

250303

AN ASSESSMENT

BY THE EMBASSY

AS BACKGROUND FOR THE DRAFT

APPROPRIATION DOCUMENT

This document is based upon the draft appropriation document submitted for discussions in the advisory forum 240303 and contains more detailed information than the appropriation document submitted to the director general for approval.

1. Summary

Programme number name: MOZ 2473 Common Fund Health

Agreement number/name: Common Fund Health

Main justification for recommending support:

Improved routines and systems for the management of internal and external resources in the health sector will give more health for the money. This will be achieved by having a common framework for setting priorities, articulated in an annual costed plan, including common reporting, monitoring, accounting and audit of all activities.

This will contribute to

- a) Improve the internal allocation process (MISAU) as the Ministry will have a comprehensive overview of the available resources,
- b) Allow the Ministry of Health to take the overall responsibility in setting priorities and allocating resources, and to carry out reallocations across the various departments, thus contribute to improve transparency in the internal process'
- c) Bring the planning and resources allocations from at the present being taken at the level of individual department level to a ministerial level.
- d) Improved quality of co-ordination, planning, allocation, budgeting and reporting and auditing,
- e) Allow donors to have one entry point to the Ministry of Health, both in relation to planning, budgeting, financial flows and reporting mechanisms.
- f) The financial mechanisms will facilitate the implementation of the public sector reform, particularly in relation to the ongoing reform of the public administration and financial management (SISTAFE), and support the necessary build-up of capacity and knowledge within the ministry.
- g) An improved overview of the total resource envelop to secure a sustainable expenditure level in the health sector.

2. Allocation of funds: NOK 175 million for the period 2003-2006

The annual level of Norwegian contribution is estimated to be around NOK 40-45 million, but should be considered in relation to the level of contributions from other donors and the capacity to use already received funds.

The first transfer of funds NOK 25 million in 2003 will take place upon signing of the agreement and be based on

- The Health Sector Strategy (PESS),
- The Annual workplan and budget for 2003
- The report and follow up of the Joint Review of the performance of the Health Sector (August 2002)
- The approved list of indicators (December 2002)
- Moving on budget, December 2002

The level and time for the second and subsequent transfers will be subject for further dialogue with the Ministry of Health and involved partners;

- a) the actual use of received funds and a presentation of a financial statement showing previous spending, showing the actual need for funds
- b) the presentation of a plan for the use of the programmed funds,

The support is totally within the framework of the poverty reduction strategy (PARPA) in which the healthsector is one of the six priority areas and macro-economic and financial management another. The suggested support also strongly contributes to improve the management of public expenditure, which is a main effort within the latter. As an issue with the area of Good Governance, the support will contribute to increased transparency, priority setting and improved use of available resources it be financial- or human resources.

A request for financing was received from the Ministry of Health, on 24.02.03.

3. Description of the Programme Support

3.1 Previous support and experience

Norway has for years supported various programmes in the Ministry of Health among which:

- a) Common fund for drugs (MOZ0004).
- b) Common fund for budget support to the Provinces (MOZ 0005).
- c) The National Integrated Program for Communicable Diseases (PNI-DT) (MOZ 0003).
- d) The Integrated Programme for mother and child health care - reproductive health through UNFPA (MOZ 0093).
- e) Tied funding for solarpanels (MOZ 1032).
- f) Activities related to the rehabilitation of health infrastructure, after the floods in 2000 (MOZ 2465).
- g) In addition Norway has stated the willingness to finance the construction of a central warehouse for medicines (MOZ 0011).

The experience from Norwegian support to all the different programmes is a major argument to change the way of cooperation. It is viewed necessary to move the dialogue from being sub-programme based to dealing with the overall situation within the Ministry of Health. In order to get out of a situation where it is the various departments in the Ministry setting the priorities, with or without strong

donor influence, and not having a broader consideration taking into account the total need of the sector.

3.2 The request and its background

The Ministry of Health has for several years worked to establish a common financial mechanism. Various proposals have been written and discussed on a number of occasions.

The approach pursued by the Ministry of Health towards a sector program could have been more stringent and clear, and is sometimes "disturbed" by individual heads of departments lobbying for specific direct funding for their respective areas.

During 2002 the Ministry of Planning and Finance participated in several meetings and workshops regarding the common fund. The request from the Ministry of Health is presented at the same time as the development of the new financial management system (SISTAFE) is started. There is therefore a need to make sure that the establishment of an improved planning, budgeting and reporting mechanism is carried out in a way that contribute to the introduction of SISTAFE.

