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FINAL REPORT, Q4 2018

NO COST EXTENSION OF MOZ150321T "*FOCUSED CONTRIBUTION TO HEALTH SYSTEMS STRENGTHENING*" – PHASE II

MOZAMBIQUE

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This report covers the activities under the No-Cost-Extension, *until November the 2018.*

Note that project's reporting timing is aligned with the project's time-frame, although the implementation of activities usually follows the fiscal year.

Acronyms

ACA –Joint Annual Evaluation

AWP – Annual Work-Plan

BER – Budget Execution Report (also REO - "*Relatório de Execução Orçamental*")

DAC – Department of Support and Control [a department of DAF]

DAF – National Directorate of Finance and Administration

DPC – National Directorate of Planning and Cooperation

DRH – National Directorate of Human Resources

ERDAP

FR – Fiduciary Risk

GTAF – Technical Working Group on Audit and Finance

G-19/PAPs – The group of donors providing General Budget Support (GBS), or Programme-Aid Partnership,

HPCF – Health Partners Cooperation Framework

HPG – Health Partners Group

IFE – Survey of External Funds

IGS – Inspector General of Health

MISAU – Ministry of Health ("*the Ministry*")

MoU – Memorandum of Understanding

NAI – National Auditing Institution ("*Tribunal Administrativo*", or TA - NAI is used to avoid confusion with TA as "Technical Assistant").

ODA – Official Development Assistance

ODAMOZ – Online Database of External Support to Mozambique (odamoz.org.mz)

PIPED

PFM – Public Finance Management

PROSAUDE – Pooled-Fund in the Health Sector

PS – Permanent Secretary

REO – “*Relatório de Execução Orçamental*” (also BER - Budget Execution Report)

SDSMAS – Serviços Districtal de Saúde, Mulheres e Acção Social – District Service for Health Women and Social Action.

SISTAFE – SISTema de Administração Financeira do Estado.

e-SISTAFE – The Integrated Financial Management Information System.

TA – Technical Assistance/Assistant (“*the Function*”)

1. Introductory Note

The country's socio-economic situation has remained tough over the past year, in continuity with the outlook presented in the progress report. At first, this has profoundly changed the country's context, over the past two years.

The persisting effects of negative externalities and the consequences of bad public governance have soaked into any aspect of society, public sector, businesses, and people's behaviours. If in project's Y1 this had impacts only on specific sectorial areas - its fiscal envelope and fiduciary risk perception - in Y2 it clearly transmitted to the Health National System (HNS), reducing its capacity to provide health services to the Mozambican population. In project Y2, negative externalities have clearly yielded some relief; while the consequences of bad public governance have possibly further complicated the existing scenario.

Project-wise, it became clear that in times of difficulties, the mid/long-term strengthening and reform processes give ways to a short-term *survival instinct*. When donors' confidence on country systems diminishes, when payment of salary is under threat, when huge debts with suppliers do jeopardize the provision of medicines, stakeholders will quickly adopt a *"get it fixed soon"* behaviour, until confidence is restored.

I believe that quite rightly, a lot of attention must be maintained to restoring confidence at country-level. Because this creates the bases for any support to the public sector to remain effective; thus, this is essential to make the project work as expected.

Negative externalities –

A. While the country was hit by severe **droughts** in 2016 as a consequence of the *el Niño* meteorological phenomenon, the outlook for 2017 has improved: FAO reported that *food insecurity peaked in early 2017[1]; and food security conditions are expected to improve in 2017/18, on account of the larger agricultural output (…).* WFP confirms that towards mid-2017 the *situation improves,* as [WFP] *focuses on pro-resilience activities[2]*.

B. The passing of **cyclone Dineo** in February 2017 has severely affected infrastructure and private dwellings, including hospitals and schools, in central-southern regions; although no fatalities were reported. Investments' funds were diverted from any sector pf public engagement, to care for the reconstruction phase.

C. **Commodity prices** for the extractive industries have improved: *the increase in coal prices* – and the Nacala logistics corridor became fully operational by early 2017- have *boosted exported volumes of coal[3]*.

As the World Bank reported, *strengthening prices for coal, aluminium and gas, a post el Niño recovery in agriculture, and progress in the peace talks, could steer growth to 4.6 percent in 2017, and towards 7 percent by the end of the decade[4]*.

Politics and governmental actions –

D. While in 2016 the **political situation** remained tense, despite on-going negotiations, towards the end of the year RENAMO's leader Afonso Dhlakama unexpectedly declared a ceasefire, that was later extended indefinitely (May 2017). After 4 years of sporadic although escalating violence, the

[1] FAO Mozambique, GIEWS Country Brief, 30-06-2017

[2] WFP Mozambique. Country brief, June 2017

[3] WB Mozambique Mozambique Economic Update, July 2017

[4] WB Mozambique, Mozambique Economic Update, July 2017

impression is that the situation is returning to normality. This is true for the movements of people, including displaced returning home; economic and agricultural activities; transportation. Quite importantly, parties have both given signals or renewed intentions to scale down the military operations, with the Mozambican army allegedly moving out from some of the positions it kept over the past years. The reason behind the decision to declare the ceasefire has remained unknown.

E. [from progress report: In February 2016, after a lasting pressure on officials, the government disclosed more than 2 billion dollars of **debts**, contracted by Mozambican public-private companies to finance economic investments; which were guaranteed by the State. All the elements of this story had been cautiously hidden to citizens and stake-holders: the existence, and the "missions", of the 3 private-public companies involved; the business plans that justified the contraction of such a huge debt, the state-issued guarantees, the purpose of the funds raised. Finance Minister Adriano Maleiane revealed on 25th of October 2016 that: "*Mozambique's debt levels are officially unsustainable, inflation is at 25% and rising, and the metical has fallen 70% against the US dollar in 2016 alone*".]

