

**COUNTRY STRATEGY PAPER  
2016-2020**

FOR DEVELOPMENT COOPERATION

BETWEEN THE GOVERNMENT OF MOZAMBIQUE AND THE GOVERNMENT OF  
FLANDERS

*Strengthening the Health System in Mozambique...*

*... so that no Adolescent shall be left behind*



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## Abbreviations

<b>AC:</b>	General Consultation
<b>ACP-states:</b>	African, Caribbean and Pacific Group of States
<b>APE:</b>	Community health workers
<b>ARV:</b>	Antiretroviral Therapy
<b>ASRH:</b>	Adolescent Sexual and Reproductive Health
<b>CGE:</b>	General State Budget (Conta Geral do Estado)
<b>CNCS:</b>	National Aids-council
<b>CSP:</b>	Country Strategy Paper
<b>DAC:</b>	(OECD) Development Assistance Committee
<b>DFID:</b>	Department for International Development
<b>DiV:</b>	Flanders Department of Foreign Affairs
<b>DoL:</b>	Division of Labour
<b>EITI:</b>	Extractive Industries Transparency Initiative
<b>EU:</b>	European Union
<b>FASE:</b>	Education Sector Support Programme
<b>FDC:</b>	Flemish Development Cooperation
<b>FDFFAA:</b>	Flanders Department of Foreign Affairs
<b>FRELIMO:</b>	Liberation Front of Mozambique
<b>GB:</b>	Special Programme for the Next Generation
<b>GCCC:</b>	Central Office for Combating Corruption
<b>GDI:</b>	Gender-related Development Index
<b>GFATM:</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>GGHE:</b>	Global Government Expenditure on Health
<b>GNP:</b>	Gross National Product
<b>HDI:</b>	Human Development Index
<b>HIV/AIDS:</b>	Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome
<b>HPI:</b>	Human Poverty Index
<b>HRH:</b>	Human Resources for Health
<b>ICRH:</b>	International Centre for Reproductive Health, Ghent
<b>IHP+:</b>	International Health Partnership
<b>INS:</b>	National Health Institute
<b>IOR-ARC:</b>	Indian Ocean Rim Association for Regional Cooperation
<b>ITG:</b>	Institute of Tropical Medicine, Antwerp
<b>MAP:</b>	Multi-Country HIV/AIDS Programme – World Bank
<b>MDG:</b>	Millennium Development Goals
<b>MDM:</b>	Democratic Movement of Mozambique
<b>MINEC:</b>	Ministry for Foreign Affairs and Development Cooperation

<b>MINED:</b>	Ministry of Education
<b>MISAU/MoH:</b>	Ministry of Health
<b>MJD:</b>	Ministry of Youth and Sports
<b>MoH:</b>	Ministry of Health
<b>MoU:</b>	Memorandum of Understanding
<b>MTR:</b>	Mid-Term Review
<b>NAIMA+:</b>	Network of NGOs Working in Health and HIV/AIDS in Mozambique
<b>NAPA:</b>	National Adaptation (to climate change) Programme of Action
<b>ODA:</b>	Official Development Assistance
<b>ODAmoz:</b>	Official Development Assistance to Mozambique Database
<b>OECD:</b>	Organisation for Economic Cooperation and Development
<b>PAF:</b>	Performance Assessment Framework
<b>PARP:</b>	Action Plan for the Reduction of Poverty
<b>PARPA:</b>	Action Plan for the Reduction of Absolute Poverty
<b>PEPFAR:</b>	President's Emergency Plan for AIDS Relief
<b>PESS:</b>	Health Sector Strategic Plan
<b>PMTCT:</b>	Preventing Mother-to-Child Transmission
<b>PRISE:</b>	Integrated Road Sector Programme
<b>PROAGRI:</b>	National Agricultural Development Programme
<b>PROSAUDE:</b>	Health Sector Common Fund Project
<b>RENAMO:</b>	Mozambican National Resistance
<b>REO:</b>	Report of Budget Execution (Relatório de Execução do Orçamento)
<b>RHR:</b>	Department of Reproductive Health and Research
<b>SADC:</b>	Southern Africa Development Community
<b>SDA:</b>	Sustainable Development Agenda
<b>SISTAFE:</b>	Public Financial Management Reform
<b>SME:</b>	Small and Medium-Sized Enterprises
<b>SRHR:</b>	Sexual and Reproductive Health and Rights
<b>SWAp:</b>	Sector-Wide Approach here used as synonym for Health Sector Common Fund
<b>TB:</b>	Tuberculosis
<b>THE:</b>	Total Health Expenditure
<b>TIFA:</b>	Trade and Investment Framework Agreement
<b>UN:</b>	United Nations
<b>UNAIDS:</b>	Joint United Nations Programme on HIV/AIDS
<b>UNICEF:</b>	United Nations Children's Fund
<b>WHO:</b>	World Health Organisation
<b>WTO:</b>	World Trade Organisation

# 1 Introduction to the Third Country Strategy Paper

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With the third CSP the Government of Flanders and of Mozambique are, to a big extent, opting for continuity in their development cooperation. The health sector will remain at the heart of our cooperation with overall Health System Strengthening (HSS) as our central concern and ambition. However, wherever relevant, an additional focus will be placed on service provision and accountability towards the realization of the right to the highest attainable standard of health of adolescents (10-19 years old), with special attention for adolescent girls. This focus is inspired by:

1. **Policy of the GoM** as defined through its Strategic Plan for the Health Sector, 2014-2019 (PESS) and the Programme for Adolescent (Sexual and Reproductive) Health (ASRH);
2. **A gaps analysis** of overall service provision in the health sector for specific groups of the Mozambican population, amongst whom adolescents figure prominently, and the resulting negative health-impact on adolescents<sup>1</sup>;
3. The **proportion of children and adolescents** in the overall Mozambican population;
4. The special emphasis placed on due attention for the **unmet needs of young people** in the 2030 SDA.

The title given to this CSP, namely: “Strengthening the Health System in Mozambique, so that no Adolescent shall be left behind” is already hinting towards particular elements for adding this additional focus that both partners will introduce in their common efforts to pursue their overarching goal: **the overall strengthening of the health sector**:

1. **Service delivery**: focus on accessibility of services by adolescents, removing physical, cultural and emotional barriers in provision of promotional, preventive as well as curative services;
2. **Health workforce**: responsiveness to special needs/approach of adolescents by all members of the health workforce from a quality of care perspective
3. **Health information systems**: special emphasis will, wherever relevant and/or feasible, be placed on the importance of the collection of age and sex disaggregated data at the level of adolescents (10-19 years, preferably to be divided into 10-14 and 15-19 years cohorts, following WHO definitions), to inform on specific health status and gaps in service delivery for adolescents and to develop evidence based approaches towards both age –groups
4. **Access to essential medicines**: removing financial and non-financial barriers to access to essential medicines (e.g. parental consent) and provision of best/adapted regimens/formulae, where relevant
5. **Financing**: through PROSAUDE (non-earmarked!), direct provincial support after positive assessment and through specific projects/programmes
6. **Leadership/governance**: sufficient attention is given to the special needs and approaches of adolescents during policy dialogue and within policy documents and strategies on health issued by MISAU, the Governor of Tete, the DPS, and the districts. Oversight by local NGO’s will be supported.

The main reference remains, of course, the policy documents and dedicated programming of the Mozambican Government in this area, such as:

- *Plano Quinquenal do Governo*, PQG, 2015-19
- Strategic plan for the Health Sector, PESS 2014-19;
- HIV Strategic plan, PEN IV (2015-19);
- Special Programme for Adolescent (Sexual and Reproductive) Health.

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<sup>1</sup> For instance, the use of modern methods of contraception falls back to 5.9 % in the category of 15-19-aged married women from 11,3% in the overall category of married women of reproductive age. Among girls and young women between 15- 24 years hiv-prevalence is 13.2% as compared to an overall prevalence of 11.5 %, which indicates that Mozambican women to a considerable extent get infected early in life, while girls are particularly vulnerable to hiv-infection (CNCS, Global AIDS Response Progress Report, GARPR, Country Progress Report Mozambique, 2014, table 2, p. 21.).

The PESS establishes a focus on the children and adolescents where it states in the summary of problems and priorities of the health sector:

*This (health-)profile establishes the need to concentrate the means of the system in interventions of health promotion and prevention of illnesses, **with a focus on children and adolescents** and in the reduction of geographical, socio-economic and gender-based inequities.<sup>2</sup>*

Other inspirations will be provided by specialized multilateral organizations such as UNFPA through its report: “*O Poder de 8 Milhões, Adolescentes e Jovens Moçambicanos na Transformação do Futuro*” of 2014<sup>3</sup>, and WHO in its “Health for the world’s Adolescents-guidance” that defines four core areas for health sector action towards adolescents:

1. Providing health services;
2. Collecting and using the data needed to plan and monitor health sector interventions;
3. Developing and implementing health-promoting and health-protecting policies;
4. Mobilizing and supporting other sectors<sup>4</sup>.

Another new element that will have to be taken on board is the fact that both partners recognize that they find themselves in a phase of transitioning from an agenda based exclusively on the Millennium Development Goals (MDG) towards an agenda and modus operandi inspired by the sustainable development goals and targets (SDG), such as defined by the “*2030 Agenda for Sustainable Development (2030 SDA)*”<sup>5</sup>. This supposes i.a.:

1. Active looking for interlinkages with work in other sectors/ towards other goals (e.g. education, gender etc.);
2. An emphasis on youth as one of the most vulnerable population groups vis a vis various development challenges;
3. Supporting all levels, including the local level and the individual citizen to be able to reach the most vulnerable/deprived;
4. Working towards a data revolution, including disaggregation and other quality issues, that will equip policy-makers with the right tools to design, implement and adapt their sustainable development agenda;
5. An alignment with the goals, targets and indicators of this global framework, also inspired by the national strategy of Mozambique to implement the agenda.

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<sup>2</sup> PESS, 2014-19, p. 32: «Este perfil ressalta a necessidade de concentrar os recursos do sistema em intervenções de promoção de saúde e prevenção das doenças, com enfoque na população infanto-juvenil e na redução das iniquidades geográficas, socioeconómicas e de género.»

<sup>3</sup> <http://countryoffice.unfpa.org/mozambique/drive/UNFPASuplemento2014LowRes.pdf>

<sup>4</sup> [http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/second-decade/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/second-decade/en/)

<sup>5</sup> <https://sustainabledevelopment.un.org/post2015/transformingourworld>

## 2 Context Analysis: Mozambique in 2015

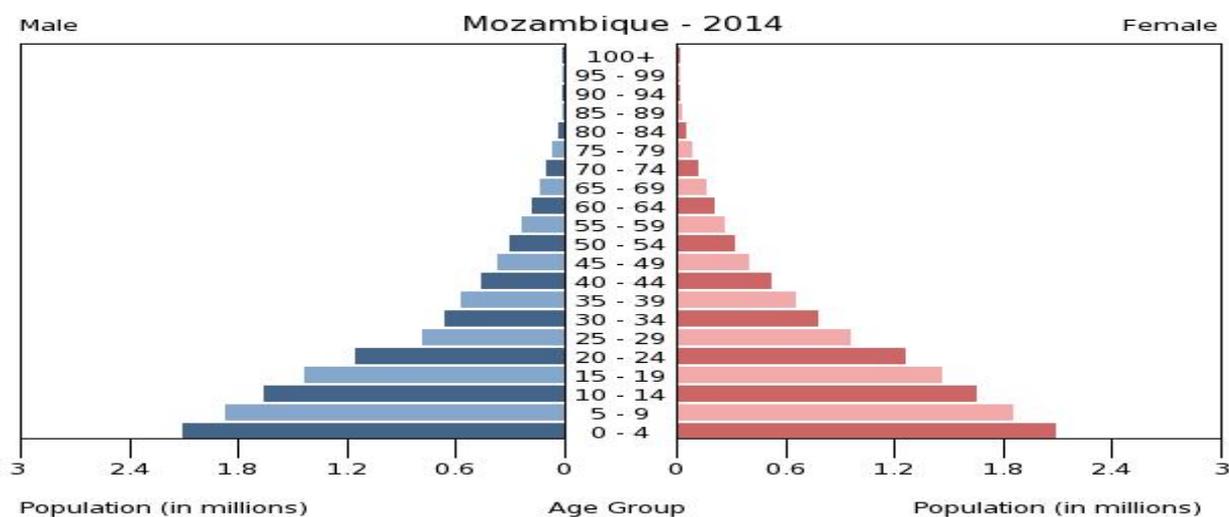
### 2.1 HUMAN GEOGRAPHY



The population in Mozambique is now estimated at slightly more than 25 million inhabitants. While almost half of them are between 0 and 14 years old, slightly more than two thirds are between 0-24 years old. The average age is 17 years. The population growth figure is 2.45 % *per annum (p.a.)*. Population growth is still comparatively high. With an increase of about 2.4% p.a. there will be an estimated 29 million people living in the country by 2019.