SISTAFE will not be introduced to the various ministries during 2003, and the features and scope of the system is still not defined, neither are the requirements of SISTAFE in regard to the existing capacity and resources of the Ministry of Health. However, it is important to note that a closer collaboration between MPF and the ongoing efforts to strengthen capacity at the Ministry would be beneficial. The previous experience so far with MPF is quite negative in terms of quality and quantity in regard to communication. MPF has now shown to have the necessary capacity to relate to the Ministry of Health at an early stage. This has changed somehow the last 8-10 months, but still has great potential for improvement. The understanding of SISTAFE, its effect, the consequences for the ministry and decentralised levels is still poorly understood, as they are for most donors.

The introduction of a budget process producing a comprehensive annual, costed and prioritised workplan for the health sector will greatly facilitate the introduction of SISTAFE. The full benefit of SISTAFE cannot be expected to be harvested for another 3-4 years.

The establishment of a common health fund will imply that all Norwegian funding to the health sector with the exception of one programme (UNFPA) will be channelled as un-earmarked sector programme support to the Ministry of Health, through the treasury, thus on budget. Any remaining funds from previous support to the Ministry of Health through bilateral agreement regarding the MOZ 0003 National Integrated Program for Communicable Diseases, will enter into the FC-PESS as an incoming balance, and be used according to the priorities set out in the Plano Operacional 2003.

The two existing pools (Support to Provinces and Drugs) will be held outside the financial mechanism (FC-G) for the time being. The reason for not including these pools from the start is the step-by-step approach has been chosen or the time being is the need to go step-by-step, and then gradually the next couple of years as SISTAFE develops, bring these two funds into the mainstream. Effort will be made to gradually merge other funding into the FC-G while all the necessary mechanism and administrative and financial resources are put in place.

The drugpool is a pool operated in FOREX, financing the importation of drugs and consumables. It is now in most aspects already controlled and administered by the Ministry of Health, and reflected in the statebudget.

As for the provincial pool, the financial flows are following almost the same procedures as the state mechanism, but have separate accounts. The management deviates from the present public financial management system on some selective and important points, particularly with regard to the disbursements of funds (three times a year, to be changed to twice a year in 2003). The agreement partner for the Pool for budget support to the provinces is the Ministry of Planning and Finance, and the external funds are as such "on-planning".

The transformation of the FC-Provinces (MOZ 0005) into a similar financial mechanism (on budget through Treasury) should take place probably already in 2004. However, the Ministry of Health has opted for not doing this now but start with the FC-G to gain experience.

The first real challenge in this regard will be to establish one common planning process for all three funds, then to the extent possible also work to have one financial mechanism. There is no line of flow of funds from Ministry of Health central level to the provincial health authorities. All funds from central level flow through the Ministry of Planning and Finance. It is therefore important to distinguish the flow of funds from the actual planning process, and at the present stage there is an urgent need to concentrate all effort on establishing a planning/budget process.

The provincial integrated planning is now being conducted with heavy technical assistance from SDC and physically situated inside the office of SDC. It will now be transferred to the Ministry of Health. How this will be done is now being discussed with the Ministry of Health and stakeholders. The present agreements in relation to the drugpool and the provincial pool end 31.12.2003. There is thus an urgency related to the matter.

The constant lack of liquidity in treasury is a huge challenge frequently pointed to from the experience of PROAGRI, and also described in the study "Moving on-budget".

3.3 Goal hierarchy and monitoring of results, outcome and impact

The PARPA and the Health Sector Strategy provide the guidance in determining priorities for the health sector. Below is an overview showing the various instruments. It should be noted that the Action plan for Poverty Reduction (PARPA) was elaborated before the PESS was approved. PESS is therefore more updated. The intention was that PARPA should be a "living" instrument, but the document has not yet been updated since it was published 2 years ago, and it is not yet clear how and when it will be updated.

The Ministry of Health together with the partners embarked in 2001, on a rather lengthy process around the elaboration of indicators for monitoring of progress and impact in the health sector. The process was inclusive and both multilateral agencies and donors participated together with the Ministry of Health. A particular working group for monitoring and evaluation, of which the embassy is a member, meet 2-times per month.

During the second half of 2001 one had agreed to 55 indicators and a short list (!) of 17 indicators, which together covered all aspects including input-, process-, output- and impact indicators. At this stage it was decided to leave the discussion there and make the indicators subject for a through review in the 2002 joint annual review of the progress in the health sector. This was done and the indicators were subject for a full review in the joint review of the health sector 2002. Based upon the recommendations hereof, the M/E group continued the discussions and presented finally a revised list of indicators reduced and refined, which was later approved by the GT-Swap in December 2002. At this stage also representatives from the civil society participated in the discussions.

