857.554
EC	186.313.091	170.697.813	197.391.906	213.841.236	243.750.699	0	0	1.011.994.744
FINLAND	25.937.587	28.173.683	27.917.447	40.157.143	42.642.857	11.714.286	0	176.543.003
FRANCE	18.855.399	19.952.314	19.772.899	23.442.799	24.732.287	15.148.461	4.366.353	126.270.511
GERMANY	28.735.034	44.284.160	56.042.314	19.300.000	89.877.143	40.528.990	15.714.286	294.481.927
IRELAND	26.474.160	26.679.693	60.560.081	66.500.000	75.857.143	84.607.143	84.607.143	425.285.363
ITALY	26.378.347	34.274.221	42.399.211	38.344.291	41.822.304	29.540.554	28.466.270	241.225.200
JAPAN	406.204	13.742.935	24.111.259	16.527.306	38.065.968	4.878.793	1.050.518	98.782.983
NETHERLANDS	56.725.643	66.809.387	84.242.576	110.483.060	113.107.143	102.048.680	91.465.714	624.882.203
NORWAY	46.205.920	33.207.790	25.491.562	32.491.719	55.187.597	74.098.843	62.809.917	329.493.348
PORTUGAL	25.916.560	24.695.199	15.770.811	314.286	1.750.000	0	0	68.446.856
SPAIN	22.008.321	26.217.349	32.922.486	19.029.741	29.622.393	19.609.754	14.628.571	164.038.616
SWEDEN	78.971.158	95.688.006	97.949.051	124.435.265	127.204.602	122.810.333	22.571.429	669.629.845
SWITZERLAND	21.882.352	21.175.965	16.915.922	2.039.683	17.952.625	10.285.029	6.626.984	96.878.559
UK	74.786.941	99.802.106	112.155.039	107.385.029	124.480.392	129.137.255	127.137.255	774.884.018
USA	58.348.343	79.337.636	103.400.140	0	0	0	0	241.086.119
WORLDBANK	240.820.000	222.685.000	236.316.821	92.996.000	232.850.000	232.560.000	169.930.000	1.428.157.821
GRAND TOTAL	1.205.664.844	1.242.862.597	1.360.382.059	1.101.998.902	1.604.508.106	1.123.501.581	746.614.602	8.385.532.692
UN Agency	2005	2006	2007	2008	2009	2010	2011	Total
FAO	4.388.713	8.340.096	9.260.050	3.106.737	991.728	0	0	26.087.324
UNDP	4.887.919	6.327.496	10.737.934	2.662.328	1.470.000	0	0	26.085.677
UNESCO	0	333.431	3.028.147	2.792.098	1.025.739	0	0	7.179.415
UNFPA	0	0	18.535.922	0	0	0	0	18.535.922
UNHABITAT	442.992	161.581	0	0	0	0	0	604.573
UNHCR	0	0	450.750	0	0	0	0	450.750
UNICEF	7.466.660	8.110.257	25.946.393	27.808.000	27.995.000	250.000	0	97.576.310
UNIDO	101.212	1.874.700	1.283.000	1.528.447	600.000	600.000	0	5.987.359
WFP	27.248.000	28.784.000	32.462.640	0	13.029.000	0	0	101.523.640
WHO	0	2.283.509	7.198.493	4.433.500	4.433.500	0	0	18.349.002
GRAND TOTAL	44.535.496	56.215.070	108.903.329	42.331.110	49.544.967	850.000	0	302.379.972

Source: http://www.odamoz.org.mz/reports/annual_totals.asp

Table 2: USAID activities in 2007. (Sector: 12000 HEALTH)