**Table 1: Actual age structure of Mozambique\***

Age-cohort	%	Male absolute nr. est.	Female absolute nr. est.
0-14 years	45.13%	5,740,743	5,677,563
15-24 years	21.43%	2,657,099	2,764,109
25-54 years	27.09%	3,201,321	3,654,012
55-64 years	3.44%	415,357	455,450
65 years +	2.91%	338,552	398,907



\*<https://www.cia.gov/library/publications/the-world-factbook/geos/mz.html>

These figures point to the fact that currently almost half of the Mozambican population is younger than 14 years old, while more than one fifth belong to the 15-24 years age-cohort. In the upcoming five years a lot of young Mozambicans will enter the adolescent phase of their lives and Mozambique will have to be able to cater for the increased specific social (including health) and economic needs that are characteristic for this age group. More in general, at least 37% of the Mozambicans live in urban environments, while the remaining 63% reside in often difficult to reach rural areas. The most important cities are: Maputo-city (est. 1.226.000), Matola (est. 893.000), Nampula (est. 606.000) and Beira (est. 460.000). Almost two-thirds of the population inhabit the coastal areas (120 persons/sq km compared to a national average of 25 persons per sq km). The country is characterised by ethnic diversity (Changanan/Tsonga, Makua/Lomwe, Sena, Ndaou and others). The languages spoken there include Portuguese (official language), Emakua, Elomwe, Chisena, Chindau, and Echwabo and they have many ties with languages in the neighbouring countries. About 99% of the Mozambican population are African. Only 0.1% are of European, while 0.5% are of Indian descent<sup>6</sup>.

## 2.2 RECENT POLITICAL CONTEXT AND EVOLUTION

Mozambique has a presidential political system that recognises the principle of separation and interdependence of powers between the executive, legislative and judicial branches. The President is the head of government and of the executive branch. The parliament consists of 250 elected representatives and is the highest legislative body in the Republic of Mozambique. The judicial branch is in its turn chaired by judges (Supreme Court, Administrative Court and lower courts). In 2014, the fifth general elections (presidential, parliamentary and provincial elections) resulted in the election of President Felipe Nyusi with 57.3% of the votes, against 36.6% for the RENAMO leader, Afonso Dlakama. Daviz Simango, of the more recent *Movimento Democrático de Moçambique* (MDM), became third, winning 6.4% of the votes. The same elections gave FRELIMO 144 representatives in Parliament, whereas RENAMO and MDM conquered 89 and 17 seats respectively. During the last local elections of 2013, though, MDM had triumphed in Beira, Quelimane and Nampula, remaining just a fraction of the votes short to also win the vote in Maputo-city. It should be noted that in these elections, FRELIMO won in 50 of the 53 cities and villages.

As regards the application of human rights, most freedoms of the citizens are formally recognized in Mozambique. More recently the law penalizing same sex relationships was lifted while the law on abortion was reformed. However, the lack of, for instance, sufficient financial and human resources, impedes the actual promotion and protection of human rights and violations do occur sporadically.

## 2.3 ECONOMIC SITUATION

Already over the last decade and a half now, the Mozambican economy is producing strong growth figures, averaging 8 per cent annually. This trend is projected to be sustained in the following years, resulting in a 7.5

<sup>6</sup> Demographic data are compiled from, MISAU, MISAU, Plano Estratégico do Sector da Saúde, 2014-2019, p.6 [http://www.indexmundi.com/mozambique/demographics\\_profile.html](http://www.indexmundi.com/mozambique/demographics_profile.html).

% growth for 2015 and 7% for 2016<sup>7</sup>. This growth is mainly driven by foreign direct investment in the natural resource sector for fossil fuels, mainly coal and gas. However, due to a lesser demand for coal at the global marketplace, the further development of coal plants is severely threatened, while existing ones are cutting down on production or even close operations. Also the weakened price for aluminium, also one of Mozambicans most important sources of foreign revenue, gives cause for concern. It is now mainly up to the development of the enormous gas reserves in the Rovuma Basin to support further growth in Mozambique.

The overall positive growth-figures conceal the ongoing problem of economic diversification of the Mozambican economic base, a problem that, since long, has been recognized by the GoM. As a result thereof Mozambique still showed a trade deficit of 4035,2 million US \$ in 2014. Consecutive high fiscal deficits, reaching 10 % of GDP in 2014, have pushed public debt to 56.8% of GDP. A danger of mineral-resource dependence with its expected negative impact on social and political stability is already looming and should be avoided. At the same time a decrease in donor budgetary funding is most likely. For all of these reasons the GoM is expected to take the path of fiscal consolidation for 2015 and 2016 while continuing its efforts to increase its domestic resource mobilization (23% of GDP in 2012). Also Mozambique might be looking to increase its demands for non-to-semi-concessional loans from the IMF, diversifying its financing sources away from the more traditional concessional loans and grants from development partners<sup>8</sup>.

## 2.4 SOCIAL SITUATION: SIGNIFICANT PROGRESS BUT EVEN GREATER CHALLENGES...

### 2.4.1 Progress

Thanks to the relatively healthy economic situation and a policy of centralising general human development, Mozambique can boast good progress on the human development index in the long run. As such the country has been able to make up for part of the setback in the field of literacy, education level, average income and average life expectancy of its population. More specifically, Mozambique has made convincing progress in improving the general state of health of its population. A retrospective analysis covering a sufficient period and focussed on the MDG health goals immediately allows for an accurate assessment of what has been realised:

Progress towards accomplishing the health-related MDGs in Mozambique <sup>9</sup>								
MDG-related indicator	1990	1995	2000	2009	2014	1990 /2000-2014		
						Absol	%	
Complete vaccination received by children ≤ 1yr	59%	61%	71%	77%	82%	n.a.	+ 23 %	
Infant mortality rate to 1,000 children born alive	158	147	124	90	62	- 96	- 61 %	
Knowledge on HIV								
• Male 15-24	n.a.	n.a.	32.8	35.1	51.8	n.a.	+ 19 %	
• Female 15-24	n.a.	n.a.	20	36.7	30.2	n.a.	+ 10.2	
ART-coverage								
• Adult ART-coverage	n.a.	n.a.	3%	52%	62.8%	n.a.	+ 59.8	
• Paediatric ART-coverage	n.a.	n.a.	0%	20%	36%	n.a.	+ 36%	
Contraceptive prevalence rate	n.a.	5.1%	17%	13.9%	11.6%	n.a.	+ 6.5%	
Births under guidance of medical personnel (%)	No data	42.2	47.7	55	71%	n.a.	+ 28.8%	
Maternal mortality rate to 100,000 children born alive	1500	1000	660	520	408	- 1092	- 73 %	

<sup>7</sup> [http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2015/CN\\_data/CN\\_Long\\_EN/Mozambique\\_GB\\_2015.pdf](http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2015/CN_data/CN_Long_EN/Mozambique_GB_2015.pdf)

<sup>8</sup> In 2012 still 21.3% of the state's budget was financed through such grants. See: F. Vollmer, Mozambique's Economic Transformation, Are efforts to streamline the fragmented aid landscape undermined for good?, in : German Development Institute Discussion Paper 12/2013, p.6.

<sup>9</sup> Numbers based on: MoH, *Matriz de Desempenho do Sector Saúde 2009 & Idem, 2014*; WHO, *WHO country cooperation strategy, 2009-2013, Mozambique*, 2009, p. 9, [http://www.unaids.org/sites/default/files/country/documents/MOZ\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/MOZ_narrative_report_2014.pdf), pp47-48, & WHO, *World Health Statistics, 2010, passim*.

## **2.4.2 Overall challenges**

Notwithstanding such progress, the structural challenges at the social level remain considerable and pose a threat to the internal social stability of the country. The third and last big census on poverty in the country indicated that the progress realized nationwide in fighting structural poverty in the first decade after the peace agreement started stalling during the last decade, while inequality augmented to a score of 45,7 on the Gini-coefficient in 2013<sup>10</sup>. In the area of human development Mozambique globally still only ranks no. 178 on the list of 187 weighted countries of 2014. With a per capita income of 1011 weighted dollars; an overall life expectancy at birth of 53.1 years; only 3.2 as the value for mean years of schooling and an overall resulting score of 0.393 on the Human Development Index there is still ample room for improvement<sup>11</sup>. Also according to the Multidimensional Poverty Index MPI that combines values of specific indicators from both social sectors and income as an alternative for mere income figures, Mozambique still counts with almost 17.250.000 socially and economically deprived people<sup>12</sup>. Converting the impressive and continuing macroeconomic growth into social progress for all Mozambicans thus remains a huge challenge not only for the Mozambican government, but also for private players and the development partners.

At the same time, inequality translates into many areas. Aside from normal general differences in income, there are dissimilarities between regions, between and even within provinces, between the rural<sup>13</sup> and urban population, while there is downright inequality between men and women. Mozambique occupies the 146<sup>th</sup> position in a ranking of 151 countries that provided data for the Gender-related Development Index (GDI, 0,657) in 2014<sup>14</sup>. Much progress is therefore still to be achieved in the social sectors 'education' and 'health' to render services more efficient, more effective and more inclusive for large groups of poorer Mozambicans.

## **2.4.3 Specific challenges in the Health Sector**

Despite the historic progress that has already been documented, the health sector in particular still faces many structural challenges. A closer inspection of the general health indicator scores immediately reveals the relatively low life expectancy; the high prevalence of HIV/AIDS combined with a relatively high number of patients who still seek access to treatment; the large number of patients with tuberculosis and deaths caused by malaria; the very limited use of modern contraception; the acute need for medical personnel at all different levels and the highly precarious situation in the field of access to safe sanitary facilities, certainly at the country side. For matters of consistency and to remain sufficiently concise, the further analysis of health sector constraints will limit itself mainly to those issues that are reflective of the problems in health this CSP is looking to address specifically. Special attention will also be given to social determinants that further determine the severity of the problem, analyzed for certain social groups.

The challenges in the area of SRHR and the resulting adverse health impacts for especially (young) women remain considerable. The use of modern methods of contraception<sup>15</sup> is about 30% for women in the richest quintile and about only 3 % among women from the poorest quintile, indicating a regression from 2003 figures<sup>16</sup>. Also there is a big discrepancy in prevalence of modern contraception methods according to age: while for all married women of reproductive age it stands at 11.3%, it falls back to 5.9% for married women in the 15-19-age category. Also, the overall unmet need for modern contraceptives remains high at 22.3 %. The use of long-term methods of contraception such as intrauterine device and implants is even overall negligible. If all figures are combined, one can only conclude that modern methods of family planning are virtually absent in poor households with a young wife. This in a context with a high incidence of early marriage - 17.7% of girls are married before their 15<sup>th</sup> birthday – and in which a considerable proportion of female adolescents, namely 37.1%, are currently married or in union. Here again we find a big increase for women of the poorest quintile. Adolescent boys are less affected, since only 8.2 % of them are married. However, this indicates a considerable age-disparity between husbands and wives, creating a higher

<sup>10</sup> Terceira Avaliação Nacional da Pobreza, 2010, PESS 2014-19, p. 7 & <http://hdr.undp.org/en/content/income-gini-coefficient>

<sup>11</sup> <http://hdr.undp.org/en/content/table-1-human-development-index-and-its-components>

<sup>12</sup> UNDP, <http://hdr.undp.org/en/content/table-6-multidimensional-poverty-index-mpi> (MPI).

