Joint Assessment of the Mozambican Health Sector Strategic Plan (PESS, 2014-2019)

August 2013

Abbreviations

Abbreviations	Explication
ACA	Joint Annual Evaluation
AIDS	Acquired Immune Deficiency Syndrome
APEs	Primary Health Care Workers
ARV	Anti Retroviral
AS	Situational Analysis
CCS	Sector Coordinating Committee
CMAM	Centre for Medicines and Medical Products
CSOs	Civil Society Organisations
CFMP	Medium Term Expenditure Framework
DAF	Directorate of Administration and Finance
DFID	Department for International Development (UK)
DHS / IDS	Demographic and Health Survey / *Inquérito Demográfico de Saúde*
DNAM	National Directorate of Medical Assistance
DNSP	National Directorate of Public Health
DPC	National Directorate of Planning and Cooperation
DPs	Development Partners
DPS	Provincial Health Directorate
DRH	Directorate of Human Resources
EPI / PAV	Expanded Program of Immunisation
FICA	Flanders International Cooperation Agency
GFATM	Global Fund to combat AIDS, TB and Malaria
GOM	Government of Mozambique
GTT	Technical Working Group
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HPG	Health Partners (working) Groups
HRH / RH	Human Resources for Health
HSS	Health Systems Strengthening
IGS	General Health Inspectorate
IHP+	International Health Partnership
I-NGOs	International Non Governmental Organisations
IFMIS	Integrated Financial Management Information System
JANS	Joint Assessment of National Strategies./ Avaliação Conjunta das Estratégias Nacionais de Saúde

M&E / M&A	Monitoring and Evaluation
MF	Ministry of Finance
MPD	Ministry of Planning and Development
MDG / ODM	Millennium Development Goals
MOH / MISAU	Ministry of Health
MTEF	Mid-Term Expenditure Framework
NCD / DNT	Non Communicable Diseases
NGO / ONG	Non Governmental Organisation
NTD / DTN	Neglected Tropical Diseases
OE	Strategic Objectives (SO)
OGE	General Government Budget
PES	Economic and Social Plan
PESS	Health Sector Strategic Plan
PF	Family Planning
PHC / CSP	Primary Health Care
PIMA	Planning, Infrastructure, Monitoring and Evaluation Group (MOH & Partners)
PPP	Public Private Partnerships
PQG	Government Five Year Plan
PRSP / PARP	Poverty Reduction Plan
PT	Traditional Midwife
QAD	Performancer Assessment Framework
RH	Reproductive Health
RHS	Human Resources of the Health Sector
RSS	Review of the Health Sector
SDSMAS	District Services of Health, Women and Social Action
SIS	Health Information System
SISTAFE	Government Financial Management System
SMI	Mother and Child Health
SNS	National Health Service
SSR	Sexual and Reproductive Health
TARV	Antiretroviral Treatment
TB	Tuberculosis
TOR / TdR	Terms of Reference
UGEA	Procurement Management and Execution Unit
UHC	Universal Health Coverage
UNICEF	United Nations Children Fund
WB / BM	World Bank

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- Finally, the team would like to thank the various partners who supported the JANS exercise financially (DANIDA, GFTAM, IHP+, USAID, WHO and FICA).

Introduction

Background and Objective

Since independence in 1975, development in Mozambique has been guided by a sequence of Five Year Plans, (*Planos Quinquenais de Desenvolvimento*). In 2002 the Government of Mozambique (GOM) initiated a series of reforms in all development sectors, aiming to start a process of decentralisation and bringing management closer to the lower levels of state organisation (Provinces and Districts). For the Municipalities, a devolution model was chosen that is currently in the process of being rolled out to all municipalities in the country. It is within this context that the health sector initiated its Five Year Strategic Plans (*Plano Estrategico do Sector da Saúde* - PESS) in 2000 with the aim to gradually improve the health status of the people. The current PESS is the third of its kind (PESS III), representing a continuation of this good management practice in the country, aiming to improve access and quality of current services (*Pilar* 1), while at the same time continuing a series of Reforms within the health sector that aim to improve effectiveness and efficiency in overall service provision at all levels (*Pilar* 2).
The health sector distinguishes four levels of service provision, going from Health Posts and Health Centres at the level of villages and sub-districts to District Hospitals to Provincial Hospitals and finally to the Central / Specialised Hospitals at the top of the health pyramid.