Project Title	HIV/AIDS Program				
Donor Project Number	656-0090				
Donor	USA				
Project Description	The objective of the HIV/AIDS program is HIV transmission reduced and impact of the AIDS epidemic mitigated. This will be accomplished through a strategy that includes prevention, treatment, care, and support and that builds upon existing community, government, and civil society activities.				
Duration	11/9/2003 - 30/9/2010				
Project Status	Ongoing				
Funding Type	Grant Off Budget (for 2007)				
Total Amount	US \$ 100.130.000				
Total Disbursed	US \$ 100.730.000				
Total Disbursed until end of 2004	US \$ 6.781.000				
Undisbursed	US \$ -600.000				
Disbursements to Date (Year)	Quarter 1 2005	Quarter 2 2005	Quarter 3 2005	Quarter 4 2005	Total 2005
	4.785.250	4.785.250	4.785.250	4.785.250	19.141.000
	Quarter 1 2006	Quarter 2 2006	Quarter 3 2006	Quarter 4 2006	Total 2006
	6.622.250	6.622.250	6.622.250	6.622.250	26.489.000
	Quarter 1 2007	Quarter 2 2007	Quarter 3 2007	Quarter 4 2007	Total 2007
	12.079.750	12.079.750	12.079.750	12.079.750	48.319.000
USA Contact	Linda Lou Kelley Telephone: +258 21 352068, Email:				
DAC Codes and Sector	12250 Infectious disease control				
Government Counterpart	0 Unknown				
Implementing Organisation	<p>Name: CARE Mozambique Coordinator Name: Coordinator Phone: Coordinator Email: carem@care.org.mz</p> <hr/> <p>Name: Confederação das Associações Económicas de Moçambique (CTA) Coordinator Name: Coordinator Phone: Coordinator Email: www.cta.mz</p> <hr/> <p>Name: Elizabeth Glaser Pediatric AIDS Foundation Coordinator Name: Coordinator Phone: Coordinator Email:</p> <hr/> <p>Name: Family Health International Coordinator Name: Coordinator Phone: Coordinator Email: www.fhi.org</p> <hr/> <p>Name: Foundation for Community Development Mozambique (FDC) Coordinator Name: Coordinator Phone: Coordinator Email: www.fdc.org.mz</p> <hr/> <p>Name: Health Alliance International Coordinator Name: Coordinator Phone:</p>				

	<p>Coordinator Email: high.chimoio@teledata.com</p> <hr/> <p>Name: Hope for African Children Initiative Coordinator Name: Coordinator Phone: Coordinator Email: mfripzler@savechildren.org</p> <hr/> <p>Name: John Snow Inc. Coordinator Name: Coordinator Phone: Coordinator Email: adpp.sede.@adpp.co.mz</p> <hr/> <p>Name: Population Services International (PSI) Coordinator Name: Coordinator Phone: Coordinator Email: www.psi.org</p> <hr/> <p>Name: Project Hope Coordinator Name: Coordinator Phone: Coordinator Email: projhope@tvcabo.co.mz</p> <hr/> <p>Name: Save the Children Coordinator Name: Coordinator Phone: Coordinator Email: mozfo@savechildren.org</p> <hr/> <p>Name: World Relief International Coordinator Name: Coordinator Phone: Coordinator Email: www.wr.org</p> <hr/> <p>Name: World Vision Mozambique (WV) Coordinator Name: Coordinator Phone: Coordinator Email: www.wvi.org</p>
Location	National
MDG's	<p>Goal 4: Reduce child mortality Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate Goal 5: Improve maternal health Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio Goal 6: Combat HIV/AIDS, malaria and other diseases Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS</p>
Comments	<p>This program is part of the unified U.S. Government assistance provided to Mozambique under the President's emergency Plan for AIDS Relief (PEPFAR or 'Emergency Plan'). Activities funded under the Emergency Plan are developed and implemented within the priorities of the Health Sector's National Strategic Plan to Combat HIV/AIDS/STI and the Mozambique National Strategic Plan to Combat HIV/AIDS.</p> <p>U.S. Government agencies involved in the Emergency Plan in Mozambique include: USAID, U.S. Centers for Disease Control and Prevention, U.S. Department of State, U.S. Department of Defense, and Peace Corps.</p>
Last Update	15/11/2007

Source: http://www.odamoz.org.mz/reports/rpt_desc.asp?pn=1024

Table 3: UK activities in 2007. (Sector: 12000 HEALTH)

Project Title	Health Sector Support Programme				
Donor Project Number	044 -054-001				
Mozambique Budget Project Number	tbd - CF Prosaude				
Donor	UK				
Project Description	To support successful implementation of the government of Mozambique's health sector strategy (PESS) within the context of second PRS				
Duration	1/4/2007 - 30/12/2011				
Project Status	Ongoing				
Funding Type	Grant On Budget (for 2007) FC Prosaude				
Total Amount	GBP 25.500.000				
Total Disbursed	GBP 7.400.000				
Total Disbursed until end of 2004	GBP 0				
Undisbursed	GBP 18.100.000				
Disbursements to Date (Year)	Quarter 1 2007	Quarter 2 2007	Quarter 3 2007	Quarter 4 2007	Total 2007
	0	0	3.700.000	0	3.700.000
	Quarter 1 2008	Quarter 2 2008	Quarter 3 2008	Quarter 4 2008	Total 2008
	3.700.000	0	0	0	3.700.000
Disbursements Forecast	Total 2009	6.700.000			
	Total 2010	6.700.000			
	Total 2011	5.300.000			
UK Contact	Katie Bigmore Telephone: +258 21351400, Email:				
DAC Codes and Sector	12100 Health, general				
Government Counterpart	580100000 Ministério da Saúde				
Implementing Organisation	Name: MISAU - Mozambican Health Ministry Coordinator Name: Coordinator Phone: Coordinator Email:				
Location	National				
MDG's	Goal 4: Reduce child mortality Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate Goal 5: Improve maternal health Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio Goal 6: Combat HIV/AIDS, malaria and other diseases Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS Goal 8: Develop a Global Partnership for Development Target 17: In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries				
Last Update	13/2/2008				