<sup>13</sup> <http://www.ruralpovertyportal.org/web/guest/country/statistics/tags/mozambique>

<sup>14</sup> <http://hdr.undp.org/en/content/table-4-gender-inequality-index>

<sup>15</sup> If not referenced otherwise, data on anticonception and fertility are derived from: PESS, 2014-19, p. 18 and MISAU, Avaliação Conjunta Annual do Desempenho do Sector de Saúde -2014, p.24.

<sup>16</sup> J.G. DIAS & I. TIAGO DE OLIVEIRA, Multilevel effects of Wealth on Women's Contraceptive Use in Mozambique, in: *PLoS ONE*, 10(3): e0121758, p. 2.

vulnerability of the young spouses to infection by hiv and/or other STI's and of higher fertility. All these factors combined contribute significantly to a high fertility rate of 5.3 and to too many early pregnancies and births. By the age of 18 40.2%, adolescent girls have already given birth, delivering 167 of every 1.000 reported births. This again goes accompanied with a high urban (141) and rural (183) disparity. Also, 51% of pregnant adolescents do not have any level of schooling, while those who have at least have reached secondary schooling only contribute with 26% to the early pregnancies. It goes without a doubt that such a high amount of early pregnancies and deliveries contribute significantly to an overall maternal mortality rate that is already for some years now plateauing at the far too high level of 408 for every 100.000 life-births. This while Mozambique should be enabled to reach the relevant target for the 2030 Sustainable Development Agenda, which is fixed at 70 maternal deaths. In conclusion, it will still require a lot of work before Mozambique will enter into its demographic transition and that all adolescents are protected from unhealthy and too often life-threatening early pregnancies. However, the fact that the number of potential users of contraceptives finding their way to the health facilities increased substantially from 13.9% in 2009 to 28% in 2014, brings first hopes that important results are possible from a middle term perspective.

Service delivery to pregnant women seems high at the first sight: 90% of pregnant women receive prenatal consultation. However, only 67% get their blood pressure measured and only 40% get their urine tested. 71% of all pregnant women deliver in a hospital facility, up from 44% in 1994. One should realize however that while 93% of women with a secondary level diploma deliver their babies in a hospital facility, only 40% of women without schooling give birth in such a context. During childbirth, 2-5 per 1000 delivering women still get an obstetric fistula, while 11.2% of still births are experienced by women who, while entering the maternity, carried a fetus with a heartbeat. This reveals serious issues of quality of care in the maternities.

At the same time, infrastructure needs further expansion and equipment, since the number of health posts that can provide emergency obstetric care is limited to only 2.2 per 500.000 people. Also, although post-partum care is already wide spread, in many cases it fails to be delivered during the first week after birth, the most important period for preventing neonatal mortality and avoiding complications after birth<sup>17</sup>. It should thus not come as a surprise that neonatal mortality is still high. Constituting up to 16% of the under-five child mortality (U5M), it goes down much slower than the overall U5MR. After all, specific strategies are required to lower it further, seen the fact that 81% occur in the first week and 32% even during the first day. Prematurity, asphyxia and neonatal sepsis contribute respectively with 35, 24 and 17% to this mortality. Malnutrition is the underlying cause of approximately 30% of U5M. Direct causes for maternal mortality are mainly rupture of the uterus (29%), severe bleeding (24%) and sepsis (17%) next to post abortion complications. At the same time, HIV and AIDS and malaria constitute with 54 and 40% respectively the most common indirect causes of MM, while anemia is also quite common in women of reproductive age (54%)<sup>18</sup>.

Concerning other issues of SRHR one can observe enormous increases in ARV-coverage, with almost 600.000 adults receiving ARV's now. However, the gap between people who are (and remain) on treatment and those who in fact need to be/remain on treatment is still considerable. This gap is even more pronounced for children and adolescents, and for the middle and the northern part of the country overall. At the same time hiv-incidence, certainly amongst adolescents girls, is not falling, while retention in care during and after pregnancy remains a challenge. Tb-hiv-coinfection is also rising - from 47% in 2007 to 63% in 2011 - while multi resistant TB had already increased to 1.500 cases in 2011. This made HIV, with an overall prevalence of 11,5 % in the 15-49 age group, responsible for 27 % of overall mortality in Mozambique in 2012. Cervical cancer screening and free medication and prevention programs for cervical cancer and cancer of the womb were recently integrated in the SRH-program of the Government. Malaria with 3.2 million reported cases in 2012 caused 29 % of overall mortality in Mozambique that year, mainly among pregnant women and children! Here, the health system is trying to bring intermittent treatment of pregnant women back to acceptable levels from an absolute low in the 2010-11 period (13.5%). Also, artemisinin-based combination treatment of children with fever fell back from 26% in 2008 to 15% in 2011<sup>19</sup>, while intermittent treatment of pregnant women also went back from almost 70% in 2009 to 44% in 2014<sup>20</sup>.

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<sup>17</sup> Analysis of the pre-, intra- and post-partum care is mainly based on PESS, 2014-19, pp. 17-19.

<sup>18</sup> PESS 2014-19, pp. 8-9

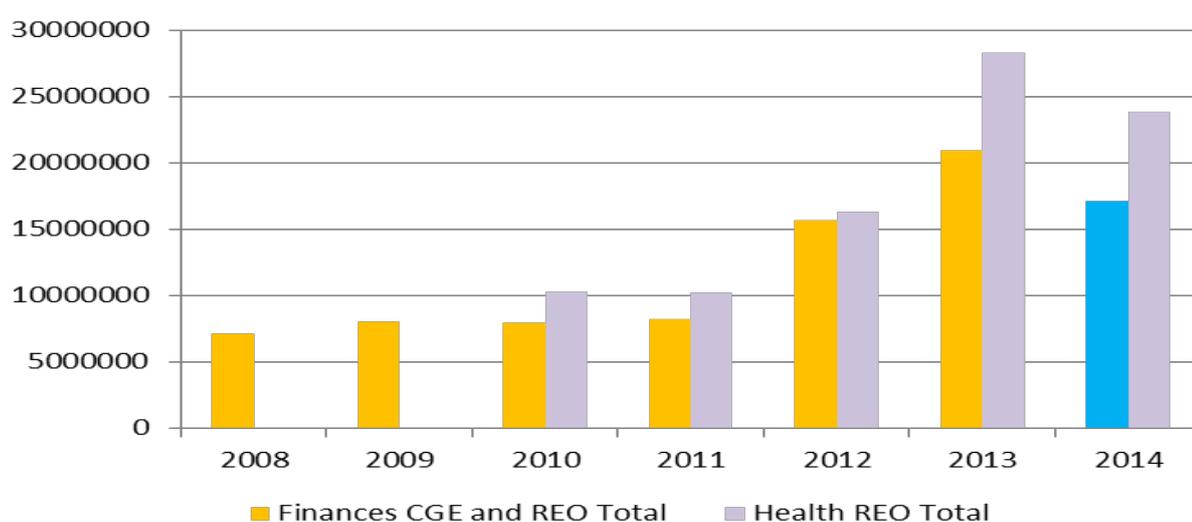
<sup>19</sup> Analysis in this alinea mainly based on PESS, 2014-19, pp. 20-21 and MISAU, Avaliação Conjunta Annual do Desempenho do Sector de Saúde -2014, pp. 29-39.

<sup>20</sup> MISAU, Avaliação Conjunta Annual do Desempenho do Sector de Saúde -2014, p. 33 & Figura 9.

In the area of HRH, Mozambique already made tremendous progress in general terms. Between 2000 and 2010 the country doubled available health personnel from 15.920 to 34.507 people. The current plan for training contributed to this remarkable result. It mainly focused on creating new education facilities and on post-graduate trainings for specific skills with special emphasis on mid-level professionals. Notwithstanding this progress, in 2014 Mozambique still counted only with 70.9 health personnel per 100.000 inhabitants<sup>21</sup>, far removed from the minimal 230 per 100.000 ratio as defined by WHO-guidelines. The further increase in health personnel will still have to overcome structural barriers, since endogenous growth is too slow, while retention of health staff in a very competitive environment with mostly the private (not for profit) sector remains an issue. This is even more so the case for the upper level professionals. The output of medical doctors from universities is still only around 200 doctors a year! Also in the areas of preventive medicine, nutrition and supporting services, the scarcity of well trained personnel remains huge. A lot more training of nurses and other health personnel through mainly technical and vocational training will have to be pursued, while the quality and comprehensiveness of their education will have to be raised significantly. At the same time the absorption capacity of the health system needs to be improved, since it stands at only 1.000-1.500 health personnel a year. The problems caused by the current strategy to solve part of this problem, namely to recruit a considerable part of this personnel out of the actual formalized system, *fora do quadro*, mainly financed through external funds, has already proven to cause serious instabilities within the sector.

Another important problem is the highly concentrated residence of the biggest part of the health personnel in and around the country's main population centers. Currently this is being tackled by a more obligatory spreading of personnel throughout the country. The very low levels from which many previously marginalized regions in the country have to start result in very slow process, though. The best indicator reflective of the depth of this problem is the distance to a first level health facility in the various provinces. In Tete this distance remains the biggest at 18 km, as compared to the average national distance of 14 km and to the lowest distance of 2 km in Maputo city. This also puts enormous pressures on the entire referral system, unable to work effectively in a context of such enormous scarcity at the primary level. Another strategy is based on increased task shifting to community-workers, the so called polyvalent community agents, or to self-organizing community groups. These are already engaged in activities in the area of ARV and FP. The MoH also build a strategy around the involvement of traditional medical practitioners strategy seen their wide spread presence, their position as persons of thrust in the community and their proven healing skills. For example, they are used as intermediaries for distributing anticonceptiva (condoms)<sup>22</sup>.

Concerning the challenges of financing the health sector, in 2013 ca. 40 US\$ per capita were spent on health in Mozambique. This is a serious increase from previous investment levels of 33 US\$ in 2012 and only 23 US\$ in 2010<sup>23</sup>. This is greatly due to the fact that the GoM decided to invest again a more substantial part of its budget on Health. In 2013 and 2014 up to 11,5% of the global state budget was dedicated to health. Through this increased investment Mozambique has crossed an important threshold. The country is now financing much more than half, namely 56%, of its health expenses.