The main update on point E. is that in 2017, the Office of the National Prosecutor agreed to the implementation of an independent external audit, which was funded by the Embassy of Sweden in Mozambique, and performed by the private firm Kroll. Since the completion of the audit, the Office published Kroll's executive summary, which basically confirms most of the anticipations, and important facts-finding, notably: lack of cooperation from senior government officers; some $0.5m of untraceable funds; almost 100% of funds never entered the country. The group of Budget Support donors concluded that *the auditors were denied full cooperation from all institutions (national and international)*[5]. The publication of the final report is pending.

Overall, there is a sense of impotence and some resignation within the Mozambican society. While the details have been slowly revealed, it became clear that the whole operation was designed to benefit a group of powerful people linked to the politics and the military, with little advantages – and a lot of costs – for the society. The General Assembly, with the vote of the ruling party, approved the integration of the guaranteed debts into the Final State Accounts 2015, making them accounting as official public debt. Several press agencies and civil society organizations - including religious – did position themselves against the decision. Other parties and prominent public figures have called for bringing people involved to judgement. So far, the party and the government could avoid that.

The fiduciary risk associated to development cooperation has been perceived as dramatically increased. Budget support donors, the World Bank and many other donors have all conveyed recently that Kroll's executive summary was insufficient to allow a resumption of direct funding to the government. An IMF mission in the country was concluded with no steps forward in resuming the programme with Mozambique[6]. The dialogue will continue.

The effects of that on the sector have been increasingly tangible: from a fiscal point of view, the sector has seen its allocations decreasing, in real terms, when compared to previous years. However, not even allocations have been guaranteed, given the severe tightening on liquidity. At local level, departments have contracted huge debts just to make the services working: purchase of medicines, gasoline, of just food for patients. If this has been on-going for at least the past twelve months, it is evident that it can't last for long.

E. **Corruption** has been on the rise, which was to expect when money does not flow smoothly through the official channels. In its report 2016, Transparency International (TI) reports that *Mozambique presents a textbook case of a country whose legal and institutional framework has been brought into line with international good practice, but whose good governance window dressing is unable to compensate for blatant abuses of power*[7] (position in the TI index: 142/170).

E. Overall, the events that so far have brought a story of evil macro-economic management, are all in

[5] Internal report of G-14 Budget Support donors, July 2017 – quoted by Mozambique 380 (News Reports & Clippings) – 31 July 2017

[6] Transcript of IMF Press Briefing, 20 July 2017

[7] Transparency International, Country Profile Mozambique 2016

place to return one of high-level **impunity**.

No Cost Extension –

GTAF phase II – MOZ150321T ended with a balance of EUR 59,604.25. The savings were due to the under execution of the expenditure for salaries. Considering the savings of the project, Enabel asked the Government of Flanders for a *no-cost-extension* which was granted with a letter ref. BUZA – 2017 – 00953 dated 18th of December 2017

Enabel proposed to use the funds granted in line with the overall objectives[8] of both phase II and phase III. In particular, it was suggested to use the funds to finance activities that would have improved financial management and resources control in the framework of the decentralisation process.

MISAU-DAF's set of activities linked to the Reform Agenda, aimed at enhancing the *Comprehensiveness and Transparency of the Sector Budget* through devolving the functions of financial administrations to 33 units at central and at decentralised level (SDSMAS Rural and District Hospitals) 9.

Enabel approached MISAU-DAF and proposed to finance the decentralisation of functions for some institutions. MISAU and Enabel chose to finance the training of personnel deployed in *four* health institutions in Tete[10]. In addition, resources were also allocated for the installation of the terminals of e-SISTAFE in the newly decentralised National Directorate for Farmacy (DNF), and in *three* district health institutions in the province of Tete[11].The Final Report of GTAF II has taken these activities into account in paragraph 2.3.1.2 .

The Report is doing some suggestion about how to link the phase 2 and 3.

[8] The project "focused contribution to health system strengthening in Mozambique".

[9] These activities were supposed to be financed with external funds, yet they remained unfunded. The Global Fund was initially suggesting to use the funds devoted to the Health System Strengthening for expanding the e-SISTAFE to more district services for health. Those resources were afterward devoted to other activities.

[10] SDSMAS Mutarara, Angonia and Cahora Bassa and Rural Hospital in Songo.

[11] SDSMAS Mutarara, Angonia and Cahora Bassa.

2. Capitalisation and Key-Findings

*This chapter will focus on **health financial management aspects**, in line with the project's specific objective of "*contributing to the improvement of the Public Financial Management of the Ministry of Health, especially of the Common Fund PROSAUDE*". In this regard, the most comprehensive overview is given in* 2.3 "Evolution in Sector PFM Aspects". *The other chapters are complementary to this.*

At the beginning of each chapter, I present a table summarizing the main conclusions from the progress report (phase II year 1), and final report (phase II year 2)

2.1. Evolution in Policy and Planning

Progress report	Final report
There were no relevant developments - and few clear shortfalls - in sector's policy and planning.	There were **no relevant developments** in Y2. However, some important processes have started, and reached a phase that would indicate progresses over the medium term

The **Health Sector Reform Unit (URESS)** has moved on swiftly with its chronogram. The extent to which it could foster improvements in the mid/long-term will depend on the Ministry's openness to **operationalize and sustain change**. There were good progresses made by the Unit, notably:

- Approval of URESS Working Group ToR;
- Regular WG meetings, an internal Ministerial workshop and a workshop with partners;
- Agreement on a conceptual frame-work, identification of specific objectives macro-activities;
- Problem analysis under efficiency and quality criteria, through the system blocks that contribute to service delivery; alignment with health PES, the implementation plan of the decentralization strategy (PIPED); and the plan for reform of the public sector(ERDAP);
- Selection of activities, elaboration of a Matrix of Reform Activities 2017, with a Work-Plan 2017;
- (on-going) Definition of the profiles of experts, and elaboration of a three-year Reform Plan.