The drafting of the PESS 2014-2019 has gone through a long and participative process involving National and Provincial State Organisations (MOH, MF, MPD and DPS), other key national institutions, international partners and national / international NGO's. It builds on an extensive situation analysis and evidence from previous surveys and studies. The process also included a comprehensive exercise (OneHealth) to calculate the cost of the plan and the development of a robust monitoring framework.

As a final stage before formalization of the plan, the MOH and Partners decided to conduct a JANS, being an Independent Joint Assessment of the content and the process of the PESS within the context of the International Health Partnership (IHP+). The JANS was undertaken in two phases: a first phase between 10 - 16 March and a second phase between 14 - 24 July 2013. Reason for this phased approach was the observation by the team in March, that the draft PESS was not yet ready for a full assessment (in the absence of a full costing and monitoring framework). Fortunately, it proved possible to have the same team back (minus one person) three months later in July, when a full draft PESS had been finalised.

The Terms of Reference (TOR in Annex 3.1), guiding this assessment, mentions the following objectives for this assignment:
Analyze the preliminary version of the PESS III, using the various JANS tools and guidelines, in order to identify its strengths and weaknesses, and to recommend improvements where deemed necessary:
Specifically, the mission will develop a profile of the strengths and weaknesses of five sets of attributes:

1. The situation analysis, and coherence of the PESS III and its strategies with that analysis;
2. The process through which the national plan and its strategies have been developed,

including its alignment with national policies and multi-sectoral strategies, and the role of key stakeholders;
3. The adequacy of financing projections and strategies, and financing and auditing arrangements;
4. Implementation and management arrangements, including those for procurement; and
5. The results, monitoring, and review mechanisms including risk management and mitigation plan

Methodology

A mixed international and national team reviewed the National Health Sector Strategic Plan (PESS 2014 - 2019), using the combined Joint Assessment Tool and Guidelines[1] (version 2, September 2011), as developed by the IHP+ Secretariat.

The methodologies used to reach the conclusions and recommendations were:

Document review (Annex 3.4): Well before the start of the assignment in March, the team received a substantial amount of key documentation, covering major areas of programs, systems, finance and M&E. Before and during the second phase of the assessment (in July) the team received additional information, with more details about the process of the development of PESS, including the minutes of meetings that had taken place with State Institutions and Partners in all the Provinces of the country.

Key informant interviews and discussions: During the mission in March, the team met with (i) the technical working group on Planning, Infrastructure, Monitoring & Evaluation (PIMA), (ii) the technical working group, responsible for the drafting of the PESS, (iii) donors and (iv) other stakeholders.

When the team came back in July, they met again with PIMA, and GTT. Based on the previously elaborated work program (annex 3.2), the team initiated the same day an intensive series of interviews, aiming to meet with almost all stakeholders (Annex 3.3), being Senior Management in MOH, all Directorates and relevant Departments, all major programs of the sector, members of all six Aid Effectiveness working groups (both from donors and MOH), a large representation of donor agencies present in the health sector and the coordinating body for the (inter)national NGOs. Only the private sector has not been interviewed.

Field visits were conducted in March to the provinces of Sofala, Gaza and Maputo, where the team interviewed responsible staff from the Provincial Health Directorate (DPS), the NGOs and other funding partners in the Province. In addition 1-2 districts were visited in each Province, where management staff of the district and the district hospital or Health Centre staff were interviewed.

In addition and at the request of the IHP+ secretariat in Geneva, the team gave special attention to the alignment of the PESS with the strategies and plans of the various (major) programs in the country, funded mainly through GFATM. Focus was on issues related to balance, coherence and alignment in funding and in monitoring between specific program strategies and the overall sector strategy.