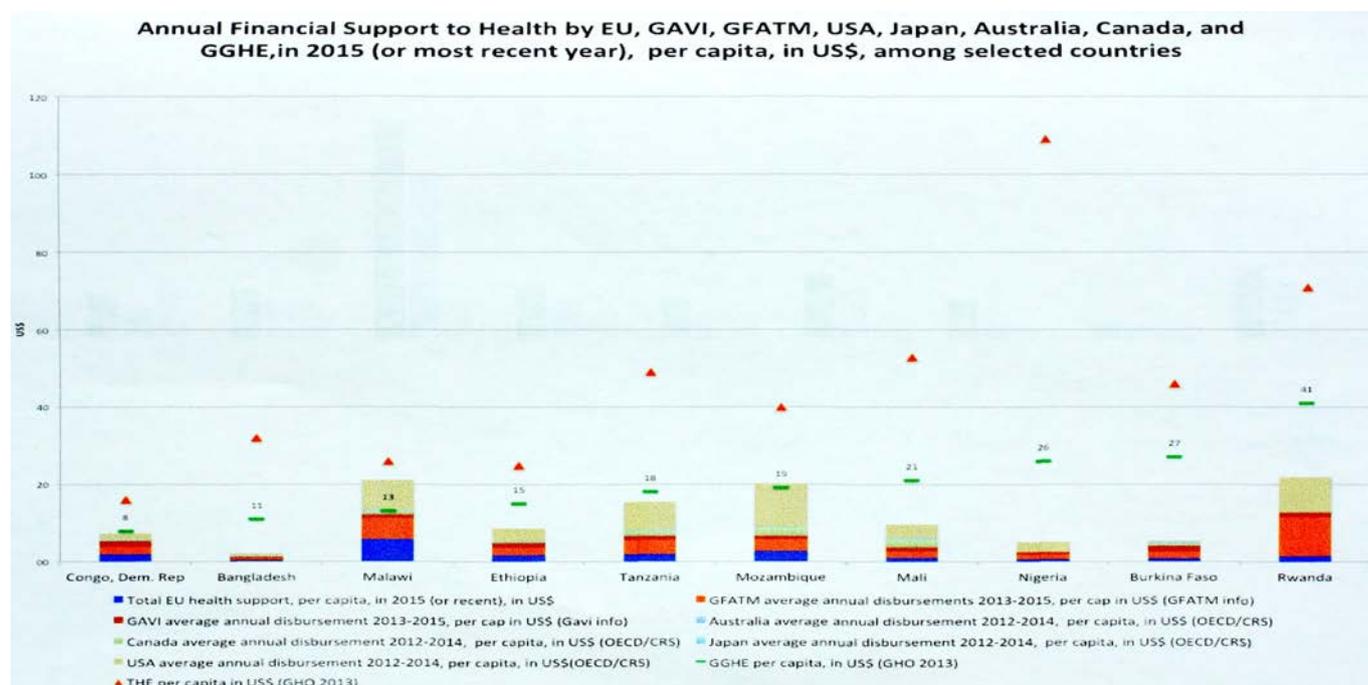
<sup>21</sup> MISAU, Avaliação Conjunta Anual do Desempenho do Sector de Saúde -2014, pp. 43-44 & Figura 16.

<sup>22</sup> PESS, 2014-19, pp. 23-24.

<sup>23</sup> <http://data.worldbank.org/indicator/SH.XPD.PCAP>

In 2014, the health budget totaled 762.8 million US\$, of which 44% came from donors; including through in-kind donations of medicines and medical equipment<sup>24</sup>. However, other enormous amounts from external donors or their funds flow directly to private not for profit service providers, mostly international NGO's. Big donors and important multilateral funds, such as GFATM, keep these parallel channels wide open since they assess that investing through the public system still entails too much fiduciary risks, while they are doubting the absorption capacity of the public system. Another, more endogenous challenge in this area is the insufficient percolation of the state budget for health to the districts. In 2011 the districts only executed 11% of this budget, while, according to the law, they in fact have a central role to play in health service delivery. At the same time, the fact that such funds are channeled by the districts to their wider budget for social development, makes tracking of these resources and of the purpose they ultimately served, quite hard. Finally the 13% of overall health investments involve private service providers and are spent in pharmacies or for out of pocket expenses in the health posts. Even with the additional money from domestic resources the *financing gap*<sup>25</sup> in the health sector remains considerable. A projection for 2016 indicated a gap of 200 million US\$. This would mean that even with the bilateral support of the donors to the sector, the financing gap will be at somewhat more than 20%. Taken into account the most realistic scenario of inflow of external funds to compensate part of this deficit, the full costing of the health plan or its entire implementation period, i.e. 2014-19, is still 1.48 billion US\$ short<sup>26</sup>. This can, on the one hand, be explained by the difficulties that Mozambique is experiencing in trying to wholly fulfil its obligations under the Abuja commitment<sup>27</sup>. Instrumental factors here are, amongst others, the competing demands of a whole series of likewise under-financed social and economic sectors. But, also, the still limited absorptive capacity within this sector, in its turn owing to the lack of predictable financing that would allow longer-term and larger structural investments within the sector, contributes to the explanation of the deficit.

In this regard, it is crucial to be able to estimate the longer-term impact of the current division of labour (DoL) amongst (European) donors on the (external) financing of the Mozambique health sector. For instance, the number of donors present in PROSAUDE is likely to decline in the future, while no new donors have presented themselves to replace the ones that most probably will leave. Finally, it must be noted within the framework of this European division of labour that the European Commission and Mozambique have not selected Health as a sector of focus in their current strategy paper on development cooperation.



EU Health Advisory Services, 2015

<sup>24</sup> Estimates derived from A. MUSATTI, How to improve management of Mozambique's health budget and reduce the risks, march 2014, <http://www.btcctb.org/ni/node/11724>.

<sup>25</sup> *Financing gap*= The difference between the volume of cash resources available from various channels and the estimated sums that are needed in order to realise an objective.

<sup>26</sup> PESS, 2014-19, p. 127.

<sup>27</sup> At the Abuja Summit of the African Union of 2001, the African government leaders solemnly pledged that they subscribed to the objective of ultimately allocating at least 15% of their respective budgets towards the enhancement of their nation's health care systems. The Ministry of Health (MoH) once again urges with respect to the realisation of the five-year plan of the Mozambican Government that this commitment be honoured (Ministério da Saúde, Proposta PARP 2010-2014, p. 3.

## 3 Context of the Flemish Development Cooperation with Mozambique

### 3.1 FLEMISH DEVELOPMENT COOPERATION IN GENERAL

It is the Government of Flanders' ambition to contribute to a prosperous and democratic world, in close cooperation with its international partners. For this reason, Flanders has defined the contribution to poverty reduction and the socio-economic development of developing countries as the general goal of its development cooperation policy. As one of the most prosperous regions in the world Flanders in this way intends to help achieve the Sustainable Development Goals. FDC is also in line with the international agreements on good donorship as laid down in the Paris Declaration (2005); the Accra Agenda for Action (2008), the Busan Partnership for Effective Development Cooperation (2011) and the EU Code of Conduct on Division of Labour in Development Policy (2007). Flanders concentrates the provided aid, geographically speaking, amongst others in the region of Southern Africa and more specifically in its three partner countries: South Africa, Mozambique and Malawi; and sectorially speaking in Access to Health, Agriculture and Food Security, Job Creation and SMME Development, and Trade and Development<sup>28</sup>.

### 3.2 EVOLUTION OF THE FORMAL COOPERATION WITH MOZAMBIQUE

Flanders and Mozambique have maintained strong cooperation ties since 2002, when Mozambique became the second official partner country for the FDC. The severe social damage caused by the HIV/AIDS epidemic was the direct reason that the aid was mainly targeted towards the battle against the disease. 2004 saw the first formal cooperation protocol between the Flemish and Mozambican governments and this important health theme became the focal point within the agreement. UNAIDS, the Institute of Tropical Medicine in Antwerp, the International Centre for Reproductive Health of the University of Ghent and Doctors without Borders were the main participants in implementing the cooperation agreement during that period.

Since 2004, the cooperation between both partners has been intensified both fundamentally and in terms of quality. It made a strong leap forward with the negotiation of the first Country Strategy Paper (CSP I). This strategy paper, launched in June 2006, formed the framework of the cooperation between Flanders and Mozambique for the period between 2006 and 2010. It also secured compliance with the legal requirement to structure FDC with concentration countries accordingly<sup>29</sup>. Cooperation was also adapted to the international criteria on efficiency and effectiveness of the development cooperation laid down in the Paris Declaration in 2005<sup>30</sup>. From that moment on, via SWAp and other structures, Flanders would be providing direct support to the Mozambican government in setting up and implementing its own programme to again turn the health domain into a powerful sector and to staff it with new, yet to be trained medical personnel. At the same time the support via indirect and direct actors in the battle against HIV/AIDS and for retention of motivated and well-trained medical personnel and community workers continued in the province of Tete. Construction of health infrastructure was added as a sub-sector. Both partners also decided in favour of intense cooperation within the Mozambican education sector and more particularly the sub-sector of technical and vocational education.

Mainly on the basis of a policy evaluation of the first CSP the second CSP, now covering the period 2011-2015, was designed. Both partners agreed to further intensify the sectorial concentration policy by focussing on one single sector with the highest added value for Flanders, namely the health sector and, where relevant, devote specific attention to sexual and reproductive health. However, attention was also paid to examining possible entry in the Food Security/Nutrition sector as the aid sector par excellence in a multisectorial approach of the theme "access to health". During this implementation period, a more strategic supply of sufficient sectorial expertise was organized to the greater benefit of MISAU and of the entire health donor group. While potential scaling-up and a programmatic approach in the cooperation were favoured, also some room for innovative initiatives, such as the further introduction of the community ART Group Model in Tete and tb-screening by rat-technology, were provided. The portfolio approach, containing a mix of various aid modalities next to combined support to the national government on the one hand and to provincial

<sup>28</sup> G. Bourgeois, *2014-2019 Policy Paper on Foreign Policy, International Enterprise and Development Cooperation*, pp. 40-49.

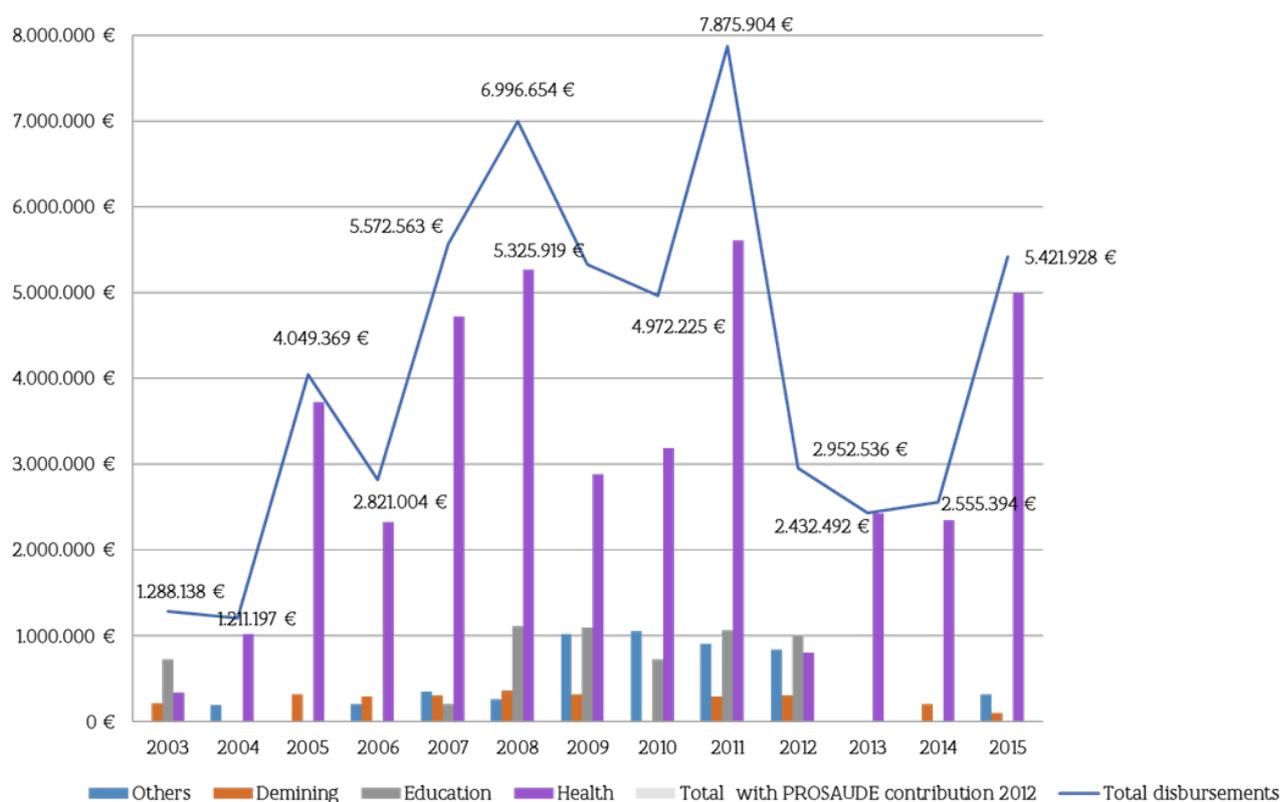
<sup>29</sup> Framework Flemish Parliament Act on International Cooperation of 22 June 2007, Chapter VI, Art. 13.