A **new Ministry's organic structure** was approved with Resolution 4/2017. The Ministry is now working, under the coordination of its legal department, to pass an internal regulation. This is going to introduce remarkable changes to the current Ministry's organogram, although nothing more is known yet. One thing that possibly could be anticipated, in light of **Decree 12/2015**, the budgeting unit that is currently under DPC will most likely be passed to DAF.

The **planning exercise 2018** started regularly, in continuity with previous planning exercises. In February, a sector's Mid-Term Expenditure Framework (MTEF/**CFDMP 2018/20**) was completed, and timely submitted to the Ministry of Economics and Finance (MEF). The actual role of the global MEF's MTEF/CFMP in providing an outlook of the fiscal envelope three-years upfront has already been challenged[12]. That does not differ from its sectors' components: the health CDFMP remains an internal exercise, which has not been regularly shared and challenged with external parties; and which do not represent a strong instrument to project the sector's fiscal envelope over the mid-term period.

The central level organized **provincial visits** to guarantee alignment - between government objectives and sector plans – which were duly implemented. In June 2017, the Ministry organized its **XII National Planning and Finance Meeting** (RNPF), where all the main sector's institutions at

[12] See IMF Fiscal Affair Department, PFM Monitoring Missions, 2012-2015

central and provincial levels gather in the capital city, under the leadership of the Permanent Secretary, to develop the Health Socio-Economic Plan (Health PES) 2018.

The meeting, if innovative on some points of view, was a cumbersome exercise when central level was pushing for more alignment with government priorities; while provinces where claiming they have no funds to run the hospitals and they had to contract debts. It emerged as well that attribution of function, and responsibility of funding, is still controversial between central and provincial levels. The impression is that budget units are requested to run their activities on increasingly tightening budgets

As part of the health CFDMP 2018/20 process, I supported the Ministry's Directorate of Planning and Cooperation (DPC) to collect, control and organize the information on the externally-financed initiatives ("the external component"). The exercise, based on Ministry's Database of External Funds (**IFE**) was quite successful, gathering information that would not be collected elsewhere. Restitution meetings were organized for the officers of the Department of Health Economics (DPC/DPES) and for Health Partners' Group (HPG); and tables were extrapolated for different purposes. However, DPES has not develop capacities to run such an exercise independently, for which it would rely on external/TA support to be performed.

Budget ceilings for 2018 were presented in May 2017, for central institutions and for provinces. They do not differ substantially from the previous year, obviously with some reshuffle, and an inflated external component – particularly support to the purchase of medicines – because of the depreciation of the rate exchange. In light of the high inflation that the country has experienced over the past two years, it could be said that the sector's budget in real terms is clearly going to reduce significantly.

DPC continues to be responsible for the design of programmes activities, in *harmonization* with government plans, and attending sector's priorities; while budget allocations, disconnectedly, are attributed to health institutions from the MEF. There were no improvements in the **alignment between the health Socio-Economic Plan (health PES) and the budget**. However, a team of TA's under a USAID-funded project has been recently deployed, to articulate between DPC and DAF on that[13]. The weak articulation between different classifiers used by different institutions persisted - eg the institutional/administrative used by the finances, and the programme classifier used by the sector.

DPC can elaborate and supervise the central level health PES, but has no capacity to aggregate provincial PES and budget under a single frame-work. While DPC does not seem itself as responsible for supervision and coordination of the activities in the whole sector, I argue this role is crucial, and is currently vacant. That is why in January 2017, TA-to-GTAF responded positively to a solicitation from DPC to organize an exercise to elaborate the **health national programmes with budgets**: a matrix showing health programmes, levels/provinces and their budgets. The results of the exercise were remarkable, considering the limited time and resources; however, they were neither adopted nor promoted by DPC.

Good estimations of future funding, including areas of concentration of development partners do remain largely weak. A way out of that could be resuming the work on the **Health Financing Strategy** (HFS), towards its swift completion. So far, DPC has lead the process to elaborate the HFS for the past three years, which stopped at a phase where all the options were clearly presented; though no decisions were taken. This process **did not move any step forward in the past year**, pending urgent and delicate political decisions on the options presented. A potential change factor is the appointment at the World Bank in Mozambique of a Senior Health Economist, tasked specifically to bring the HFS to completion, who has recently made positive moves in this direction[14]. The project should ensure all possible support and follow-up to this effort.

The debt-crisis has spread the perception of **weakened "country-systems"**, for not been able to raise any flag, when the murky operations were made. The fiduciary risk was perceived as rapidly

[13] The project is known as HP+ and implemented by the US-based NGO Thinkwell

[14] This includes: a direct involvement of DPC Director in the HFS road-map; the organization of a three-days event with seminars on HFS subjects, bringing international experts to the country; the appointment of an Health Economist tasked with the HFS at MEF.

deteriorated, and donors required analyses and opinions on the status of the systems. In such a context, donors have temporarily suspended their alignment to country-systems (eg channelling to the Treasury), or called for the introduction of additional mitigating measures[15].