The latest JANS tool reduced the importance of reviewing fiduciary related issues, as JANS does not substitute for a fiduciary assessment by the DPs. However, as the Mozambican JANS team had a financial management specialist, the report does include some important observations in this field.

[1]. IHP+, September 2011. Combined Joint Assessment Tool and Guidelines (draft, Version 2)

At the end of the assignment the team debriefed informally with the JANS organising committee (PIMA)and the PESS writing team (GTT). On Tuesday 24 July the team gave a full debriefing to all stakeholders (some 100 participants). The meeting was chaired by the Permanent Secretary.

One week later (2nd August), the team leader met with DPC to agree with the MOH which of the JANS recommendations were to be included in the final version of the PESS and which were to become part of the upcoming annual plans for 2014 and 2015.

JANS Team

Members of the JANS team in Mozambique (all team members participated in their personal capacity):

NAME	PROFESSION	ATTRIBUTE FOCUS	ATTRIBUTES
Jarl Chabot, Team Leader	Public Health / Services	Governance	1 - 4 & 14
Helder Nhamaze	Anthropologist	Situational Analysis & Programming	1 - 4
Carolina Omar	Public Health Expert	Process	5 - 7
Nicolas Bidault[2]	Medical Engineer	Process	5 - 7
Bernt Andersson	Health Economist	Costs & Finance	8 - 9 &13
John Fieno[3]	Political Scientist	Implementation and Management	10 - 12
Notburga Timmermans	Health Systems Specialist	Implementation and Management	10 - 13
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Financial support for the whole JANS exercise came from DANIDA, GFTAM, IHP+, USAID, WHO and FICA.

[2] Nicolas Bidault participated in the first JANS mission in March and provided technical support and inputs from his GFATM office in Geneva.

[3] John Fieno participated only in the first JANS mission in March.

Main Observations (Executive Summary)

1.1 Overall observations and recommendations

The Mozambican Health Sector Strategic Plan (PESS 2014 - 2019) has been developed by the Ministry of Health (Department of Planning and Cooperation) together with the other Departments of the Ministry, the Provincial Health Departments (DPS), technical and financial partners and with indirect support from Civil Society Organisations. The document contains a fully costed Strategy over a five year period (developed using the OneHealth tool) and a Monitoring Framework capable to assess annually the performance of the main programs (*Pilar* 1). The PESS has been developed over a period of slightly more than one year, during which the last 4-5 months have seen an impressive process of building awareness and ownership among all stakeholders.

The document contains a detailed and comprehensive situation analysis based on extensive background documentation, including overall policies, service delivery mechanisms, health systems and governance and leadership issues. Next to its Vision and Mission statements, it proposes two intervention pillars, *Pilar* 1 focusing on more and better service provision and *Pilar* 2 addressing a series of reform areas as part of the decentralization agenda of the Government. Underpinning both *Pilars* are seven strategic objectives that respond to the various principles that guide the sector, being: improve access and utilisation; improve quality of care; reduce inequalities; improve effectiveness and efficiency; improve partnerships and transparency and - finally - strengthen the various health systems (building blocks).

In *Pilar* 1, most programs are well aligned to the PESS (e.g. priorities, indicators, budget), while in *Pilar* 2 the document has a systems-related focus, where interventions and targets still remain to be defined in some more detail. Overall, targets for *Pilar* 1 appear realistic within the 5 year time period depending upon the extent of (external) financial support and the commitment by (higher) political levels (MF, MPD). The PESS is costed using unit costs from all the building blocks and programs. It suggests three alternative scenarios. However, with the available resources, as described in the GOM Poverty Reduction Strategy, scenarios 1 and 2 are not likely to be materialized.

Given the very limited timeline to finalise the PESS, the JANS team suggests its recommendations to be considered by MOH and Partners under two headings: short-term (to be finalised within 3-4 weeks) and medium to long-term (to be included in the upcoming Annual Plans of 2014 and 2015).
Below we have summarised only our essential recommendations[4] for the short-term:

- Include the attainment of Universal Health Coverage (UHC) as an overarching aim of PESS.
- Include a description of the existing coordinating structures at central and provincial levels.
- Align the PESS to the next Five Year Plan of the Government, by changing its start to 2014 and by adding one more year to its duration. In this way PESS III will last between Jan 2014 - Dez 2019.