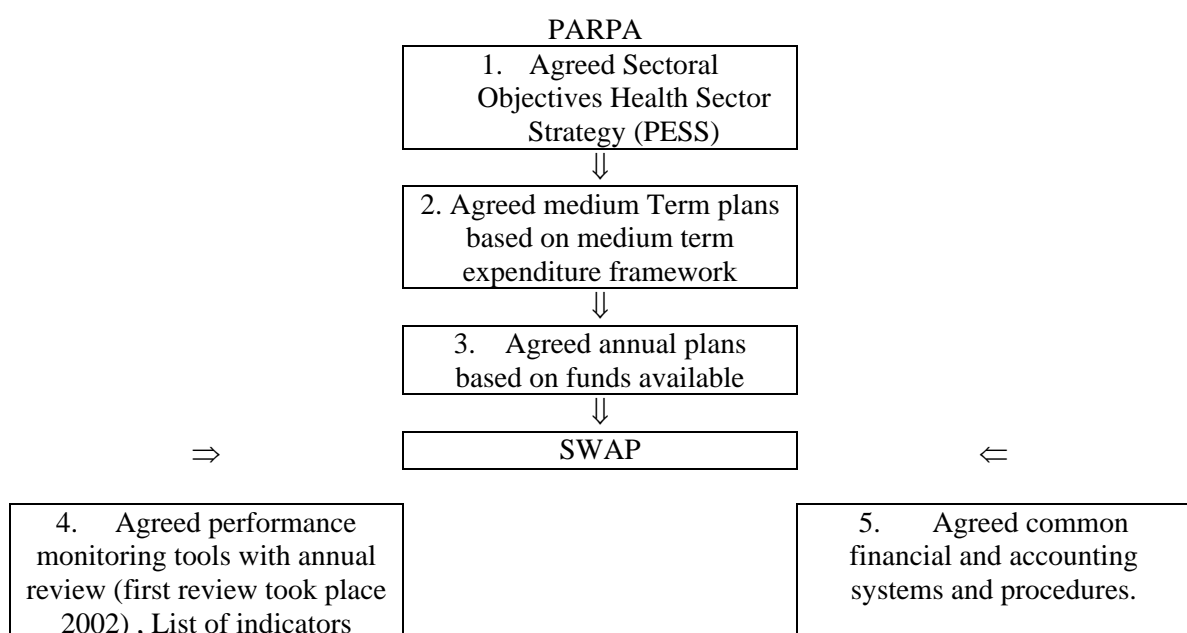
With the point of departure from the revised list the PARPA indicators are now being reviewed and adjusted to be coherent with the indicators agreed to at sectorlevel.

Norway together with Denmark and Sweden support the National Institute of Statistics (INE) both in terms of financial support as well as technical support from the Scandinavian national institutes of statistics. This will contribute to improve the data both in terms of quantity, but more particular in terms of quality. The Ministry of Health collects substantial quantity of data, but the methodology and quality of the data still leave much to be desired.

There is a need to improve the health information system to secure reliable data both in terms of quantity and quality, in order to monitor the development. In this regard the ongoing support through NUFU and the University of Oslo (Jørn Braa) is important, and this could possibly be increased and strengthen through an increased support to that particular project.

The joint annual review process will be used for regular monitoring of the progress of the health sector, and measure that investments done do create results, outcome and impact.

Table 1: The various SWAP components.



Tabell 2: Framework for monitoring and evaluation of the health sector strategy (PESS)

Keyissues	Functions	Main objectives
Access, equity and gender Quality in priority programs and services Advocacy and individual and collective strengthening Financingstrategy Institutional development	Management Financing Allocation and administration of available resources Quality in the healthservice	Reduction of absolutt poverty Improved health

The goal is poverty reduction through improved health situation

The Health Sector Strategy (PESS) emphasis that this will be done through focus on the management, financing of the sector, the allocation process and administration of available resources and the improved quality of health services.

The justification for moving towards program support rests in the understanding that it will lead to improved health services, by being able to an improved overview of available resources and a real prioritisation. This cannot be achieved through a project approach. It is therefor important to continue the emphasis on output and outcome of the investments.