As a consequence, the **integration of externally-funded initiatives** in the health sector planning and budgeting has rapidly worsened. The share of external funds captured and visible in the state budget has decreased. The entire planning process became a bit hectic, and an ad-hoc basis. The usual tools used to capture external funds in planning and reporting – **ODAMOZ** at governmental level, plus **IFE** (Survey of External Funds) specifically for the sector - have been almost abandoned in 2016; despite huge efforts to put together some useable outputs from the latter.

The Mozambican planning methodology, and the one adopted by the Ministry of health, have finally demonstrated all its limits, to provide reliable outputs in a changing environment. The recent RNPF has been the occasion to verify Ministry's and partners' agreement on the need to substantially **revise the sector planning process**. As part of that, a consultancy has just started its work to revise the format of the Health Activities Report (*Balanço do PES*). A diagnostic of the current planning system is also expected to start. Although not yet clearly articulated, this is an initiative that the TA-to-GTAF must follow closely.

2.2. Evolution in M&E

Progress report	Final report
There were only minor and dispersed improvements in the sector M&E.	Overall, the appreciation does not change from the previous year. There is some M&E, although not comprehensive, accurate, transparent and easy-to-manage as should be. DAF's efforts are remarkable, though not entirely integrated in the sector's M&E.

Sector M&E is the ultimate responsibility of the Ministry's Directorate of Planning and Cooperation (DPC), Department of Monitoring and Evaluation. But for the sake of this project, the Directorate of Administration and Finance's (DAF) M&E is also considered.

DPC, DAF and the Ministry **have done their regular monitoring and evaluation** through the usual country reporting system, notably:

- A sector Balance of the Socio-Economic Plan **(health BdPES)** has been released every semester;
- The **ACA report, under a simplified methodology,** was issued in April 2017;
- Sector Budget Execution Report (**Health BER/REO**) were always issued on time (within 45 from the end of the period), in quarterly reports; and distributed to internal and external stake-holders. In Q1 2017, GTAF successfully completed the revision of the current format of the health REO, which is now more user-friendly for public sector health managers.
- Since Q3 2016, DAF has started issuing monthly Budget Execution Report for the central level (**Health BER/REO central**), with the purpose to allow a more regular control on budget execution.

The main **monitoring framework** remains that of the Strategic document (PESS 2014-19), with a matrix of indicators. However, there has not been any evaluation on this matrix since the approval of the strategy. A **mid-term evaluation of the Health Sector's Strategy (PESS 2014-19)** was expected to be performed in 2016, but did not happen, and has slightly moved out of the agenda.

[15] For the sake of completeness, the tendency of donors not to rely on country-systems for channelling external support had started before the debt crisis. The current situation has accelerated an existing trend.

The main monitoring and evaluation exercise, based on a fixed set of indicators, remain the **Annual Joint Evaluation (ACA)**. The XVI' ACA happened between February and April 2017, with a simplified methodology, considering that the ACA methodology is currently under revision. The ACA final report says that *the performance of the health sector in 2016, in the perspective of the Performance Assessment Framework (PAF/QAD) was positive, considering that* ***67.9% of the targets were met***[16]. Both indicators for the PFM/areas of support were met.

Since 2012, partners have demonstrated increased interest to implement **PFM strengthening plans** in the health sector. This has been regularly done with different instruments, developed and monitored over the period, monitored autonomously by each directorate, under the coordination of DPC. In June 2016, the latest of them, an Accelerated Plan of Institutional Reforms (**PARI**), which covered eighteen months, was finally evaluated. Quite interestingly, its legacy was taken forward by the Reform Unit (URESS), which incorporated the recommendations from its evaluation into its reform plan. I expect the **broad and systemic PFM issues** – such as decentralization, strengthening internal audit - will now be tackled at that level.

DAF and GTAF felt however, that some monitoring was required at a lower-than-reform level. An opportunity was seen after the approval of the sector's PEFA report (presented at MISAU's Technical Committee on September 2015), which set out a long series of concrete recommendations, to all areas involved in the broad PFM areas. The idea was to use these recommendations, to elaborate strengthening activities, subject to frequent monitoring and adjustments, although not mandatory. Therefore, GTAF developed a **Plan of Action for the Follow-Up of PEFA recommendations**, which was already submitted to departments and will start its monitoring in Q1 2017. Ideally, this instrument will capture all recommendations issued in subsequent studies, and will represent a unique tool to accompany progresses against evaluations.

Other than that, DAF has demonstrated **flexible and prompt reaction** to ad-hoc requests on specific reporting, eg for PROSAUDE. This proved the existence of solid databases, and capacities to extract required information. In other occasions, eg reporting on the use of incentives, this has not happened.

Note: this report does not consider any other M&E process reporting on sector's specific programmes, eg HIV/AIDS with IMASIDA 2017.

2.3. Evolution in Sector PFM Aspects

For the third consecutive year, this report is confirming **progresses in the sector PFM aspects**, although associated with persisting **systemic/structural weaknesses**. Progresses are visible, although limited to micro-processes in the areas of expenditure and control; while weaknesses/gaps remain associated to programming/planning.

There are several other aspects that should complement this analysis:

1. How the slow pace of the **whole public sector reforms** is halting the sector's;
2. How the lack of progresses in complementary areas are keeping **DAF's progresses** rather **confined**;
3. How the Ministry's **procurement**, which is not under DAF's control, remains a critical area of financial management, although not on top of reforms priorities.
4. How progresses in financial management improve **service delivery**.