[4]. Annex 3.5 provides the full list of both short and long term recommendations, together with the comments and observations given by the MOH

- Elaborate as part of *Pilar* 2, Terms of Reference with timeframe, roadmap and milestones for the main Reform related interventions, as specified below in page 31-32; In this context, consider the establishment of a "Reform Unit".
- Strengthen dialogue with all PROSAUDE partners to ensure that the challenges of this important funding mechanism are addressed; MOH is requested to provide credible and strong leadership to overcome the current stalemate and / or provide medium to long term alternatives.
- In addition, PESS should include (i) a description (and costing) of the current large infrastructure development efforts; (ii) qualitative information on training additional health workers, projections and gaps; and (iii) a situation analysis on logistics management of medical and non-medical equipment and non-medical supplies. Finally, it should mention objectives, strategies and indicators for strengthening the procurement system.
- Balance the list of programme indicators, reflecting better (more balanced) the priorities defined in the PESS. Review end-of-PESS targets for the final year of the PESS (2019).
- Review and complete the list of sources of information, baselines and targets needed to assess performance.
- Align priorities and Strategic Objectives of the PESS (with its two *Pilars*, its monitoring framework and budget, based on the One Health tool) in the Annual Plan 2014, currently being developed.

1.2 Situation analysis and programming

The Situation Analysis made use of a wide range of data and information produced in a systematized way by various studies and reviews. It benefited from a broad and holistic view of the sector at large, with a refined description of the social determinants, the programs and their support systems. On the basis of this exercise it was possible to see the relationships between indicators, such as the characteristics of agricultural production, the socio-cultural matrix or environmental conditions, and the state of health in the country.

The systematic analysis carried out was connected with the strategic principles and objectives of the Plan, these latter provide a true picture of the response to the dynamics described. However, it is noted that the analysis on the one hand did not emphasize the numerous ongoing achievements of the Ministry of Health (MOH), particularly in the field of reforms, and on the other hand seemed to have been very critical of the Ministry's performance, while ignoring the relative weight of the contribution and responsibilities of other stakeholders.

Maybe related to the last point, the Plan does not include a description of the various coordination structures in the sector, although their existence is widely recognized. Likewise, the Plan falls short in defining in detail the mechanisms for collaboration between state and non-state actors. Internally it would also be an asset if the PESS III directly addressed the vertical nature of many of its programs, one of the critical points when one tries to realise the core objectives by decentralizing decision-making.

It may be noted that the MOH intervention strategy continued to focus on the curative component, with low prevalence of both the preventive dimension and of the structures attached to it, such as community health and the Health Promotion Department. The basic package of services is indicated at

the start but the document does not operationalize its implementation. The JANS team therefore recommends that the sector coordination mechanisms and structures are clarified and documented. This will help in identifying the roles and responsibilities to be assigned to each of the stakeholders.

1.3 Process

The process whereby the PESS 2014-2019 was developed showed ownership of MOH. It was led by a technical working group (GTT), established in June 2012 and consisting of senior staff from the National Directorate of Planning and Cooperation (DPC) and technical cooperation partners of MOH, who were responsible for coordinating the steps required for the elaboration and approval of the PESS within a period of one year. As the Ministry acknowledges, the timeframe was a crucial factor in conducting the process and including all aspects inherent to the elaboration of the PESS.

The elaboration of the PESS involved a process of internal consultation in which the heads of programs, departments and institutions subordinate to MOH worked with the GTT team, contributing to the development of the PESS document and to bring it in line with the existing strategies and operational plans. In addition the six joint Technical Working groups of the health sector (being Administration and Finance, Human Resources, NGOs, Service Delivery Systems, Drugs, Logistics, Procurement and PIMA) participated systematically in the development of the PESS, either collectively or individually. They all gave their contribution to improve its content and edit the first (November 2012), the second (March 2013) and the third (May 2013) draft PESS document.