The improvements of the health sector will be monitored through an annual joint review where the progress in relation to the national list of indicators will be subject for assessment. Special reviews will be initiated when considered necessary. In this relation the Norwegian support to UNFPA for strengthening of the country office capacity to participate in the SWAp should also been mentioned. UNFPA will through this agreement, enter into a co-operation with the Regional Centre for Health Development (CRDS) in Maputo. There is little tradition in using evidence-oriented research to obtain data usable for policy setting, and even more rarely is that when these evidence exist, are hardly ever been used for this purpose. The interaction between research and decisionmaking is practically inexistent, turning many reports, assessments and consultancy products into academic exercise without any practical consequence. CRDS has straight links with the departments in the Ministry of Health which gives the centre an excellent potential to play a more important role, given they have the resources.

3.4 Total cost estimate and financing plan

An operational Plan (version 2) has been distributed and discussed among the donors. The plan need still to be futher refined, but there has been a huge effort invested in the elaboration of the draft.

The following donors will provide support to the ministry for the interim periode; Ireland (approx. USD 375.000), DFID (approx. USD 350.00) and Norway. When the FC-G is up and running by 1.7.03 other donors will joing, and the European Commission, Netherlands and Finland have confirmed their participation. It is also expected that some of the UN organisations will use the fund. Having said that it is important to emphasise that the most urgent and important task is to get the support from donors towards the planning and budget process .

The financing plan for year 2004 and onwards will be formulated during the next months. Also Denmark has the intention of using the FC-G for central support, but has not decided as of when. Denmark is providing substantial provincial support to the health authorities in Tete province, but has decided to gradually phase out the support to the health sector during a period of five years. The intention is to use the common funds in the phasing out period.

Table 1 The total financing need for the periode 1.1-30.6 (interim) is estimated to be USD 4.509.000.

Donor	Funding
DFID	USD 400.000
Ireland	USD 450.000
Norway	USD 350.000 (remaining fund PNI)
Norway	USD 3.400.000
Total	USD 4.600.000

The table below is indicative based on pledges. For FC-Drugs and FC-Provinces the figures are based on already existing agreements.

Table 2 Funds available for the FC-G for 2003 (including the period up to 1.7.03) ¹in USD

Donor	FC-G (MOZ 2473)	Medicines (MOZ 004)	FC-P (MOZ 005)	Other	Total
SDC		1.143.500	2.131.060	4.303.340	7.667.900
Netherland	500.000	3.674.000			4.174.000
Ireland	800.000	1.200.000	800.000	1.800.000	4.600.000
Norway	5.322.830	4.657.476	133.707	2.328.738	12.442.751
DFID	1.069.207	7.298.500			8.367.707
European U.	947.173	2.929.401	1.952.934		5.829.508
Finland		788.000	426.000	1.459.000	2.673.000
Denmark	300.000	210.000			510.000
France		1.952.934	976.467		2.929.401
Total	8.939.210	23.853.811	6.420.168	9.981.078	49.194.267

¹ Indicative figures as of 080303.

Several of the donors such as Finland, Denmark and European Union still have considerable amounts in parallel set-ups directly to the provinces the next couple of years. In addition support from NGOs should be added although amounts are less significant. Total external financing to the Health sector is annually approx 60-65 million USD. There has been an increase in the domestic contribution to the sector the recent years which has been possibly mainly due to increased general budget support (macrofinancial support).

There is a need to focus more to capture the possible "receitas"/fees. An improved financial management system (SISTAFE) could contribute positively to this process. The issue of corruption in the sector is on the agenda, and health is prone to particularly petty corruption, where health workers charge patients for services. A national non-governmental organisation (Etica) receiving Norwegian support will during the next 1-3 years focus on campaign and information, and sectors prone to corruption will benefit from this.

Table 3 Operational Plan for the Ministry of Health² (in USD million) for 2003

Needs	Statebudget	Donors	Credit	Total	Deficit	% deficit
114.670.	15.136	52.729.	2.300	70.165	44.505	39%

Table 4 Needs according to cost centres. The operational plan is divided into needs according to departments and programs, and available funds according to resources.

Cost Centre	Global needs	Allocated amount	% of needs
National Health Dept (DNS)			
- Community Health	12.320.210	3.681.500	29.9%
- Epidemiology	16.298.907	1.290.152	7.9%
Fin.-Adm. dept (DAG)	7.270.300	971.000	13.4%
Hum.Resource (DRH)	7.041.000	1.134.00	16.1%
Plan- and cooperation (DPC)	2.140.000	1.700.000	79.4%
Ministers office	240.000	162.158	67.6%
Total	45.310.417	8.939.210	19.7%

The plan describes what activity/program within each cost centre, which will receive funding, as well as how much for each of these. What is important to note is that more departments are receiving funding. Both the increased financial support to DAG, DPC and DRH should be considered as great improvements, contributing to building a stronger ministry able to deal with the challenges ahead.