<sup>30</sup> OECD, *The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action*, 2005/2008.

initiatives in Tete on the other, was maintained. The same annual funding level (EUR 5 million/annum as an indication) for the bilateral cooperation was maintained. Good governance in Mozambique in general and within the cooperation in particular, alongside the incorporation of the other transversal themes of FDC viz. gender, children's rights, HIV/AIDS and sustainable development continued to be guiding principles in our cooperation while the strategy for result-oriented management and risk management within the broad scope of mutual accountability was further developed. Lastly, first efforts to further determine the best position for efforts against the negative impact of climate change and a more structural form of emergency aid and humanitarian aid within the strategy paper were undertaken.

Finally, on occasion of the Annual Consultation of 28 of May 2015 between representatives of both Governments, the guiding principles for the development cooperation under the third country strategy were finalized (see annex). These principles are mainly based on the recommendations stemming from the Mid Term Review of the Second CSP. All principles have found their due translation in this document.

### Sectoral and Total ODA Flanders-Mozambique



### 3.3 THE SECOND COOPERATION PROTOCOL (MEMORANDUM OF UNDERSTANDING)

The (qualitative) growth and increasing diversification of the cooperation between the two partners as well as the amended international consensus on efficient and effective development cooperation, forced the partners at the start of 2009 to adapt their general cooperation protocol (MoU). Both partners decided that the choice of intervention sectors will not be decided any longer on a unilateral basis and will no longer be limited to cooperation in the area of the fight against HIV/AIDS. Another principle was increased overall conformity with the international principles on efficiency and effectiveness of development cooperation, i.e. (1) country ownership; (2) increasing harmonisation and integration of the Flemish development efforts with the initiatives and follow-up instruments of other donors; (3) result-oriented management and (4) mutual accountability via monitoring and evaluations. Also, the optimisation of the conformity with the Framework Flemish Parliament Act for Development Cooperation via (1) the extension of the directory principles mentioned under the previous point; (2) reference to the necessity of contributing to achieving the Millennium Development Goals, and (3) the incorporation of the transversal themes as defined for the FDC, namely gender, HIV/AIDS, children's rights, good governance and sustainable development should receive sufficient attention. Also the portfolio-approach whereby Flanders would support other forms of

cooperation and the involvement of various actors in the implementation of the cooperation, such as multilateral institutions, indirect actors and trilateral cooperation, was accepted by both parties. The definition of the status of the foreign staff that will be employed, is addressed while the place in the cooperation of the CSP was defined.

## 4 Indicative Programme 2016-2020

### 4.1 THE CONTINUATION OF HEALTH AS EXCLUSIVE FOCUS

Flanders and Mozambique decided to maintain their exclusive focus on access to Health. The relative added value that the Flemish-Mozambican cooperation can offer within the already crowded donor landscape in Mozambique is still mainly situated in this sector due to i.a. **the readily available expertise within the Flemish territory which can be applied to development contexts**. A second criterion is, even more than before, the **pursuit of continuity** within the bilateral cooperation, since, after broad evaluation, the actual practice has proven its effectiveness. A third, equally important criterion which inspired the exclusive focus on the theme "Access to Health" within this Country Strategy Paper was an **objective needs analysis** of the Mozambican population. Within the broader health sector, Mozambique and Flanders also jointly decided to maintain a focus on sexual and reproductive health, due to the huge challenges in this subsector. Additional attention will be given here to adolescent health, mainly, but not exclusively, focusing on adolescent girls and young women (10-24 years of age), based on the much higher vulnerability of this important population group to severe adverse health results in this area. in combination with the analysis of the threatening gap between required and available international funding for Health in Mozambique, due to the loss of several important donors in this sector.

### 4.2 OBJECTIVES

#### 4.2.1 General objective

The development cooperation between Flanders and Mozambique during the period 2016-20 will be guided by our common mission to further promote the fundamental right to the **highest attainable standard of health** for the entire Mozambican population in general and of its adolescent population more specifically, and this as **part of a strategy to reduce absolute poverty in the country**. Together we will put the mission of the Ministry of Health of Mozambique (MoH), as defined in the current strategic plan for the sector, the so-called PESS, 2014-19, into practice:

*"To give leadership in the production and delivery of more and better basic health services that are universally accessible, through a decentralized health system that privileges partnerships, to maximize the health and/or overall wellbeing of all Mozambicans, which will allow them to live a productive life, leading to personal and national development."*<sup>31</sup>

At the same time the general framework of this cooperation ties in perfectly with the role the European Union and its Member States have identified for themselves in the international cooperation aimed at promoting Global Health:

*"The EU has a central role to play in accelerating progress on global health challenges, including the health MDGs and non-communicable diseases, through its commitment to protect and promote the right of everyone to enjoy the highest attainable standard of physical and mental health. The Council emphasises the common agreed EU values of solidarity towards equitable and universal coverage of quality health services as a basis for the EU policies in this area."*<sup>32</sup>

<sup>31</sup> Ministério da Saúde, *Plano Estratégico do Sector da Saúde, 2014-2019. O nosso maior valor é a vida*, p. xi.

<sup>32</sup> EU and Member States, *Council conclusions on the EU role in Global Health*, 3011th Foreign Affairs Council meeting, point 4.

The second pillar of the strategy next to the production and delivery of more and better basic health services, speaks about the **need to decentralize the health system** in order to make those services universally accessible. From the beginning of their cooperation both partners were already convinced that such a two track approach, combining support at the national level with focused provincial support, was indeed a precondition for a strong and performing health system in a country as vast and diverse as Mozambique.

As such, it is no coincidence that decentralization is taken in principle as the starting point of the structural and deep reforms that will be identified and implemented within the Health System during and beyond the implementation period of the actual PESS<sup>33</sup>. For this reason, provincial support, preferably focused on the province of Tete, will be maintained as part of the portfolio approach within the Flemish-Mozambican cooperation. This means that both partners, wherever feasible, not onerous and/or relevant, will systematically try to involve the province of Tete as a beneficiary of their common efforts. The choice for Tete is based on considerations of continuity and reliability of the Flemish provincial support, a needs based analysis which shows some particular vulnerabilities<sup>34</sup> of the health system in Tete, and the possibility to strategically partner with other health donors..

Thirdly, both partners confirm their analysis that Health requires a **multisectorial approach**. In this frame the technical health sector is only one tool to promote health. Other sectors therefore need to be involved in order to promote the impact of our efforts. This particular need for a multisectorial approach is explicitly recognized as being a direct result of the adoption of vision of the PESS 2014-19, where it states that the health sector will contribute to maximizing the health of all Mozambicans, with particular attention for the most vulnerable, and this again as a contribution to the fight against poverty and for the promotion of the overall development of the country<sup>35</sup>. At the same time the EU and its Member States apply this multisectorial approach as a good practice for Health Cooperation with developing countries<sup>36</sup>. Also the UN global strategy for promoting the health of women and children is also based on the need for a multisectorial approach<sup>37</sup>. Finally, the new 2030 SDA of the UN stresses the importance of stimulating such multisectorial approaches in order to be able to capitalize on important interlinkages between the identified goals and dimensions of sustainable development. Although more complex and demanding, this approach will lead to better and more sustainable results. Both partners agree that such multisectorial support will be framed by already existing multisectorial strategies for adolescents.

#### **4.2.2 Specific objective and sub-objectives**

The listed basic principles of the cooperation, including (1) collaboration on the theme of access to health as an integral part of a broader strategy to combat poverty, (2) the choice for a two track approach combining national and provincial support and (3) the need for a multisectorial approach in order to effectively promote health amongst adolescents lead us to determine the following specific objective for this cooperation:

*“To contribute to the development and implementation of an efficient and effective health policy at national level and in Tete Province with sufficient attention for adolescents.”*

and this in conjunction with the following sub-objectives from which the Flemish-Mozambican cooperation wishes to derive its real added value, namely to:

1. *Contribute to the further development of a critical mass of well trained and motivated health workers, who are skilled to also serve the adolescent population effectively;*

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<sup>33</sup> PESS, 2014-19, pp. 47-48.

<sup>34</sup> For instance, Tete has the worst score on the crucial indicator of distance to the nearest health facility (18 km), one of the most important contributors to (lack of) access to health services, PESS, 2014-19, p. 17.

<sup>35</sup> PESS, 2014-19, pp. 35-36: “*Esta afirmação (...) mostra o reconhecimento, por parte do sector, da importância do papel dos outros sectores na melhoria do estado de saúde, bem como destaca, implicitamente, a necessidade de colaboração intersectorial (...)*.” Notice that such a multisectorial approach forms also part and parcel of the basic principles concerning basic health services and partnerships within the PESS (PESS, 2014-19, pp. 37-38).

<sup>36</sup> “...particular attention will be devoted to the four main health challenges (sexual and reproductive health, child health, communicable and non-communicable diseases) and to the multidimensional nature of health, with close links to gender, food security and nutrition, water and sanitation, education, and poverty.” EU and Member States, Council conclusions on the EU role in Global Health, 3011th Foreign Affairs Council meeting, 2010, punt 6.

<sup>37</sup> Ban Ki-Moon, Global Strategy for Women’s and Children’s Health, p. 5, pp. 7-8, p. 10& p. 16.

2. *Contribute to good health research and monitoring of diseases and epidemics with, wherever relevant and appropriate, sufficient attention for the underserved adolescent population;*
3. *Contribute to the promotion of sexual and reproductive health and rights of all Mozambicans, with a special emphasis on the most vulnerable populations, in particular adolescents, i.a. through the promotion of a multisectorial approach.*

By embracing these objectives, all basic principles for health service delivery as defined by the the PESS, referenced hereunder, will receive attention through broad or specific support and/or in the way this support is provided and used:

1. Basic health services;
2. Equity;
3. Quality;
4. Partnership;
5. Community-involvement;
6. Research and technological innovation;
7. Integrity, transparency and accountability.

In combination with the principles, the cooperation will contribute to achieving all seven strategic objectives of the PESS, 2014-19<sup>38</sup>:

1. Increase access and use of health services;
2. Improve the quality of the services that are provided (i.a. through a user-tailored approach);
3. Reduce inequities of access to health services based on geographical and social determinants;
4. Improve the efficiency in health services provision and in resource-use (i.a. through integration);
5. Strengthen partnerships for Health on the basis of mutual respect;
6. Increase transparency and accountability on the way public resources have been used;
7. Strengthen the Mozambican Health System, including through supporting the decentralization-policy.

These principles and strategic objectives should allow all people of Mozambique to get access to more and better services in the short term (first pillar of the PESS). In the middle term, the combined efforts of the MoH and all of its partners should contribute to a structural reform of the health sector itself, so that the collective gains in service provision and Health can be sustained in the long term (second pillar of the PESS).

Finally, both partners declare the following gaps as of particular interests to their cooperation:

1. The need to increase demands for services in the area of maternal health including through advocacy;
2. The need to increase the quality of maternal health services' provision, including in the area of safe abortion, in an integrated way
3. The need to implement the Strategy for Family Planning (FP) to make it universally accessible;
4. The need to improve the management of health personnel, as well as to increase the level of the humanity of service with specific attention to the qualitative reception of adolescent users as well as meeting their needs;
5. The need to ensure the sustainability and sound financial management of the sector, by strengthening institutional capacity at all levels and by consolidating the partnership mechanisms and actions to prevent corruption at all levels.