The external consultation process, despite not having been systematic during the development of the PESS, took place in two phases. In the first phase, in February 2013, there was a consultation process with the MOH development partners and a national consultation involving all Provincial Health Directorates and representatives of civil society. In the second phase, in June 2013, there was a consultation process with civil society in the 11 provinces of the country that also included consultations with seven Provincial Governments and a consultation with Government institutions at central level. This consultation process was led by senior staff and technicians of MOH and also included representatives from the Development Partners (DP).

This consultation process saw a broad and comprehensive participation of provincial, district and municipal government institutions, public representatives, development partners and civil society, although private sector health care providers were not represented. MOH recognizes the efforts made to include all stakeholders in the participatory process of elaborating the PESS. However, the large-scale consultation of civil society and provincial governments was carried out at a time when the priorities of the sector for the next five years had already been decided upon, thus casting doubt on the contribution these stakeholders could make in influencing decision-making in the sector.

In Mozambique, the existence of sectoral and multi-sectoral policies such as the PQG, the PRSP and the MDG, as well as of relevant laws such as the Constitution of the Republic, guide the objectives of and the benchmarks related to the role of the health sector in the national development agenda in the short

and medium term. They facilitate their implementation, thus showing political commitment at the highest level. The PESS 2014-2019 document includes the main national political strategies and relevant legislation, consistency among programs for specific diseases and other sub-strategies of the sector, although it has to be realigned with the next planning and programming cycle of the Government, which will take place at the end of the current mandate.

The PESS document is expected to be endorsed at the highest level with the opinions of the Coordinating Health Council, the development partners (in the CCS) and approval by the Advisory Council of the Minister of Health and the Council of Ministers of Mozambique.

The main recommendation is:
Systematically integrate the consultation process of civil society in the strategic and operational planning at a moment that allows the inclusion of their views in the prioritization of strategies and recommended interventions.

Box Nr. 1: Main Events in the Development of the PESS 2014-2019

DATE	EVENT
November 2011	Review of the Health Sector (approved in October 2012)
June 2012	Establishment of the GTT
November 2012	First PESS 2013-2017 draft (circulated within MOH for comments)
December 2012	Start of the costing exercise
February 2013	Consultation of Provincial Directorates and the representatives of civil society
March 2013	Second PESS 2013-2017 draft (without costs) submitted for evaluation by the JANS team (Phase 1)
April 2013	Presentation in the CCS: Main PESS subjects and priorities to be included in the PES 2014
May/June 2013	PESS Prioritization Exercise and finalization of OneHealth
June 2013	Consultation meeting: Consultation of 11 Provinces and Provincial Government sessions
July	Fourth PESS Draft (10.07.2013) for Evaluation by the JANS team (Phase 2)
July 2013	Visit by the JANS team

1.4 Cost and budgetary framework

The PESS is costed using “OneHealth”, a tool providing templates for developing and linking costing, budgeting and financing estimates. The cost estimates of PESS are based on the coverage targets of the plan and inputs required. The costing exercise was participatory, with consultation of programs and units and includes all relevant components such as human resources, infrastructure, medical equipment, medicines, and recurrent costs. The scope of costing is limited to public sector services, due to lack of data about the private sector. The use of the tool OneHealth has provided an opportunity to do, for the first time, a comprehensive costing of a five-year plan, based on detailed calculations of cost for all

activities for all programmes and areas, needed to achieve the targets of the PESS. It is based on current costs and on existing strategic plans and acceleration plans for human resources, infrastructure, HIV/AIDS etc. The initial costing has been scrutinized to reduce costs through rationalizations and by detecting and eliminating duplication of costs. The result was a cost reduction of about USD 700 million or about 10% of the total estimated cost.

The PESS also describes three funding scenarios with detailed explanations of the assumptions for each of three scenarios and includes a gap analysis.