Source: http://www.odamoz.org.mz/reports/rpt_desc.asp?pn=492905

Annex 6 – Presentation to partners, 11 April, Maputo

Mozambique: Taking forward Action on Human Resources for Health (HRH) with DFID/OGAC and other partners

Initial feedback and discussion

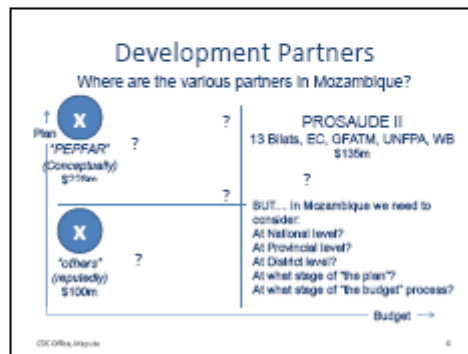
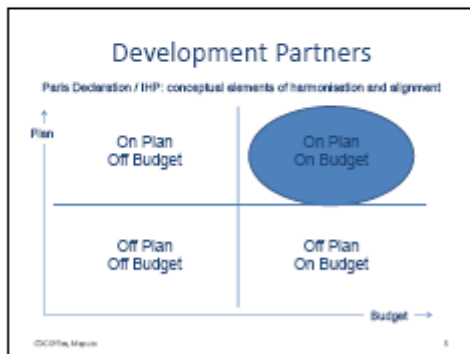
Barbara Stilwell and Jim Campbell
11th April, 2008
CDC Offices, Maputo

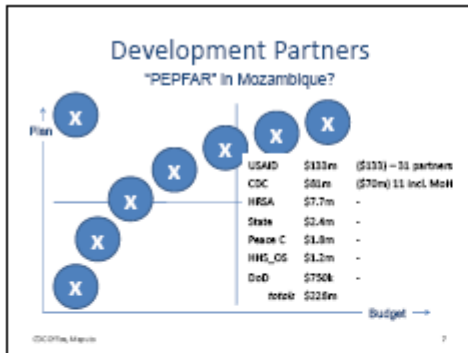


HRH Plan

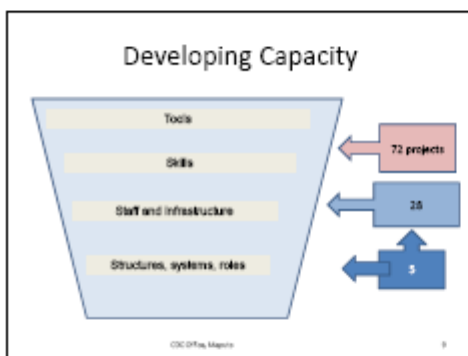
- ❖ National framework is needed to support workforce development – task shifting, new cadres, changing roles
- ❖ Objectives or strategies?
- ❖ Data driven decision making - or data free zone?
- ❖ Construct around all the elements of a capacity development framework

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- ### Some examples
- CDC – MISAU: \$3.95m (\$3.75m + \$200k)
 - On plan: agreed with MoH, meets their needs
 - Addresses HRH strengthening (curriculum, training, staff salaries, job descriptions) M&E, procurement.
 - On budget: managed by MISAU (*how well?*)
 - PEPFAR – ‘Capacity support’
 - By ‘emphasis areas’ - \$89m of overall funding has sub-activities directly related to HSS. % - ??
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- ### Opportunities for consideration
- (*context*)
- Changing environment/focus– not static
 - Shared recognition / realisation on HRH
 - PEPFAR II - guidance imminent
 - CDC / USAID
 - increasing capacity; proven flexibility
 - One focal donor for 1) Health & 2) HIV/AIDS
 - A ‘window of opportunity’ exists
 - (in Mozambique; between USA/UK and; globally)
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- ### Opportunities for consideration
- (*for discussion*)
- Knowledge Management
 - evidence; best practice
 - Information Management (partners/govt)
 - communication; exchange; guidance; ‘mapping’
 - Cycles / calendars / management
 - H&A (OP/OB, IHP, MTEF, GFR8); \$ projections
 - Management Information
 - Mobilising more resources for scaling-up
 - Efficiency of existing \$; new \$
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- ### Opportunities for consideration
- (*for discussion*)
- What next?
- What will the matrix of priority actions include?
 - MISAU
 - ‘PEPFAR’ + implementing partners
 - DFID + DPs
 - Wider constituents
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Annex 7 – MISAU calendar for public financial management and planning