### 4.3 CROSS CUTTING ISSUES

When programming and realizing their cooperation, the partners will also fully integrate the cross cutting issues 'Gender', 'HIV/AIDS' and good governance into their development cooperation. It is worthwhile noticing that, when deemed necessary, dedicated funding can also be provided within the initiatives supported by the FDC to make the work on these cross cutting issues more concrete and visible. In addition, the other cross cutting issues that have been identified by the framework Flemish Parliament Act on

<sup>38</sup> PESS, 2014-19, pp. 39-44.

Development Cooperation, viz. children's rights, persons with disabilities and sustainable development, will have to be given sufficient attention in all projects and programmes supported by Flanders<sup>39</sup>. Finally, through the incorporation of elements within the (regional) cooperation sufficient attention will be paid to the cross cutting issues that have been identified by the Mozambican Government that do not overlap with the Flemish themes<sup>40</sup>.

## 4.4 STRATEGIC APPROACH

### 4.4.1 Sectorial common fund remains the first option instrument

A strong and adequately funded health system is the basic condition for achieving sustainable progress in terms of access to health. In this frame the vast majority of efforts have to focus on one single strategy which has been designed by the Mozambican government itself. The administrative and technical implementation of this sector-wide programme too has to be coordinated as much as possible by this Government and its institutions. The aid modality which is best suited to such a "horizontalisation" within the health sector is undoubtedly the sector-wide approach for the health sector in the country: SWAp health. The EU and its Member States have therefore made the commitment to:

*"(...) wherever possible, channel two thirds of their annual health contributions through programme cooperation to the partner countries. In this frame at least 50% of these funds will be deployed through the country's own systems, including the mechanism of sectorial budget support. Simultaneously, they will pursue the necessary predictability in the medium to long term to facilitate the design and implementation of national health strategies<sup>41</sup>.*

Both partners therefore agree to keep on programming a significant contribution of at least EUR 2 million per year for PROSAUDE or its successor fund whenever it by and large shares the same characteristics with PROSAUDE. Additional resources will be provided to make sure that Flanders continues to be a reliable partner in the burden sharing within the health partners group, providing technical support to strategic working groups.

### 4.4.2 Focusing on specific sub-sectors

#### *Human resources for health (HRH)*

Mozambique continues to be confronted with one of the worst crises worldwide in terms of available human resources for health (HRH). The lack of sufficiently trained personnel impedes progress in virtually every component of health care. It was calculated that for the first year of the implementation of this CSP, for instance, the ratio between the necessary versus the available personnel would be 187% for GP's, 806% (!) for gynecologists and obstetricians and other higher medical personnel involved in maternal and infant care, 608% (!) for other specialists and 115% for nurses of the different categories<sup>42</sup>. Both partners have agreed to keep on paying considerable attention to this issue at the various levels of their cooperation in order to contribute to the scaling up of efforts in terms of training and motivation of health personnel.

This personnel will also progressively acquire skills and infrastructure adapted to also cater for adolescents in a more attractive way. This as part of the planned efforts to provide more user-friendly services.

#### *Sexual and reproductive health and rights (SRHR)*

The FDC derives part of its added value from its work in the area of SRHR<sup>43</sup>. A significant part of the cooperation will specifically prioritize the sub-sector of sexual and reproductive health and rights, with

<sup>39</sup> Framework Flemish Parliament Act on Development Cooperation of 13 June 2007, Chapter III, Art. 10.

<sup>40</sup> PARPA II, pp. 61-72. PQG, pp. 100-110.

<sup>41</sup> EU and Member States, Council conclusions on the EU role in Global Health, 3011th Foreign Affairs Council meeting, Point 9.

<sup>42</sup> PESS, 2014-19, Tabela 5, p. 126.

<sup>43</sup> Recently, this added value was recognized internationally by appointing the Flemish Representative as chair of the Special Programme of Research, Development and Research training in Human Reproduction, sponsored by UNDP, UNFPA, UNICEF, WHO and the World Bank (<http://www.who.int/life-course/partners/human-reproduction/en/>).

sufficient attention to adolescent SRHR, while progress in this area will receive special attention when assessing overall performance of the health system.

Any multilateral and indirect programmes that benefit from support in this field will be based on the relevant national plans and strategies, such as the “Plan for Accelerating the Reduction of maternal and Neonatal Mortality”, and the specific national programmes for SRH, for children’s health, for hiv and aids and for adolescent (SR)H<sup>44</sup>. The data exchange with the health services of the Mozambican Government will also be guaranteed. Although the focus is on SRHR, this does not, in any way, preclude the recognition that further integration of such SRHR-initiatives with preventative and curative (basic) health services against major infectious diseases (mainly malaria and TB) and with the implementation of vaccination schedules for infants and mothers and the prevention and treatment of diarrhoea-related diseases and intestinal parasites will have to be pursued at the same time<sup>45</sup>.

From a global perspective, the cooperation will also contribute to achieving the global targets set by the UN Global Strategy for Women’s and Children’s Health<sup>46</sup> and by the goals 3 and 5 of the broader framework of the Sustainable Development Goals within the 2030 Agenda for Sustainable Development

Finally, the more specific efforts to establish and/or stimulate a multisectorial approach on health promotion amongst adolescents will also be situated in this sub-sector. Through this cooperation one or more of the following basic components of sexual and reproductive health and rights that cannot be solely addressed through the health sector will be addressed<sup>47</sup>:

1. Comprehensive Sexuality Education (CSE);
2. The fight against HIV/AIDS and other sexually transmitted diseases;
3. Provision of the best modern method of FP through youth-tailored services;
4. Improving gender relations and the fight against gender based violence (GBV);
5. Combatting harmful traditional practices, such as child, early and forced marriages.

### *Support of evidence based medicine and health-monitoring*

In order to make the most efficient and effective use of the scarce health resources, a proper collection of medical data, epidemiological monitoring, and accurately and ethically performed health research are indispensable. Only then can the government make the right choices in terms of general prioritization within the health policy and select the most appropriate treatment methods<sup>48</sup>. Therefore, part of the cooperation between Flanders and Mozambique will be focused on supporting the actor(s) who can offer the biggest part of the following services in the most efficient and effective way:

1. Monitoring the state of health within the national territory or part thereof, with sufficient attention for adolescent health, wherever feasible and/or convenient;
2. Managing and disseminating health records and data that are of strategic importance for the policy and that are sufficiently disaggregated on the basis of sex and age;
3. (Supervising) the quality control of vaccines, medicines, tests and health services;
4. Managing medical reference laboratories;
5. Ensuring rapid diagnoses in case of diseases/the sudden outbreak of epidemics;
6. Training researchers and research assistants for the laboratories and the use of short-term tests;
7. Disseminating targeted health information to the population, including adolescents, within the framework of the general health promotion.

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<sup>44</sup> As referenced by the PESS, 2014-19, respectively on pp. 51-53, p. 53, pp. 56-57 & p. 62.

<sup>45</sup> For this strategic need for integration, see African Union Commission, Maputo Plan of Action for the Implementation of the Continental Policy Framework for Sexual and Reproductive Health and Rights, 2007-2010, Maputo, 2006. And also: PESS, p. 43, p. 45, p. 64, p. 68 & p. 86.

<sup>46</sup> Ban Ki-Moon, Global Strategy for Women’s and Children’s Health, p. 5, pp. 7-8, p. 10 & p. 16.

<sup>47</sup> About the need for integration, see among other things:

[http://data.unaids.org/pub/BaseDocument/2010/20100604\\_26thpcbthematicbackground\\_final\\_en.pdf](http://data.unaids.org/pub/BaseDocument/2010/20100604_26thpcbthematicbackground_final_en.pdf). It must also be noted that the ‘fight against HIV/AIDS’, ‘children’s rights’ and ‘gender’ are also transversal themes for the general Flemish-Mozambican cooperation.

<sup>48</sup> This research theme is therefore one of the priorities within the PESS (PESS, pp. 55-56). But health research and its structural needs are also addressed within the Mozambican Innovation Strategy for Research, Technology and Innovation, GoM, Mozambique Science, Technology and Innovation Strategy (MOSTIS), 2006-2016, pp. 32-33.

In this context the Flemish-Mozambican cooperation will further prioritize the support to research and monitoring in the fields of sexual and reproductive health care and rights, giving, wherever feasible and relevant, also due attention to adolescent sexual and reproductive health and rights. In the first instance it will be examined how the strengthening of the National Health Institute can be further supported as priority partner in the field of health research and health monitoring. This will, to a big extent, contribute to the sustainability and potential upscaling at the national and even regional scale of work in this area<sup>49</sup>.

### *Cooperation in Tete Province*

In principle, the Flemish-Mozambican cooperation will continue to give priority to cooperation in Tete Province and its health districts that may include support of provincial government institutions, specific research tasks, NGOs that contribute to the development of the aforementioned sub-sectors and of potential joint programmes with other donors. This choice is partially inspired by:

1. The recognition by both partners of the importance of an effective decentralization process as a strategy to improve health sector performance;
2. The need to provide sufficient continuity of the provincial support;
3. An analysis of the specific vulnerabilities of the health sector in this province<sup>50</sup>.

However, this paragraph is not meant to assign absolute exclusiveness of local cooperation to Tete-province.

#### **4.4.3 Indicative programme for the deployment of resources**

Indicative financing of the Flemish-Mozambican cooperation for the CSP III, 2016-2020	
Year	2016-2020
To contribute to the development and implementation of an efficient and effective general health policy*	11.000.000
Provincial support to Tete	1.200.000
To contribute to the further development of well trained and motivated health personnel and volunteers at the national level and in Tete province with a view to i.a. increase access and attractiveness of health services for the adolescent population	4.500.000
To contribute to the promotion of sexual and reproductive health and rights with specific attention for adolescents	3.500.000
To stimulate multisectorial action for promoting adolescent health	1.500.000
To contribute to good quality health research and monitoring of diseases and epidemics with sufficient attention for adolescents	2.500.000
To promote accountability and sensitization for the right to health and information of adolescents, including for combatting harmful traditional practices	800.000
<b>Total</b>	<b>25.000.000</b>

\* of which at least 2 million € per year will be disbursed to the common fund for Health

<sup>49</sup> In the wake of the ongoing ebola-crisis French development cooperation decided to strengthen the national health institutes of particularly vulnerable countries as an entry-point to improve the overall capacity of the national health systems in these countries, in order to deal much more effectively with such future crises. These institutes will be placed in a network stimulating cooperation between peers in these countries and relevant French Institutes.

<sup>50</sup> Tete has the second worst doctor versus number of inhabitants to serve ratios (1/44.789 inhabitants), while it has the biggest average distance to a health center (18 km.).

## 5 Implementation and Monitoring of the Strategy Paper

### 5.1 VERTICAL COMPONENTS IN THE IMPLEMENTATION

#### 5.1.1 *Portfolio approach*

A portfolio approach will be used for the implementation of this strategy paper. This involves:

- (1) different terms of funding or implementation;
- (2) different administrative levels of implementation (*cf. supra* decentralized levels);
- (3) different categories of implementing actors (direct, indirect, multilateral, ...)

in the cooperation and to combine those modalities with one another in a complementary and mutually reinforcing manner. This portfolio approach ensures the necessary flexibility for the spending of resources while spreading the risks to a certain extent.

The GoF will inform the GoM in a motivated note of any decision to not intervene directly through state actors in order to avoid the risk of insufficient harmonisation with the plans of the GoM. However, Flanders will also pilot efforts to launch (a) call(s) for proposals jointly with the GoM in areas as defined by the strategic approach. Once the CSP III is adopted, a special dialogue on this new modus operandi will be launched between representatives assigned by both governments.

It will also insist with the actors and organisations to which it provides support that, when operating in Mozambique, they align their programmes as much as possible with national plans and make them as compatible as possible with the administrative procedures that are applied within the public health service.