There are some challenges. There is not yet a multi-year budget attached to the plan. The costing of the plan has a structure that is different from the MOH budget structure, although OneHealth has a module that can be used for transforming the costing to the budget format of MOH;

The calculation of the costs for human resources is based on the HR strategic plan. The need for human resources to implement the PESS is in reality greater than what will be achieved under the HR strategic plan and there is no discussion in the PESS on how to close this gap by adding resources to increase training or provide incentives to increase hiring or retention of HR.

Since several donors cannot commit funds for the whole planning period, projections of donor support for the last years are based on historical trends. Funding projections do not include private contributions and locally collected fees, for which there is no comprehensive information of how much is collected. Private sector contributions may be substantial as found by the health sector review (13% of total health sector budget in 2006). A recent study was conducted on cost recovery and patient contributions / out-of-pocket expenditure. Since Government allocation to the health sector is about 9% of Government expenditures in 2013 (and will remain about the same level until 2016 according to the projections in the MTEF), it is not likely that scenario 1 and 2 will materialize in the coming years. Given this situation and since there is no prioritization of the plan to show what should/could be achieved in scenario 0, the PESS does not give any guidance for prioritization of targets for service delivery and coverage in the light of funding availability in 2014. As private financial contributions have not been taken into account in the scenarios of available funding, this will have underestimated the available funding.

Main recommendations are:

- The Government should allocate 15% of the Government budget to the health sector according to the signed Abuja agreement;
- A multi-year budget for 2015 – 2019 should be developed and attached to the plan, using the OneHealth budget tool;
- Priorities should be defined to ensure their priority in funding. In addition, the plan should be adapted to different funding scenarios. The targets for service delivery and coverage should be adjusted in the light of funding availability.
- The debate on alternative financing mechanisms of the sector should continue to ensure sustainability. The description of the cost recovery elements should be better developed in the new health financing strategy. A future challenge of MOH will be to increase interest and involvement of the for-profit private sector in health sector provision and financing;
- The PESS should include alternatives on how to close the HR gap.

1.5 Implementation, Financial Management and Governance

Implementation:

To guide the implementation of the PESS, MOH develops one overall annual health sector operational plan (PES) at central level. In this process, the districts start with developing their annual plans guided by the sector priorities set by the CCS in March of each year. The district plans then feed into provincial plans which in turn feed into the central level PES plan.

Various sub-sector (programmatic / thematic) plans supporting the PESS are being developed. The implementation of the annual PES and of a number of thematic / departmental annual plans is closely monitored by MOH and partners, and performance against these plans serves as milestones for disbursement of the health sector common fund PROSAUDE.

The PESS document refers to equity issues in various sections, including to distribution of human resources between health services. It mentions the equity criteria of the allocation of government funds to provinces. There is, however, no reference of the allocation formula for PROSAUDE funds to the provincial level.

The PESS includes strong references to capacity issues related to human resources and the logistics of drugs and medical supplies, including related information systems, and identifies strategies and interventions to address these issues. The need for strengthening of the HR and Logistics information systems is acknowledged and included as a priority intervention.

Main recommendations are:

- PESS chapter 2 should include (i) a description on current large infrastructure development efforts; (ii) qualitative information on current efforts to train additional health workers, projections and gaps; and (iii) a situation analysis on logistics management of medical and non-medical equipment and non-medical supplies.
- PESS section 5.2 should include objectives, strategies and indicators for infrastructure development.
- Section 5.2 could also mention that increasing training of new health workers is only one way to increase service delivery capacity, and that MOH and partners may wish to consider developing alternative strategies, or make sufficient additional funding available to further accelerate HR training and HR contracting with external resources
- Include the recommendation from the 2012 Health Sector Review (RSS) that a National Pharmaceutical Policy be developed.

Financial management

The sector has been subject to several PFM assessments and related exercises. Several action plans have been developed. The reform plan (Plano Acelerado de Reformas Institutionais, PARI 2013- 2015) includes the need for strengthening the PFM system and defines activities that should be implemented to strengthen the system at central, provincial and district level. Actions are being taken to improve the functioning of the PFM systems, with capacity building and staffing, according to action plans, although progress on impact of improving the system is slow.