The Financing plan for 2004-2005-2006 is still being elaborated.

- DFID has pledged around USD 1.6 mill for 2004 and the same amount for 2005.
- Ireland has pledged

² MISAU operational plan 2003, version 2 (February 2003)

- The Netherlands has pledged approx. USD 1 million for 2004 and an equal amount or more for 2005.

USAid has not indicated any participation in the general common fund (or any of the two other funds), and the present engagement does not prove promising in any change of attitude in this regard. Most of the support from USAid is operated directly from their office in Maputo, with a huge number of subcontracts administered by USAid. However, they do participate in the regular co-ordination mechanisms even in those where they do not contribute financially. And at this point that is judged as the most important issue.

As the proposed fund (FC-General) is to a great extent a central fund (although will include investments programs/projects) it is not expected that all donors will participate with funding. The important issue here is to have the support and participation from all donors for the overall planning and budget process, which will allow for a prioritisation of activities according to available resources. However, it is expected that over time, the agencies providing funding to central level use the FC-G as the main financing mechanism.

4. The flow of funds, administrative and financial procedures.

The Planning and co-operation department (DPC) is responsible for the process surrounding the annual plan and budget. Approval of annual plan and budget is done in the GT-SWAp/CCS. The administrative set-up for the FC-G is presently being discussed between the stakeholders, and there are strong incentives to build upon existing well-established platform for dialogue.

The interim financial mechanism is attached to a software developed at DPC, able to transfer information from both individual external funds, as well as a cost item based structure of statebudget resources into a list of costed activities.

The assessment done by Sjølander³ point to the need for more sophisticated system, featuring double entry accounting. Although, the interim financial mechanism is assessed as satisfactory at the present stage, new funds like the World Bank/MAP and PRSC, the Global Health fund for HIV/Aids, Malaria and Tuberculosis and the Bill Clinton Initiative will put additional pressure on the Ministry of Health. The interim financial management system will allow for more time to further explore which system the intended hard- and software applications compatible with the SISTAFE requirements.

The Ministry of Health has requested Norway to hire a consultant to assist in the discussions on an appropriate future system and map out the necessary steps to get this going, in order to increase capacity, purchase software and employ the necessary technical assistance. The consultancy will take place during May. The Ministry will after that use 6-9 months for the purchase of systems, training, employing technical assistance and get the system going. It is expected to be in operation as of early 2004. There is a general perception among the donors that the Ministry is making a huge effort in this regard, and has done a lot of thinking around the issue. A financial

³ "The relevance and Possibilities of an introduction of a general common fund at the Ministry of Health" (April/May 2002).

management group has been established within the Ministry with participants from all cost centres today handling funds, to draw on the existing knowledge and experience and co-ordinate all activities.

Representatives from all departments within the Ministry of Health, donors and multilaterals and representatives from the civil society meet every second week in GT-SWAp. Formally the permanent secretary chairs this meeting, but in practice the National Director for Planning and Co-operation is chairing that meeting.

Two times a year an extended GT-SWAp (CCS- Co-ordination Council for the Health Sector) is held (June/November) chaired by the Minister of Health. When there is a need for it the minister will chair extra GT-SWAp meetings.

There will be one common planning process, but for some time a number of different financial mechanisms. It is therefore important that all donors, also those that do not participate with funding to FC-G be part of the discussions around the annual plan and budget. In this regard it is important to underline that the establishment of the FC-G and the common framework (plan and budget) have the support of all donors.

When SDC is not channelling funding through FC-G, that does not mean they do not agree with the set-up, but that they limit their *financial* contributions to the two other pools, but participate in the general discussion. There have been several discussions regarding dialogue without funding, and there is broad understanding that there is a need to keep all stakeholders within the common framework and encourage a dialogue including all partners.

In relation to the FC-G the risks involved are mainly connected to the availability of funds in treasury. As the money will be deposited in a forex account the "rules" to be determined in dialogue with MPF should put a maximum time for transfer of funds from Ministry of Planning and Finance to the Ministry of Health. There has been put attention to the fiduciary risks related to provide funding directly through Treasury using the existing public management procedures. To reduce the risks involved the management of the FC-G will differ from the present management of the statebudget. This goes particularly in relation to the

- The question on the frequency of transfer. The public financial management system now uses what is called "duodecimo" (2/12), and transfers 2/12 of the budget, and only releases the next tranche when the accounts for the first transfer have been returned.
- Difficulties in relating expenditures to budget, and activities.
- In the state system 10% of the funds are retained, and
- at the end of the year the remaining funds are returned to treasury.