In a *compartmentalized* public sector, such as the Mozambican, where planning and execution are tasks of two different national directorates (DPC and DAF); and where procurement is responsibility of neither one or the other, but it is split in 3 different procurement units, **these issues can't be solved by either one or the other entity**: they have to be seen in combination, and brought to a higher level.

[16] ACA Final Report for dissemination, June 2017

The creation of a Reform Unit, under the direct supervision of the sector's Minister, where eg *restructuring the sector planning and budgeting* is flagged as one of the strategic objectives, is actually a positive sign. However, its real impact in the mid-term will depend on its leadership and relative power, in the articulation with other reforming ministries (public sector), and the willingness to include all the areas of interest (eg procurement).

This narrative is reporting distinctly on **PFM systemic and operational aspects**.

2.3.1. Systemic

2.3.1.1. Sector Financing

The sector has been **seriously affected** by the foreseeable consequences of the public finance and economic crises. Since August 2016, health institutions have started reaching out their usual donors, with ad-hoc requests to fund the most essential services, such as food for the patients, for which there were no funds until the end of the year. The situation is tense and is rapidly deteriorating. Partners tried to conceive a more coordinated approach to "emergency funding". GTAF worked with MoH DAF, to present an aggregate of priority needs. According to DAF, at national level, there is a **financial gap for US$3.8m of essential goods and services**: food for patients, hygiene and cleansing materials, fuel for ambulances and malaria pulverization. GTAF has calculated that if needs for salaries and medicines are included in the calculation, the financial gap would raise to US$13m.

The **same scenario is expected in 2017**. There will be shortage of funds for salaries, goods and services, medicines. The financing transferred to the sector will not suffice to guarantee the provision of the essential services. The most remote areas will be most affected, compared to the central/provincial levels; where the system will make to hold the funds. Out-of-pockets and off-budgets will increase. Stock-outs will be more frequent. In lack of external financing, the internal will prioritize salaries above all.

The unfortunate picture above clashes with the official history of sector's financing. On paper, the government is making an attempt to maintain and increase funding to the health sector: eg a budget revision was approved by the Parliament in July 2016, where the health sector had a nominal increase in funding; although with a pure accounting procedure, which was possible for the depreciation of the local currency. The budget proposal 2017 has not considered external funding, and has put a huge increase in internal funding to the sector (although the assumptions behind the entire State budget do not seem credible).

With such emergencies, short-term financing will be the results of bargains and negotiations, between the Ministry and different donors. The entire exercise will focus on priority needs, and lose the broader focus of sector financing. The political speeches on the "defence" of the allocations to the health sector will soon be exposed to reality.

This is going to be an extremely challenging environment, for improving PFM in the health sector.

2.3.1.2. Comprehensiveness and Transparency of the Sector's Budget

Comprehensiveness and transparency of the sector's budget have **probably worsened** in the period. This is quite common, in contexts of reduction of funding, predictability and dispersed external support.

The Ministry's Planning and Cooperation Directorate's (DPC) has almost given up to its crucial task to **foresee and coordinate the external financing to the sector**. The usual tools available - ODAMOZ, an on-line software; and IFE, an excel-based database – were not properly used for the planning exercise 2017. The lack of commitments from the pooled-fund donors and the proliferation of vertical funds structures might have prompted considerations about the cost-effectiveness of investing time in

such complex exercises. This is going to seriously affect the Ministry's capacity to allocate funds where most needed; and coordinate its donors towards the objectives set in the sector's strategy.

Along the same lines, the health sector possibly retains the highest **structural off-budgets** within all sectors. These are funds used in health, which remain invisible to local and sector governments, thus to the integrated planning exercise and to the public finance.

Another side of the same story is the lack of progress in the identification and registration of **sector's own revenues**. Budget Execution Reports (BER) have shown no progress in raising this important source of revenues. Most likely, both collection and utilization remain far from being visible in the sector budget. The combination of external and internal off-budgets is undermining the credibility of the sector's envelope.

In terms of transparency, the disclosure of the budgets and expenditure to **districts' level institutions (SDSMAS)** in the Budget Execution Reports was a positive development in 2015. There has not been any significant follow up to that. Extracting the details of SDSMAS per province or district remains impossible. In terms of **de-concentration** of expenditure, since 2016 there were two new institutions with budgetary management autonomy: The Central Hospital of Quelimane, and the Health Sciences Institute of Manica.

The sector **decentralization** agenda is stalled. Feeble attempts are in place in the Maputo – the capital – municipality, to pass the management of health units to the decentralized government. Although detailed reporting is missing to understand the real state of it.

Financing the decentralisation of Financial Administration

In 2018, the URESS, the coordination unit of the sector reform, made sure that the various department planned and financed a number of activities under their respective responsibility linked to the reform agenda. Such activities were part of 2018 PES and Budget.
MISAU-DAF's set of activities linked to the Reform Agenda, aimed at decentralising the function of financial administrations to 33 units at central and at decentralised level (SDSMAS, Rural and District Hospitals). These activities were supposed to be financed with external funds, yet they remained unfunded.

MISAU proposed Enabel to finance the decentralisation of financial management to the National Directorate of Farmacy (DNF) and to four SDSMAS in Tete. The activities consisted in training administrative personnel deployed in SDSMAS in Mutarara, Angonia and Cahora Bassa and in the Rural Hospital of Songo. In addition, resources were also devoted to provide the physical means to start managing the share of the budget devoted to their institutions. The Hospital in Songo had a functional e-SISTAFE point, whilst the SDSMAS in Mutarara, Angonia and Cahora Bassa required one. Some funds were also allocated to grant the newly decentralised DNF functional e-SISTAFE facilities.