#### 5.1.2 *Integration of adaptation to climate change*

Mozambique's high vulnerability to natural disasters is definitely climate-related. Any change in climate-determining factors and global warming may thus have far-reaching negative consequences for the country. As a result Mozambique was one of the first countries to develop a National Action Plan for Adaptation (NAPA) with the support of the international community<sup>51</sup>. At the same time both partners would like to incorporate the adaptation to climate change as much as possible into their development programmes. For this purpose, when identifying, designing, implementing and monitoring new programmes or projects the intended development results will be systematically tested for climate sensitivity and where necessary these projects and programmes will be adapted. In the case of vulnerable projects and programmes suitable measures for managing climate risks will also be foreseen. Seen the necessary scale of the efforts for fighting climate change, this theme will also be tackled through regional initiatives supported through the FDC (*cf. infra*).

### 5.2 IDENTIFICATION OF PROGRAMMES AND PROJECTS

The assigned representatives of the Flanders Department of Foreign Affairs (FDFFAA) in close collaboration with the relevant Mozambican authorities (*cf. supra*) are responsible for the identification of programmes and projects to be implemented within the framework of this CSP. Projects and programmes that are subsequently carried out by indirect actors, universities or multilateral organisations will be systematically tested against the agreements in this CSP, against their conformity with the priorities set out in the relevant national strategy documents of the GoM and against the objectives and priorities proposed by the SDGs. Finally, a cost-benefit analysis of all programmes and projects eligible for funding by Flanders, will be systematically conducted.

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<sup>51</sup> Ministry for the Coordination of Environmental Affairs, National Adaptation Programme for Action, Approved by the Council of Ministers at its 32nd Session, December, 04, 2007.

When requesting programme and project proposals and when formulating the final programme and project proposals the GoM and the GoF are committed, wherever possible, to working with existing formats and/or sufficiently up-to-date information from the implementing partner in order to reduce the administrative burden as much as possible.

### 5.3 PROJECT IMPLEMENTATION DOCUMENTS

For each programme or project - except for PROSAUDE for which the applicable joint Memorandum of Understanding serves as programme agreement – a project agreement will be established in accordance with the relevant partner(s). This agreement at least specifies the key facilities relating to programmes or projects, such as: the object of the agreement, the tasks related to the implementation, coordination and monitoring of the programme or project, the contributions and commitments of all partners, the release of funds, reporting, monitoring and financial audits, entry into effect, validity, changes, termination and dispute resolution. The project/programme agreement shall provide a sufficient basis for the monitoring, follow-up and evaluation. All details relating to programme and project objectives, results and the activities required for this will be specified in a separate project document. Any changes can only be approved after joint consultation. This document will be appended to the project/programme agreement.

Here to the FDFFAA has committed to reducing the administrative burden on the implementing partner as much as possible, choosing to preferably work with the partner's own organisational formats. In the case of projects and programmes that are funded by several donors integrated project and programme proposals will take priority.

The Ministry of Health is authorised to co-sign relevant project implementation documents involving government actors on behalf of the Mozambican Government. The FDFFAA is authorised to sign the project implementation documents on behalf of the Government of Flanders.

### 5.4 FUNDING AND BUDGET

The authority for the Flemish funding of programmes and projects lies with the Flemish Minister of Development Cooperation. On behalf of the latter the FDFFAA will provide funding for programmes and projects that have been accepted by both parties. Funding can be direct or indirect. The exact available budgets will be communicated by the FDFFAA to the Mozambican Government on a yearly basis. The committed and spent resources will be incorporated in ODAMOZ. On the occasion of the Annual Consultation the FDFFAA will also provide an overview of the commitments and resources spent.

During the time that this country strategy is applicable Flanders will commit an average annual budget to the amount of EUR 5 million for its implementation. An amount equivalent to a maximum of 5 % of this budget will be managed by the local representative to assure the quality of identification, formulation, monitoring and evaluation and to provide ad hoc technical assistance within the programmes supported by i.a. Flemish funds.

Should additional resources for bilateral cooperation be available then these will be spent within the general frame of this strategy paper, and preferably after consultation with the Mozambican Government. The FDFFAA will notify the Mozambican Government of any such event.

### 5.5 REPORTING

The FDFFAA will align itself as much as possible with the implementing partner organisation's local systems and procedures for reporting and/or with other donors' systems and procedures in order to reduce the partner's administrative burden as much as possible. These reporting systems and procedures, however, have to be able to withstand a specific quality test by FDFFAA and the specific reporting needs of FDFFAA have to be sufficiently integrated or be able to be integrated into the partner's formats and systems. The reports also need to contain sufficient information about the progress in the work plans which have been agreed in the project/programme agreement. The reports will consist at least of a progress report and a financial report. This progress report, in turn, will at least contain sufficient qualitative information about:

- The actual results in comparison with the planned results;
- A summary about how the funds have been spent in comparison with the planned budget;
- An overview of any changes in the outcome;
- An internal assessment of the necessity to make changes to the work plans.

The financial reporting will provide a sufficient overview of and insight into expenditure to monitor financial management according to the agreed budget and approved work plans.

If, for any reason whatsoever, more specific reporting templates are necessary, then the FDFFAA suggests its own templates for content-related and financial reporting to the implementing partner.

## 5.6 FINANCIAL AUDITS

As a general rule, all programmes or projects will be regularly financially audited. The modalities for the audit are stipulated in the project/programme agreement. An additional audit can be commissioned by the FDFFAA. The audit is harmonised as much as possible with the partner's systems in the case of PROSAUDE. In the case of other multi-donor support Flanders will join the agreed joint audit modality. In case Flanders is the sole provider of support the audit will have to comply with the relevant international standards. When participating in joint programmes Flanders will preferably take part in joint audits with the other donors involved. In case ineligible expenditures identified by audits executed by *Tribunal Administrativo* (administrative Court) or external auditors, funds will have to be reimbursed to the Government of Flanders, or can be deducted from future disbursements. Partners will consult each other and maintain an open dialogue in order to reach agreements.

## 5.7 MONITORING AND EVALUATION

### 5.7.1 Monitoring and evaluation at implementation level

The overall responsibility for the implementation of the programme and reporting on progress and results resides with the implementing partners. The FDFFAA will monitor this process. Together with the partner and the other donors, the achievement of well-defined results as well as the expenditure of funds will be monitored. The monitoring process will consist of regular meetings – including the Bilateral Consultation – on-site visits and the above described reporting mechanisms.

As a general rule, all programmes or projects will also be evaluated. When Flanders takes part in joint donor programmes it will only take part in the jointly organised evaluations. When joining a sectorial approach, Flanders will ensure that monitoring and evaluation are harmonised with the provisions and mechanisms laid down by the relevant Code of Conduct and/or Memorandum of Understanding for this sectorial approach<sup>52</sup>.

As regards the use of indicators for the monitoring of direct bilateral cooperation at the level of the specific objective and at the level of sub-objectives 1 (HRH) and 2 (SRHR) a further selection of the relevant indicators used within the performance framework for the SWAp-Health or within the relevant, specific programmes mentioned above will be used to a large extent<sup>53</sup>.

For monitoring of the results under sub-objective 3 on health research and monitoring, the indicators will be further defined once the scope of the support has been better defined.

The indicators for direct support at the provincial level will be defined after further consultation with the provincial authorities concerning the nature, objectives and modalities of the support they wish to prioritize and with the other donor(s) already working in the same province.

The agreements for specific programmes and projects which will be carried out by indirect or multilateral actors within the portfolio approach will have to come with their own monitoring and evaluation schedule.

<sup>52</sup> For a reproduction of the current MoU in the health sector, see: <http://blogs.dfid.gov.uk/wp-content/uploads/2010/03/mou-final-version-30july08.pdf>. A new MoU will shortly be accepted though.

<sup>53</sup> GoM, *Matriz de Desempenho do Sector Saúde: Metas Referentes ao Período 2008 – 2012*, versão actualizada, 2010.

As long as minimal quality-thresholds are met, Such schedules once again will have to tie in as much as possible with the formats that are typical of the implementing organisation(s) concerned. Nevertheless FDFFAA can also choose to carry out motivated *ad hoc* evaluations.

### **5.7.2 Monitoring and evaluation at policy level**

In terms of monitoring and evaluation of the SWAp-Health, Flanders will take part in the policy dialogue with the Ministry of Health as structured for this instrument. The coordination by the leading donor is respected in this frame and thus ties in as much as possible with the principle that states that the monitoring and evaluation thereof have to be collective exercises. To this end both partners will continue to evaluate the different tools that have already been used for supplying sufficient sectorial expertise and for providing feedback about the results of the decentralised and innovative initiatives to the SWAp dialogue. However, new instruments can also be examined and used for this. In this frame Flanders will continue to work with the other donors in order to ensure that the points of view and proposals which are translated to the Ministry of Health are as coherent and consistent as possible.

The permanent instrument par excellence for monitoring and evaluation at policy level of the general cooperation between the Governments of Flanders and Mozambique is the direct policy dialogue between both partners. This mainly happens during the Bilateral Consultations (BC). During the first Consultation the start-up of activities in the frame of CSP III will be evaluated. Measures can be taken where necessary in joint consultation to accelerate certain processes and/or change certain accents.

In the frame of these Consultations both partners will exchange information about progress but also about problems in the frame of the cooperation based on an open spirit of mutual accountability and permanent improvement. The Mozambican Government will report briefly on the developments within the general policy for the Health. In addition to this (1) the health results that have already been achieved and (2) the desired results for the future will be briefly elaborated upon. Next to this the dialogue will focus on the mutual discussion of policy and the progress in terms of certain points of attention from which the Mozambican-Flemish cooperation derives its added value, i.e.:

1. General progress in terms of scaling up and motivating health personnel in Mozambique and in Tete  
*Indicator: Rate of health workers, doctors, nurses and health workers for maternal and child health, per 100.000 inhabitants*
2. General progress in terms of sexual and reproductive health of, mainly but not exclusively, adolescents in Mozambique and in Tete;  
*Indicators: Institutional Birth Rate, % new users of modern methods of family planning, % of adolescents and young people tested for hiv in the health centres*
3. Strengthening the health research and monitoring system;  
*Indicators: to be later defined within the identified initiatives but touching on the efficiency/effectiveness of the specific elements of institutional strengthening of and/or of service-delivery by the implementing organisation that is operating with Flemish resources*

As a complement to this permanent policy dialogue the Flemish Department of Foreign Affairs and the Mozambican Government will carry out an external jointly coordinated mid-term review (MTR) of CSP III in 2019. Based on this evaluation it will be possible to assess progress in terms of the implementation of the strategy paper as well as general results. The evaluating party will also have to give suggestions to introduce the necessary changes within the future cooperation in order to make it more efficient and effective. The conclusions and recommendations of this external evaluation will be mutually discussed at the last Bilateral Consultation within the time frame of this CSP.

### **5.7.3 Support of and from Parliament and civil society**

Both partners are of the opinion that Parliament and local civil society are in a unique position to monitor the Government's responsibility in terms of combating absolute poverty<sup>54</sup> and realising fundamental human rights, including the right to the highest possible standard of Health. To this end both of the above structures need to have sufficient tools and resources at their disposal and their capacities need to be developed. Resources will thus be allocated to these important actors in order to allow them to:

- monitor the efficiency and effectiveness of health policy and services, including for adolescents and other principles of good governance within the Mozambican health sector;
- identify inequalities within the right to access to the highest achievable standard of health, including for adolescents, and to make these known and discussable;
- suggest alternative policy lines to the government.

Every decision to support specific initiatives by Parliament or civil society will also be punctually announced to the Mozambican Government.