The opening of a special account in the name of MPF for the Ministry of Health will in addition secure that the health authorities receive the funds intended for health activities.

For the set-up proposed for FC-G, the particularities of transfers will be discussed during the next months, with emphasis on avoiding the abovementioned limitations in the execution of the statebudget. The new financial management law will when

implemented, take the above into consideration, and deal with these issues in a different manner.

- After consultations with the Ministry of Planning and Finance (MPF) and the Ministry of Health (MISAU), the first transfer will be to the bank account connected to the existing FC-PESS (established for the financing of the elaboration of the Health Sector Strategy) in the Ministry of Health. The management of the funds will follow the already established guidelines and accounting model for that mechanism, which is an off-budget mechanism. The Financial and Administrative department of the ministry (DAG) will administer the fund. The fund will be audited by an independent auditing firm, together with all other external funds to the Ministry (which has been taken place during the last 7 years). A dialogue has been started to connect the Tribunal Administrativo to the audit of the common fund.
- By May/June the draft guidelines for the Common Fund for the handling of the funds will be ready for the on-budget mechanism. In June/July the procurement rules will be ready. The legal department in Oslo will be consulted for advice during the process of elaboration.
- By Mid-May a draft for the revised Code of Conduct "Health Sector Co-operation Framework" will be ready. A working group consisting of representatives from the Ministries of Health, Planning and Finance, UN agencies and donors has been established for the drafting of this. Norway is part of the working group, and will contribute to the work in close co-operation with the legal department in NORAD. The intention behind the revision of the CoC⁴ is the need to "collect" all partners, including the NGOs, which were not part of the CoC from 2000, and to refer to the common framework (annual prioritised and costed plan and budget), and the platform for dialogue.
- By 1. July 2003 the Ministry of Planning and Finance and the Ministry of Health will have completed all necessary arrangements for the opening a forex account in the treasury (along the lines of the sector programme for Education and Agriculture). The funds will be transferred from the FOREX account to DAG, who will transfer the funds to a number defined cost centres in the Ministry, and as such using the existing capacity and knowledge of financial management. When the new financial management software is in place early 2004 and the technical capacity to run it is up and going, DAG will be in the position of administering all external funds to the Ministry.

Both DFID and Ireland have provided funds to the FC-PESS for the interim solution and will also do that for 2004 and 2005. Remaining/unused funds from Norwegian support to MOZ 0003 Communicable diseases (PNI/DT), and the remaining funds other donors for the elaboration of the Health strategy, will be channelled to be used for the interim period of financing the annual plan of operation (first half year of 2003). The reason for doing this is because of the need for more time for the practical arrangements, and in order not to stop ongoing activities.

⁴ Code of Conduct

The World Bank has opted for continuing using the project unit established for the World Bank Recovery Programme in the early nineties (GACOPI) for its new credit for HIV/AIDS (MAP). The bank has, however, stated their willingness to consider the use of FC-G once it is up and running, but in order not to lose time and to be able to start the funding immediately opted for continued use of GACOPI.

The discussions around PRSC and the consequences and resources for the health sector will initiate during the spring of 2003. This process will be accompanied closely.

Joint Audits of all external funds have taken place in the health sector since 1995 and this will continue and include the FC-G. Also with the joint audits special works are ordered every year, in which critical elements are more closely assessed.

So far the internal audit (IGF) of the Ministry of Planning and Finance, has had a certain role in the audit of both the two existing pools (MOZ 004/MOZ 005).

However, as the IGF has no mandate to issue an opinion an independent audit must take place. Together with other donors the embassy has initiated a dialogue with Tribunal Administrativa (TA) to discuss and agree on an (increased) involvement by the TA in such an audit, either alone or in co-operation with an international recognised auditing firm

5 Risk assessment

5.1 Capacity constrains

It is quite clear that although there are a considerable amount of technical assistance in the Ministry of Health, the capacity within the ministry continue to be weak. A number of donors have initiated programs aiming at increasing the capacity. The Sjølander report from April/May 2002 point at DAG to be the weakest point in the ministry. These is a result of decades of parallel set-ups in relation to planning, budgeting, monitoring and reporting set-ups, and as such proof of fragmented donorsupport. The Ministry of Health has elaborated a "Need for Technical Assistance for 2003", which concentrates on accounting, planning/budgetting and administration of central and provincial hospitals. Funding for this will be taken from the FC-G and be integrated into the annual plan and budget. The impact of HIV/Aids epidemic will also hit the bureaucrats at the ministerial level and should be taken into consideration, both in relation to the present workforce and to any increase in staffing.