In the week starting August the 27th 2018 a training, held by personnel from *Direção Nacional de Contabilidade Pública* in Tete, was organised in Tete, capital of the homonymous province. The training was organised in two shifts (small groups of around 10 people per shift) to be more efficient and be sure that the training was interfering only minimally with the working hours. By the end of August, 20 people had benefitted from a complete training on the use of the e-SISTAFE functionalities for managing financial expenditure.

To complement the effort and fully capitalise the initiative, in July 2018 Enabel launched the tender for contracting the service of installing fully functional e-SISTAFE points in the institutions selected.

The sites are linked to the national network after the intervention of *Telecomunicações de Moçambique*.

In the course of GTAF III the TA is focussing its effort in bringing higher in the reform agenda the follow up of the PEFA as well as a more granular follow up of the budget and its execution. The

decentralisation of financial management is functional to both objectives,

2.3.1.3. Policy-Based Budgeting

There were **no improvements in policy-based budgeting**. This is very much in line with the conclusion in the section "policy and planning".

Budget classification remains as before. GTAF made an attempt to organize an exercise between the Ministry of Economics and Finance (MEF) and MoH, with the aim to create a programme classifier for health programmes. Although parties agreed that this should be possible and feasible, there was no follow-up. As a result, the sector is still unable to articulate its administrative allocations, with its programmes.

The **multi-year perspective in planning and budgeting** is regularly made, but not used. There is no visible link between a Mid-Term Expenditure Framework and the yearly budgets; no visible link between the sector proposal and the Finance's. Inputs to the MTEF are collected on an ad-hoc basis. The MTEF itself is not used.

The concept of **"integrated planning"** has returned into the discussions for the revision of the pooled-fund MoU. However, there were no concrete steps towards it.

2.3.2. Operational

2.3.2.1. Predictability and Control in Budget Execution

There were **continuous improvements** in the predictability of control in budget execution.

The introduction of **financial management manuals** for the central and the provincial levels, and the successful implementation of an ambitious plan of trainings in every province, have substantially improved the financial management capacities, in each institution.

A more informed and strengthened approach to the "business processes" required by the country's Financial Management Software (e-SISTAFE), has guaranteed better **treasury planning**, and **several layers of control**; and has obliged – in the mid-term – health spending units to pursue improved management. These aspects had positive impacts on the rate of expenditure, and their regularity.

The increase in the **rate of sector budget execution** has probably been the most spendable single achievement, of the Ministry's financial management. It was 93% in 2014 and 96% in 2015 (for the funds under Ministry's control). It is slightly below average, at 70%, after Q3 2016.

The National Directorate of Administration and Finance (DAF), Department of Support and Control (DAC) has continued its regular activity of **following-up of audit recommendations**. GTAF organized a joint provincial visit to Cabo Delgado. A joint report was produced. This exercise has improved over the past two years, although still lack coordination with the internal auditor, the Inspectorate General of Health (IGS).

Unfortunately, the year's contingencies have contributed to worsen the **pooled-fund predictability**: despite committing, many donors have suspended the disbursements, while mitigating measures are put in place. In 2015, 95% of the commitments made to PROSAUDE were disbursed. It was only 27% at Q3 2016.

2.3.2.2. Accounting, Recording and Reporting

Accounting, recording and reporting have **all improved** in the period.

MoH DAF has regularly produced its **Budget Execution Reports** (BER/REO), which were always

published within the given deadline (45 days after the period covered), and have consistently shown improvements. As part of GTAF activities, DAF has accepted to start revision of the report template, to make it more user-friendly, more aligned with the Finance's, and more useful to health managers.

The central Department of Administration and Finance (DAF) has tightened its oversight on **opening of administrative processes**. Since 2016, only those activities that had been given a budget in the sector's PES, could be granted an authorization to start an administrative process.

Moreover, DAF has increased its capacities to liaise with provinces, and pushed for **enhanced commitment on timely and accurate reporting**.

2.3.2.3. Procurement

Procurement has remained an area with **substantial lack of monitoring and oversight**, where joint initiatives have always found some resistance. Quite remarkably, there were two advances in this area in 2016:

A. The inception of a **procurement assessment**, to take stock of anything that was reported on procurement in the health sector in the period 2009-13 (consultancy is currently on-going);

B. The inception of a **procurement audit**, to look into all the procurement of medicines, in the period 2014-15 (bidding process closed), for some 18 process of about US$100m.

It is worth saying that both initiatives, although promoted by the pooled-fund mechanism PROSAUDE, will have the occasion to take a broader look to the entire funding that went through procurement. Specifically, the latter is going to be valid as "yearly PFM assessment" for 2016.

The results of both initiatives are expected by March 2017.

2.3.2.4. External Scrutiny and Audit

The Administrative Tribunal (TA) provided the PROSAUDE partnership with the **sector-wide audit** 2013, in October 2015. The audit report included annexes, presenting the consolidated financial position. An extensive analysis was made at the level of GTAF, and a technical opinion was issued. Ineligible expenditures were easily identified and presented to the parties.

In 2016, as this report is written, the TA has not yet presented the **audit 2014**. When enquired, it claimed that it is still waiting replies from the provincial audited institutions. Worryingly, the **audit 2015** has not started yet. Thus possibly, there will be delays in the analysis and opinions expressed for the expenditure 2014 and 2015, which very likely are going to further influence the timing of PROSAUDE disbursements.