January	<p>Close of the financial year for year n-1</p> <p>Disbursement of the CPs' first tranche for year n to the PROSAUDE accounts</p> <p>Joint Annual Sector Evaluation (ACA), including key Health indicators</p> <p>Start of annual audit process:</p> <ul style="list-style-type: none"> - External Audit on the PROSAUDE funds, the OE and other external funds managed at central level in year n-1
February	<p>Joint Annual Sector Evaluation (ACA), including key Health indicators</p> <p>Audit reports of MISAU of the TA will be send by MF to the CPs</p> <p>Audits in process:</p> <ul style="list-style-type: none"> - External Audit on the PROSAUDE funds, the OE and other external funds managed at central level in year n-1 - Provincial-level audits for year n-1 undertaken by the General Finance Inspectorate (IGF)
March	<p>Joint Annual Sector Evaluation (ACA), including key Health indicators & Joint Review/ PAF</p> <p>Audits in process:</p> <ul style="list-style-type: none"> - External Audit on the PROSAUDE funds, the OE and other external funds managed at central level in year n-1 - Provincial-level audits for year n-1 undertaken by the General Finance Inspectorate (IGF) <p>First Sectoral Co-ordination Committee (CCS) Meeting</p> <ol style="list-style-type: none"> 1. Presentation of the Final Annual Implementation Report of the Sector PES for year n-1 (Balanço do PES Sectorial) 2. Presentation of the Joint Health Sector Performance Assessment Report (ACA-report) for year n-1 <p>National Health Sector Coordinating Committee (without participation of the partners)</p> <p>Sending of MTEF to MPD regarding year n, n+1 e n+2</p>
April	<p>Aide Memoir of the Joint Review</p> <p>Aide Memoir of the CCS</p> <p>1st Quarter Progress Report of the Implementation of the Sector PES for year n (Balanço do PES Sectorial- 3 months)</p> <p>Audits in process:</p> <ul style="list-style-type: none"> - External Audit on the PROSAUDE funds, the OE and other external funds managed at central level in year n-1 - Provincial-level audits for year n-1 undertaken by the General Finance Inspectorate (IGF)
May	<p>Indicative commitments on the part of the CPs (Common Fund and Vertical funds) for year n+1</p> <p>Actualization of the operational planning process of MISAU, including presentation of sector priorities for the Sector PES of year n+1</p> <p>Audits in process:</p> <ul style="list-style-type: none"> - External Audit on the PROSAUDE funds, the OE and other external funds managed

	<p>at central level in year n-1</p> <ul style="list-style-type: none"> - Provincial-level audits for year n-1 undertaken by the General Finance Inspectorate (IGF)
June	<p>Preparation of the annual Economic and Social Plan (PES) of the Sector for year n+1, including the matrices for the Cost Centres, pharmaceutical sub-sector, provincial level and vertical funds</p> <p>Presentation of Summary of Statistic Information</p> <p>Draft audit report for year n-1</p>
July	<p>Second Sector Co-ordination Committee (CCS) Meeting:</p> <ol style="list-style-type: none"> 1. Endorsement by the CPs of the final proposal for the Sector PES for year n+1, including operational matrices and a treasury plan, as well as the Health Sector PAF, including the targets to be reached. 2. Presentation of the final external audit report for year n-1 of PROSAUDE, OE and other external funds at all levels (central, provincial, including the pharmaceutical sub-sector). 3. Presentation of the provincial audits for year n-1, undertaken by the IGF <p>Confirmation of commitments of the partners for year n+1</p> <p>2nd Quarter Progress Report of the Implementation of the Sector PES for year n (Balanço do PES Sectoral- 6 months).</p> <p>Possible disbursement of the second tranche from the CPs to the PROSAUDE accounts</p> <p>Preparation of the state budget proposal for year n+1 and the information required by the MPD (by the end of July)</p>
August	Mid-year Review & revision of PAF-indicators and targets for year n+1
September	<p>Mid-year Review & revision of PAF-indicators and targets for year n+1</p> <p>Submission of the state budget to the Council of Ministers (around September 15)</p> <p>Budget Proposal submitted to Parliament by the Council of Ministers (by September 30)</p>
October	<p>Joint Enlarged Co-ordination Committee (CCC-Alargado):</p> <ol style="list-style-type: none"> 1. 3rd Quarter Progress Report of the implementation of the Sector PES for year n (Balanço do PES Sectoral- 9 months) 2. Approval of the ToR for the Annual Joint Evaluation (ACA) of year n 3. Change of focal donor team
November	<p>Joint Enlarged Co-ordination Committee (CCC-Alargado):</p> <ol style="list-style-type: none"> 1. Endorsement of the Final Treasury Plan 2. Confirmation of the Disbursement Plan <p>Start of elaboration of MTEF for year n+1, n+2 e n+3.</p>
December	