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<sup>54</sup> A platform of civil society was established when drawing up the first plan to prevent absolute poverty, PARPA I. The so-called *Observatório da Pobreza* has to support the Government of Mozambique in maintaining an open dialogue about good governance in all its dimensions, strengthening policy choices, improving public service and the administration and clarifying the State's role in a free society: "Desde a fase da concepção do Plano de Acção para a Redução da Pobreza Absoluta, PARPA, que o Governo de Moçambique tem procurado a participação e o diálogo com a Sociedade Civil. O Observatório da Pobreza foi criado com a intenção de se constituir uma plataforma para o debate aberto, entre o governo e a sociedade civil "como um instrumento vital para o aprimoramento da governação em todas as suas dimensões. A livre discussão dos problemas da população pode ajudar o governo a fortalecer as suas políticas, melhorar a provisão dos serviços públicos, melhorar a administração e clarificar o papel do Estado numa sociedade livre" (Luisa Diogo quoted in: G 20, *Relatório Anual da Pobreza*, 2004, p. 3.)

## 6 Risk Management

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Should risk factors be encountered during the implementation of the strategy paper the Flemish partner may have to take a number of measures to guarantee good management of its programmes and of the resources freed by its government.

The following elements need to be taken into consideration:

- The *Paris Declaration* principles which mutually apply to the Governments of Mozambique and Flanders should be adhered to as much as possible in considering any changes in aid modalities.
- Flanders will together with the other donors closely monitor risk factors in all its programmes of cooperation, and will also try to find solutions together with the other donors in dialogue with the Government of Mozambique.
- In the case of objectively determined reduced performance and/or increased expenditure risk of any funds to be deposited at the central level Flanders can redirect the granted funds by increasing financial support to local authorities and/or non-governmental and international organisations. These have to have in common at least part of the objectives and of the target group with the original direct bilateral support. Flanders in such a case can also decide to shift the emphasis of its cooperation to (an) other sector(s) that is supportive of the general objective of this CSP . Such decisions will always be notified punctually to the Mozambican Government. In this same context, ineligible expenses will have to be reimbursed without any delay to the Flemish Government.
- In case the basic conditions (open dialogue, good governance, etc.) for spending resources in the Province of Tete should not (no longer) be present, Flanders can progressively redirect direct support to NGO's or international organisations that operate at local level if they have in common the target group and objectives of the programme with the provincial authorities.
- In case of severe governance shocks Flanders will have to assess if the absorptive capacity of Mozambique has been affected. In extreme cases the support might have to be reduced or frozen. In accordance with what is possible at that moment this will be decided in consultation with the Mozambican Government as well as based on an assessment of the situation by the international donor community and specifically by the European Union.
- In any case the most underprivileged population groups of Mozambique continue to be the target group of the present country strategy. The final goal of the cooperation is still to help the most vulnerable among the Mozambican population, manage the risks with which they are confronted in their daily lives and to build capacity in order to ultimately reduce the established vulnerability.

## 7 The Flemish-Mozambican Cooperation outside the Scope of the Indicative Programme

### 7.1 IN GENERAL

A review of the indicative programme within CSP III is not sufficient to obtain a complete and transparent overview of all the initiatives which Flanders will be supporting in Mozambique for the duration of this CSP. That is why the financial efforts, which are not included in the scope of the indicative programme of this CSP for various reasons, and that are currently ongoing, will be explained in this chapter. Flanders first and foremost wishes to make its firm commitment to the development of the new global partnership, as described by the 2030 sustainable development agenda, more tangible with such initiatives. In part this concerns complementary initiatives with the main objective of strengthening the bilateral cooperation but which are aimed at Mozambique in part through other channels. Other hitherto minor components are also organised on a regional scale, but the main purpose is to reduce asymmetric trade relations in the region and on a global scale. Since investment priorities of the Flemish Government may shift, the following overview is time bound. Any questions on scope and status of the specific initiatives can be directed at the Flemish country representative in Maputo.

### 7.2 REGIONALLY ORGANISED INITIATIVES

#### **7.2.1 Strengthening of health cooperation through multilateral initiatives**

Flanders chooses to mainly provide support to multilateral organisations as a strengthening complement of bilateral cooperation with the partner countries and the region. In doing so, Flanders ordinarily gives part (1/3<sup>d</sup>) of its funds in the form of core support for the organization, while two thirds can be softly earmarked geographically and/or thematically. For example, Flanders is one of the main donors of the the Special Programme on Human Reproduction, HRP, embedded in the “Reproductive Health and Research” (RHR) department of the WHO. A second example is the support for UNAIDS in the frame of the second cooperation agreement with Flanders. UNAIDS is indeed considered the leading institution in terms of an integrated answer to the HIV hyperepidemic. Moreover the organisation also heavily emphasises prevention through behavioural changes. But UNAIDS also plays an incomparable role in the multisectorial approach against the epidemic by working towards removing barriers for prevention and treatment which are enshrined in national legislation and eliminating social attitudes that discriminate members of the most vulnerable groups for this disease, such as men who have sex with men, drug users but also women in general. Flanders commits itself to provide further information on the development and results of its multilateral cooperation relevant to Mozambique during the bilateral consultations.

#### **7.2.2 Disaster prevention and control and rehabilitation**

Mozambique is ranked as the third most vulnerable country in Africa for multiple weather-related risks. It is indeed regularly exposed to massive flooding, cyclones and draughts<sup>55</sup>. In the frame of the efforts that Flanders makes to ensure that the humanitarian aid it provides is as sustainable as possible, it wishes to use part of these resources for a structural approach to disaster prevention in the partner countries, including in Mozambique. If a disaster occurs Flanders, moreover, will make an extra effort to provide emergency aid and release funding for rehabilitation. For the related area of climate change the Flemish Government works i.a. through a regional programme of FAO for the further development and promotion of climate smart agriculture in the region of Southern Africa.. The countries involved are: Mozambique , Zambia and Malawi.

#### **7.2.3 Trade and development and respect for labour standards**

We note in particular the efforts in the broader context of “Trade for Development” aimed at further developing the skills for regional and/or international exports of small and medium-sized producers of the partner countries, whether or not within the fair trade circuit. This is done through various channels. There are for example the scholarships for training in port-related matters and various instruments that aim to improve production for achieving export quality and higher value-added production in marketing. A contribution is also made to the promotion of sustainable tourism. Another component revolves around promoting labour standards within the partner region. Here, cooperation is mainly with the ILO.

<sup>55</sup> PESS, figura 1, p. 5.

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### Annex 1: Guiding Principles for the set-up of the third CSP for the Development Cooperation Between the Government of Flanders and the Government of Mozambique, 2016-2020

1. The implementation period of five years will be maintained to make Flemish support more predictable and sustainable;
2. An annual investment level of, on average, 5 million EURO per year resulting in an overall investment of 25 million EURO over the whole implementation period, is reconfirmed. These investments will exclude investments for regional initiatives or stemming from departments;
3. To the biggest extent possible, the principle of country-ownership will be respected;
4. The exclusive concentration on the health sector from a human rights based approach is prolonged. This includes specific attention for sexual and reproductive health and rights and/or for basic health services and for the further promotion of evidence based health policy. Also due attention will be given to the new aid paradigm stemming from the post-2015 development agenda, in which interlinkages between health promotion and activities in other sectors than health are actively pursued;
5. Flanders commits to a full participation in the health sector dialogue. This will be done through i.a. an important annual investment in the health sector fund under coordination of the MoH, accompanied by sufficient technical expertise. In this context Flanders will also participate in the burden sharing with the other health partners;
6. An intelligent mix of aid instruments and modalities, a so called portfolio approach, in which also support for the national and the provincial level (Tete) is combined, will also be maintained. In this context we will prefer initiatives that allow for a more programmatic approach and for scaling up. This will help us to increase the efficiency and relevance of our support, while diminishing administrative overload. However, some budget can also still be reserved for piloting new approaches that do present an important potential for future scaling up. To realize all of this we will explore the possibility to work through calls for proposals. Also in this endeavor the GoM will be involved in a systematic way;
7. The untied character of FDC will be safeguarded;
8. From a coherent rights based approach, several transversal themes will be put at the heart of our development cooperation, with specific attention for the promotion of good governance and gender, children's rights and hiv and aids. All other transversal issues, namely sustainable development and persons with disabilities shall, wherever relevant, receive due attention. In this same context, support to the Parliament of Mozambique and indirect cooperation through local civil society organizations will figure as important instruments;
9. A full-fledged strategy for results based management and risk-control will be installed within the broader framework for mutual accountability;
10. When deemed relevant and/or possible we will continue to give the fight against the negative impact of climate change and our efforts to provide a more structural form of humanitarian aid a place in this CSP. This will happen through, i.a., the support of flanking/regional initiatives whose financial resources will not be deducted from the resources committed to the actual implementation of this CSP;
11. The know-how obtained through the cooperation with Mozambique should also allow (partial) reproduction in other (partner-)countries;
12. A cost-benefit analysis of the projects and funds that receive Flemish support will constitute a major criterion for monitoring and evaluation of the development cooperation between Flanders and Mozambique.

Annex 2: Punctual Advice of The Mid Term Review of the CSP II and how it is integrated in the CSP III		
Nr.	Point of Advice	Mode of Integration
1	Strengthen <i>the technical public health expertise/capacity within the Flemish Cooperation</i>	Expertise will keep on being sourced externally and positioned strategically
2	Use additional sources of funding, beyond the funds for the CSP in a flexible manner, to fund <i>relevant activities in Mozambique beyond the CSP, on demand</i>	All additional sources of regional funding have already been allocated following a separate logic that also allows strengthening of bilateral cooperation
3	better use should be made of the presence of <i>ITM in the next CSP</i>	ITM will be involved since its support is considered to be part of the added value of the FDC in the area of Health
4	plan and implement a <i>joint formulation process, to best design the next CSP, based on clear needs as expressed by the direct and indirect beneficiaries</i>	The design for an experiment with a jointly defined call for proposals will be developed and, after scrutiny by legal services and the cabinet, implemented
5	Rather than focusing exclusively on HIV/AIDS and Reproductive Health, shift the <i>focus on basic health services / basic health care' in general</i>	Both parties agreed that an additional focus SRHR remains valid in the Mozambican context. However further attempts to integrate SRHR will be supported.
6	continue to <i>support WHO-CO</i> ; however, define clearly that the flexible cofounding of the HSS-cluster of the biannual WHO plan also should <i>include 'basic health services /care'</i>	The support to WHO-MOZ will be evaluated to assess its continued relevance and best strategic use of its competencies and experience
7	Keep M&E/research as specific theme, with a clear focus on institutional <i>support to action oriented research</i>	Has been programmed as such
8	Continue the <i>dialogue between the two governments on Prosaúde-support</i>	Has been programmed as such
9	Consider <i>prolongation of collaboration in Tete</i>	Has been programmed as such
10	<i>Revisit the aid modality in Tete Province</i> . It is recommended to support the joint implementation of <i>provincial integrated health plans</i> in a flexible manner	Has been programmed as a strategic asset but actual feasibility will have to be further analyzed due i.a. to the changing donor-landscape
11	<i>delayed projects</i> , the Flemish Cooperation in Mozambique should work together with the project managers to make a clear overview of the <i>milestones and expected results/expenditure</i> by end-2015	Ongoing process
12	identify more options for <i>delegation of activities</i> to other DPs in the health sector	Has been programmed as such but will be assessed on a case by case basis
13	<i>make more use of regular, independent project evaluations</i> (besides the financial audits), to identify lessons learned	Has been programmed as such
14	Develop, as soon as possible, a strategy to fully integrate the <i>night clinic</i> in Moatize within the health system, in a <i>sustainable</i> manner	The integration of the night clinic in the health system is in process.
15	Use the current support project – and the eventual continuation under CSP-3 - to	Has been programmed as a strategic asset but actual feasibility will have to

	the development of <i>provincial action-oriented research agenda's</i> , with full participation of local health staff	be further analyzed i.a. by assessing the strength of local institutions and/or national antennas
16	Consider to strengthen M&E systems at the <i>provincial level</i> , in which action-oriented local research plays an important role	See 10 & 15
17	invest in <i>more administrative capacity</i> , in a sustainable manner	Due to severe budgetary constraints this will not be possible