This delay has influenced the way donors of the future pooled-fund mechanism projected their requirements in the fund's Memorandum of Understanding (MoU) and Procedure Manual (PM). Confronted with this sort of delay – which is pushing the release of the audit towards n-3 (!) – donors will very likely insist for an **external an independent audit firm**, to look specifically to PROSAUDE funds, within n-1.

2.4. Evolution in Capacity Development

Efforts have continued, although frequently uncoordinated, to improve capacities in the health sector.

However, the tight fiscal context has put pressures on the funding to capacity building, as any other "complementary" activity. Internal resources were moved to cover for more impellent needs (eg salaries); while the use of external resources has been weakened by the lack of predictable

information on external support.

Capacity development in the long-term is enshrined in the new "***Plan of Development for HRH 2016-25***".

2.5. Evolution in Aid Effectiveness: BS as a Modality in SWAp Contexts

The pooled-fund PROSAUDE has gone through a process of **radical revision**. The Memorandum of Understanding (MoU) and a Procedure Manual (PM) are, as this report is written, in their final elaboration. Important elements of discontinuity have been proposed and introduced, such as:

needs-based allocations, a management unit, strengthened dialogue, enhanced risk mitigating measures, an agreed plan and budget, process indicators, enhanced financial reporting and auditing.

The **changes** appear so weighty, that a new name has been proposed for the fund: **Mechanism of Integrated Support to the Health Sector (MAISS).** More importantly, such changes are possibly paving the way for increased financial contributions from new partners, including the World Bank. It is expected that the new MoU will be signed at the end of January 2017.

A huge portion of the TA-to-GTAF time was spent on PROSAUDE revision in 2015/16.

3. Other Points of Attention

3.1. Broader Approach to Areas of Support

If the project's entry-point has been the joint Working Group on Administration and Finance (GTAF), it has often contributed to advise on **close and related areas**, when deemed relevant and when solicited by DAF. An example could be the support to the National Directorate of Planning and Coordination in the mapping of the external support, through the "Survey on the External Funds" (IFE). This has been done with the certainty that strengthening sector financial management cannot be done in a *vacuum*, and it rather require articulation, coordination, reciprocal support. In this spirit, a **broader approach** to the mere technical assistance is instrumental to the attainment of the project result.

The main areas covered in this broader approach include: The Reform Unit of the Health Sector (URESS), the sector's pooled-fund mechanism, the PFM working group of the broader partnership between general budget support donors and the Ministry of Finance, the conclusion and follow-up to BTC's project in support of decentralization; and the collaboration with the Ministry to apply to the **Belgian Study Fund**. The latter, a fund managed by the Ministry of Economics and Finance, has not been sued by the health sector in the past years. The TA-to-GTAF has supported the application of sector's institution, supporting the elaboration of project documents. A first proposal was presented for DAF's *Centro de Abastecimento* (CA). More proposals are in the pipeline.

A second reason why this broader approach was implemented, is the recognition that the **project's sustainability** will ultimately depend on the **institutionalization of certain practices** that the project has pursued. In this perspective, the re-structuring - in February 2016 - of the health sector's Reform Unit (URESS), and the invitation to contribute to draft its mid-term plan, has been seen as an opportunity. The project's long-term influence will ultimately on the extent to which some of the activities will integrated in the governmental institutions and plans.

3.2. Monitoring and Evaluation

Peer-Review – Phase II/Year 1

In February 2016, the project's TA discussed a possible **peer-review of the project's implementation**, with the representative of the Government of Flanders in Mozambique. Later, ToR were designed and agreed with the Resident Representative of BTC in Mozambique. The peer-review took place in the month of August 2016. Its final report is attached to this progress report, and includes all the relevant aspects of the project's M&E.

3.3. Coping with Risks

1. Committed and available GTAF co-chairmanship

Flanders guaranteed a stable co-chairmanship for almost one year. Under such chairmanship, the relationships with the national counterparts have been excellent, which contributed to ease the implementation of activities, and do regular monitoring. Canada has now stepped in as new GTAF co-chair, with renewed commitment. Canada has already been GTAF co-chair in project's phase I.

Risk: Weak or absent GTAF co-chairmanship.	Likelihood: low	Impact: High
Mitigating measure	✓ Identify a credible and committed partner.	

2. Mismanagement of funds out of DAF control

Increasing and out-of-control top-ups and incentives to Ministry's key-functions have always the

potential to burst in a wide-spread scandal. The impression is that this kind of expenditure has reached the peak, and has now been put on hold until emergency expenditure is done. In the long-term, it would be likely to develop a retention strategy, where these payments will be linked to performance.

Although there was no serious mismanagement reported at sector level, the scandal of the unreported state-guaranteed debts has finally affected the sector. Donors feared the sectors were at risk of losing their foreign currency, as the Finance was struggling to repay the debt's interest. A flow-of-fund risk assessment was done in the health sector, showing that the diversion of sector's funds was unlikely to happen. However, mitigating measures were agreed and are now waiting to be operationalized. In the meanwhile, the Finances declared that the State is not going to pay back the companies' debts, at least until 2021. The government agreed on an audit, which is to be implemented by the private company Kroll.

The scenario is still complex, and information is scarce. Although not directly related to the sector, this aspect is going to maintain the perceived fiduciary risk high, during the time-life of the project.

Risk: Major mismanagement of funds, scandal, fraud	Likelihood: medium to high	Impact: High

3. Under-performance of other "aid effectiveness" Working Groups, whose tasks are complementary to GTAF

In 2015/16, GTAF (together with PIMA) remained the best-performers working-groups. Since better coordination was possible within these two group, and since the "broader approach" to public finance and reforms has been implemented, the lack of progresses in other groups has not seriously affected the outputs of GTAF. Impact is revised to low.