USAID started a 2-year program mid 2002 to increase the capacity within DAG, and has a team inside the ministry for this purpose. The program also aims at strengthening the provincial capacity and technical assistance has been posted in almost all provinces. European Union has a programmed support for DPC, and other programs are running within the Human Resources department. A study initiated by the Ministry of Health is underway to map out the present support within the area of technical assistance, to analyse if the available TA is the most appropriate and situated where it is most needed with the necessary knowledge.

An improved overview of the available resources will also contribute to a better focus on where the needs for TA are. Similar attention will be given to improved capacity at provincial and district level through the FC-Provinces (MOZ 0005).

The reforms in the public sector include a civil service reform and salary reform. However, the salaryreform is put on a hold until all prioritysectors have carried out a

functional analysis. This is now taking place. Only when that is done will the discussions around the salaries continue. It is though quite obvious, that under no circumstances will the reform be able to catch up with the extremely high salary levels partly created by abundant donor funding, partly result of an extreme labour policy – which effectively make it very difficult to obtain qualified staff from neighbouring countries. Thus a small exclusive educated elite in Mozambique has been able to set salary levels far beyond reach of public sector in most parts of the world.

The process of elaboration of the draft annual plan and budget has taken considerable resources, and the progress shown from the Ministry is generally regarded as very positive.

It is important to assess the ongoing process not only in relation to an optimal solution, but also to look to what did exist and see the progress.

5.2 Procurement

There is an obvious need to further assess this issue, partly because the various donors have different requirements and because this is an area where the scope for grand corruption is obvious. Terms of Reference for a study in regard to both existing procedures and donor requirements have been elaborated and will take place during spring 2003. The World Bank report⁵ from 2001 concludes that the public procurement system does NOT fulfil any of the basic requirements for proper use of public funds, and needs to be substantially improved. There is no adequate legal and regulatory framework for procurement, no central directorate or tender board, presently used procurement public funds, and there is no code of Ethics, and a huge vacuum of professional expertise in public procurement. Improvements in this area are long-term, and it is therefore necessary to use interim solutions in relation to procurement. There has been and will continue to be close contact with the legal department (JUR) in NORAD for advice on content and process in relation to the study.

5.3 Financial mechanism – the flow of funds

- The weak public financial management system and the expected delays in implementation of SISTAFE, the situation regarding all public procurement, the scarce number of qualified human resources, and the need to reduce the scope for corruption at all levels, are all risks that may influence negatively the outcome of investments in the health sector. There is a need to work jointly with improvements in all these areas, while focusing on what at the end of the day is the outcome and impact of financial support to the health sector.
- One risk not directly related to the establishment of the FC-G, is the integration of the two already existing pools for Drugs and Budget support to the Provinces, into the common framework of planning and budget. Work in this regard progressed. However, knowing the importance of the two common funds in relation to the delivery of health services, there is an urgent need to secure the transfer of the administration of the funds from SDC to the Ministry of Health. This is an issue, which to a much larger extent must be dealt with seriously by the Ministry of

⁵ Country Procurement Assessment report Volume 1, Summary of findings and recommendations, March 2002

Health during the course of the year. It is a critical factor for obtaining the expected outcome and impact of all investments. SDC has made it clear that they will not administer these funds after 31.12.03. Technical assistance to enable the ministry to undertake the management of these two common funds will be made available mainly through the General Common Fund.

- Vertical initiatives pose a risk to undermine the efforts aiming at the strengthening of health systems. The vertical initiatives have drain resources away from medium- to long-term planning. The establishment of a strong common framework for planning and budgeting, will facilitate the integration of these and future vertical initiatives.
- Liquidity problems have always existed in the Ministry of Planning and Finance (MPF). Experience from the last years shows that there are risks involved in providing the aid through the treasury of MPF, as there could be serious delays in relation to the transfer of funds to the Ministry of Health. . However, this could to a certain degree be prevented by giving a maximum time for MPF from the time of a exchange of the hard currency to the actual transfer to the Ministry of Health take place. Another issue is that as the total spending in the health sector become more transparent, the government may choose to allocate less funds to the sector. Having said that - the various global initiatives may result in a sharp increase in public spending in the health sector, which could create unwanted effect and result in a decrease in government contribution to the sector.
- Capacity to handle funds within the Financial and Administrative Department (DAG) is limited, and it is important to carefully monitor the USAid supported activities, and to assist DAG with technical support necessary to carry out the task. Costs related to this will be taken from the FC-G, and the interim period up to July will be used to hire necessary basic staff.