There are several different audits in the health sector, the Tribunal Administrative does the general audit of the Government budget, the Inspecção Geral de Saúde (IGS) is the MOH auditor, and external audits are done by donors, i.e. for PROSAUDE and for auditing of the funds of the GFATM, the office of the Inspector General is used. General findings include irregular payments, missing supporting documents and poor registering and management of inventory and fixed assets. Systems to act on the audit findings and follow up to ensure that audit findings have been corrected are weak.
Procurement by MOH is undertaken by 2 institutions. CMAM procures drugs and most of medical supplies, whereas UGEA procures medical chirurgical supplies, as well as medical and non-medical equipment, furniture, non-medical supplies and transport facilities. All procurement is undertaken according to international standards. CMAM procurement capacity and issues are well described in the PESS document. However, the PESS does not mention challenges or objectives related to procurement of medical and non-medical equipment, furniture, non-medical supplies and transport facilities.
A challenge is the multitude of flows of funds emanating from Ministry of Finance, Ministry of Health, donors and CSOs, reaching the lower levels from several directions and at different times. The fragmentation of funding from many sources places heavy strains on the system, creating significant weaknesses in the quality of financial management systems. Delays of funding are common and repeated. The lack of staff and capacity, especially at provincial and district level hinders the full compliance with the financial systems rules and regulations.

Financial reports on budget execution are comprehensive but do not report according to the structure of activities and results defined in the strategic plan. Reports are issued mainly for donor information rather than for management purposes. Lower levels of the health sector are poorly captured in the reports. Main recommendations are:

- The PFM strengthening plan should be implemented. As part of strengthening the PFM system, attention should be given to rationalizing and simplifying the flow of funds and the timeliness of disbursements;
- Section 5.2 of PESS should include objectives, strategies and indicators for strengthening of the procurement system for non-medical products, as well as all equipment, furniture and vehicles
- Audits should be strengthened by capacity building and staff, “value for money” audits should be introduced and the system for attending to and follow-up on audit findings should be strengthened.

Governance

With regard to Governance and leadership, the PESS rightly states that governance provides the basis for the functioning of the whole health system, with coherent policies, strategies and priorities linked to evidence based decision making. Cooperation, collaboration and partnership with relevant partners are a precondition for a good performance of the public sector.
Nevertheless, some of these requirements for a proper functioning of governance and leadership in the health sector have not yet been fully put in place and/ or need to be addressed explicitly in the PESS:
Our main recommendations are:

- Include the attainment of Universal Health Coverage (UHC) in the PESS as the overarching aim for its long-term objectives / targets (20 years?).

- Include a description of the existing coordinating structures at central and Provincial levels between the various stakeholders within government (with other ministries, parliament), within MOH itself (CCC and others) and with the technical working groups (various GTTs) and financial partners (CCS, PROSAUDE).
- Align the PESS III to the next Five Year Plan of the Government, by changing its start to 2014 and by adding one more year to its duration. In this way PESS III will last between Jan 2014 - Dec 2019.
- Include the need for an external Mid Term Review (MTR) in the middle of 2016 that should assess its progress in *Pilar* 1 and *Pilar* 2 and review the preliminary targets for 2017 - 2019. Recommendations should be included in the PES 2017.
- Elaborate as part of *Pilar* 2, Terms of Reference with timeframe, roadmap and milestones for the main Reform related interventions, as specified below in page 31-32; In this context, consider the establishment of a "Reform Unit", with full time staff coming from different levels / corners of the sector, that will be part of the Organogram of the MOH and directly under the leadership of the Minister. The main task of this "Reform Unit" is to move / propel the Reforms ahead in the coming two years (2014-2015).