Risk: Under-performance of WGs whose tasks are complementary to GTAF	Likelihood: medium to high	Impact: Low

3.4. Suggestions for Phase III

Having acknowledged the interest of the donor to continue with a project's phase III; and the positive evaluation of both the government and the partners (ref. peer-review), this report advances some **ideas on how to improve the design of the project**:

1. This report mentioned that progresses in sector's financial management processes are visible and continued, though **major structural weaknesses remain**.

   The entry-point for the existing WGs are National Directorates (DNs), at technical level. These DNs are used to work on its own agenda, in quite a disconnection with other Directorates. Intra-Directorates tasks are launched by the Minister or the Permanent Secretary, and have often a limited duration, eg until a task is completed. In these conditions, the TA-to-GTAF has a **limited range of intervention** to pursue improvements in areas that are not entirely under DAF control, eg decentralization, procurement, legal reforms.

   Since February 2016, as TA-to-GTAF, I offered to support (part-time) the inception of the **Health Sector Reform Unit**, with the aim to identify these major structural weaknesses, and guarantee that a supra-Directorate level – such as the Unit – would have the power to handle that.

   - **It would be advisable to institutionalize the TA-to-GTAF space to support the URESS. In that construction, there would be a first-operational level of improving financial**

management, represented by the support to DAF/GTAF; and a second-structural level, with institutional reforms, at URESS level.

- **Equally important, it seems advisable to create a stable connection with the Ministries of Economics and Finance (MEF) and the Ministry of Public Sector Affairs, where the central PFM and public sector reforms are designed and launched.**

2. A series of initiatives are likely to change, over the medium-term, the **current organizational structure of the Ministry**: eg the implementation of the Decree 12/2015 is going to merge some of the functions currently deployed by the Planning and Cooperation (DPC), and the Administration and Finance (DAF) Directorates; the creation of the Reform Unit (URESS) will re-centralize the coordination of some of the tasks currently given to them (eg decentralization); and the creation of a PROSAUDE management unit, which will necessarily interact with other entities to ensure the proper planning and reporting of the fund.

3. USAID has lead Health Partners Group since June 2016. At the beginning of its experience, USAID promoted a 2-days retreat, where some of the current settings were challenged and revisited, including the current organization of the **"aid effectiveness" working groups**[17], which were designed in perfect alignment with that of the Ministry's National Directorates. On the one hand, the current structure has ensured quick response from the responsible Directorate. Though on the other hand, it has shown that intra-Directorates initiatives are difficult to perform (eg planning and budgeting), thus limiting the added value of the WGs.

   - **Under the conditions described above, it seems important that the objectives and expected results of the position are discussed, at an early stage, with all the stakeholders, namely (not limitedly to): HPG; GTAF and PIMA; Ministry's DPC, DAF, DRH, PROSAUDE Management Unit and the Reform Unit (URESS).**

     The availability of a TA-to-GTAF must be considered vis-à-vis all other TAs available for the health partnership, eg. TAs-to-PROSAUDE. Eventually, the TA-to-GTAF could help filling some of the gaps identified elsewhere (eg. financial reporting).

     Although guaranteeing the "neutral position" that has favoured the work so far, the ToR must be presented and discussed with the parties, and particularly with the Human Resources Directorate, which is supervising the TAs appointed to the sector.

[17] This is the original denomination of the 6 working groups contributing to the Health Partnership Cooperation Framework, of whom GTAF is one

Annex 1 – GTAF Analytical Works – Phase II Year 1

The following list presents some of the evidence of the work of the TA-to-GTAF. All the documents mentioned are attached as annexes.

1. A note on the 2016 Budget proposal for Health;
2. An analysis of the budget and expenditure with PROSAUDE funds in 2014;
3. Audit of the Administrative Tribunal to health expenditure 2013:
    a. A technical opinion
    b. A database of the findings
4. A report on expenditure with PROSAUDE as presented in main budgetary document (2014-16);
5. A report on PROSAUDE initial balances 2016;
6. MoH's Treasury Plan 2016, for main external cash-based funding, including PROSAUDE;
7. An update of the Survey of External Funds supporting the health sector (IFE):
    a. The database
    b. A presentation
8. A comparative analysis of the execution in 2015, compared with the provisions of the Treasury Plan;
9. Budget classifiers:
    a. MoH's request to MEF/CEDSIF for solutioning health-related technical issues;
    b. Minutes of the meeting;
10. A proposal for a revision of the formal of the Health Budget Execution Report
11. Mapping of donors' support to PFM in the health sector
12. An analysis of sector's PFM evaluation in preparation for ACA XIV
13. An analysis of the changes for the health sector in the budget revision 2016
14. A joint report from the GTAF provincial visit to Cabo Delgado
15. Health expenditure 2015:
    a. A presentation
    b. An analysis of total expenditure with GAVI funds
    c. An analysis of the expenditure with PROSAUDE
    d. The database
16. GTAF note on the budget proposal 2017 for the health sector
17. GTAF note on aggregate priority needs for November and December 2016
18. ToR for the procurement audit to MISAU/CMAM
19. Update of PFM in health key-happenings´
20. A presentation on "what is REO Saúde"
21. Study-Fund - Proposal for MISAU/DAF/CA submitted to the study-fund
    a. Text of the proposal
    b. Terms of reference
22. URESS **-** Matrix of reforms activities for the Reform Unit
23. GTAF AWP 2016
24. GTAF note on basic needs in goods and services 2016
25. GTAF Minutes