6. Conclusions

- The elaboration of a draft proposal for an annual plan and budget, prioritising programs and activities, showing the various sources of finance *is a great step forward*. For the first time the total financial picture is presented in a readable and understandable manner. The gains from the establishment of a common fund will be more health for the money. Although there are issues that still merits further discussions it is viewed as necessary to compare what has now been achieved through this process - to what existed (one year ago, not to say five years ago).
- There are genuine interest by all major donors in providing financial support to the health sector through a common fund, such as DFID, Ireland, Netherlands, Denmark, Finland, France, European Union, SDC/Switzerland,
- The change from a project modus to a program approach has not been easy. There are forces within the Ministry of Health, which oppose the changes. The common denominator of those who oppose this is that they have something to loose namely the direct control of the funds. This attitude has certain legitimacy – as the closer you are to the funds the easier is the access. The scepticism is also

related to concrete experience with the state budget and the "normal" channel of funds, which has severe weaknesses.

- But there are also other reasons which are more based on a resistance to the increased transparency, which will be the result of a more comprehensive planning, and budget process. One touchy issue in this regard is the various topping up schemes for salaries, costs related to training and participation in seminars, which will be visible, transparent and subject for a broader scrutiny.
- It is not expected that all donors need to agree 100% with all aspects of the presented annual plan and budget, but what is important is that the Ministry through a participatory process within the Ministry has elaborated this plan, and consultations with stakeholders have been held.
- A question that has been asked frequently is "how bad can the plan be?" "How much do we have to agree with the priorities?" before we finance it. The answer is probably that if it is considered as a progress moving in the right directions, maybe through different paths than some of us would have wanted it is a reasonable plan it deserves support. Then the challenge is to continue the dialogue on issues where the plan can be improved and secure that there is an environment and organisational set-up that secures such a dialogue.
- The performance of the health sector will be assessed through a joint annual review, using the national list of indicators, which will be subject for discussion with other partners and the Ministry of Health in the preparations of the annual review. Norway could consider following the performance of programs that have received Norwegian support, such as the tuberculosis particularly and the National Integrated Program for Communicable diseases, the Reproductive Health or the development of the Health Information System.
- As donors pool funds and work more closely together in the planning and budgeting it appears also that the resource base of each donor become more available. Today there is a certain division of labour among some donors in relation to providing technical backstopping. Norway has the last year been involved in discussions and assessment around the communicable diseases program, the public financial management systems, civil society, procurement, corruption and the global initiatives (particularly the GFATM). Very often the actual "distribution of labour" reflects a certain division of burden. It depends very much to what extent we are proactive (and have the time to be so!), possess knowledge and experience, are flexible and quick, do have people who can read/speak Portuguese etc, and of course also on other donors "needs" and wishes. At the end of the day it is a matter of dialogue and negotiations not only with the Ministry of Health but also within the donor community on whose technical knowledge and assistance that should be used.
- A Memorandum of Understanding regarding the establishment of FC-G, which together with guidelines for the management of the fund will lie out the organisational set-up, the financial mechanism, accounting and auditing, will be signed in June. The MoU will be subject for an assessment by the legal office in NORAD that has already been involved in the preliminary discussions around the

drafting of a MoU. The embassy will participate actively in the elaboration of the MoU using the knowledge and experience that the legal department has.

7. RECOMMENDATIONS

- It is recommended to approve financial support to the General Health Fund up to NOK 175 million for a 4-year period from 2003-2006.
- The first transfer of NOK 25 million will take place upon signing the agreement (April 2003).
- The second transfer of NOK 20 million will take place mid 2003 when the MoU is signed and the financial and administrative rules and regulations are defined together with the organisational set-up.
- As a basis for the second transfer the embassy will write a short summary/assessment to SAFR on the progress towards the final set-up.
- The embassy will continue to closely monitor the fund and participate actively in the dialogue on the common framework (annual plan and budget).
- The time for the third and subsequent transfers will be defined in close co-operation with the Ministry of Health, Ministry of Planning and Finance, and other donors and stakeholders. The transfers will take into consideration the budget cycle of Mozambique, and should happen before 1 July each year.
- The size of the annual transfers will be around NOK 44 million, however the amount transferred on a yearly basis must take into consideration other donors contributions, and be based on an actual spending pattern.

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