1.6 Monitoring, Evaluation and Review.

The Planning and Cooperation Directorate (DPC) of the Ministry of Health has prepared a valuable and practical monitoring and evaluation framework to monitor the implementation and performance of the PESS. The recently created Monitoring and Evaluation Department within DPC is an essential condition to orient monitoring, in collaboration with the implementing and financing partners of the Ministry. Valuable procedures are in place, and used since 2011, to perform joint monitoring, including on-site verification of data quality. The current PESS draft document plus the M&E Annex contain a comprehensive set of indicators on various levels (impact, strategic objectives and results).
As outlined above, the strategic vision and plan for existing programmes and services is well developed. However, the Reform agenda (Pillar 2 in the PESS) has not yet been developed in sufficient detail. Therefore, no clear monitoring system has been presented to accompany the reforms.
Within the presented framework, the choice of indicators incompletely reflects the defined priorities. Sexual and Reproductive Health dominates the indicator list, while preventive and promotive interventions are poorly represented. Also, the inclusion of detailed clinical services in the PESS, without sufficient adequate performance indicators and measurable targets, will make monitoring of this part of the strategic plan difficult if not impossible.

Main recommendations are:

1. To balance the list of programme indicators, reflecting better the priorities defined in the PESS.
2. Review end-of-PESS targets for the new final year of the plan (2019).
3. Expand the plans and desired end results for the transition to HMIS data management using information technology.

2. Assessment of the PESS III

2.1 Situation Analysis and Programming

Situation Analysis & Programming Clarity and relevance of priorities and strategies selected, based on sound situation analysis
STRENGTHS
Attribute 1: Strategy based on sound situational analysis
Δ The Situation Analysis (AS) made a detailed description of the Health sector, with sections that focused on the country's profile within its political context, economic factors and cultural determinants; ending with the major social determinants that influence the health status of both the demand and the supply side of services. The relationships established with the country's agricultural production characteristics, the educational level of its population or the prevailing environmental conditions (water, housing, etc.), provide a thorough and systematic view on the state of health in Mozambique. Δ The above is linked with the characteristics of health services delivery in the country and its various sub-systems and elements, as a way to address the contours of the national response to the challenges posed to this sector. The performance of the various programs within the health services and their related support systems are described in-depth and consistent. Δ The AS benefited from updated analyses and data from recently conducted studies and reviews, such as those of the Health Sector Review (RSS, 2012), the Annual Joint Evaluation (ACA, 2012), the Demographic and Health Survey (IDS, 2011), or the National Survey on Prevalence, Behavioural Risks and Information on HIV and AIDS (INSIDA, 2010). These sources enabled the AS to be holistic and technically rich, thanks to access to up-to-date and disaggregated data on the prevailing situation and the quality of the current response, based on a variety of key indicators.
Attribute 2: Clear goals, policies, objectives, interventions and expected results
Δ The Situation Analysis and the principles, priorities and strategic objectives of the PESS form a coherent whole. For example, identifying weaknesses such as the low level of education of the population and cultural obstacles are linked to sector weaknesses such as poor coverage. This explains the emphasis placed on access to services by the majority of the population, which is reflected in the PESS III Vision and its Mission. The strategic objectives are aligned. They aim to improve access to services, but also to improve their quality and reducing geographical inequalities affecting different population groups. The interventions aimed at reducing inequalities ensure that the Plan addresses the needs of the most vulnerable - among whom are the poor -; a national requirement of the highest order. Δ The PESS III identified five priorities and seven Strategic Objectives (OEs) for Mozambique's health sector, each one with a baseline indicator, process/result indicators, goals and impact. These objectives jointly address the weaknesses identified in the services and support systems, and as such it is expected that they will have a significant impact on the general state of health of the population. There is thus clarity and interconnection between outputs to be achieved at different levels. The interventions and goals of the programs and services are linked to Strategic Objectives of Pillar 1 ("More and Better Health Services"), while challenges related to strengthening the system and to the desired reforms are included under Pillars 1 and 2 ("Reform

Agenda"). The use of the OneHealth tool allowed for the elaboration of a Five Year Strategic Plan that would include the costing and the possibility of three different scenarios.
Attribute 3: Interventions are feasible, appropriate, equitable ad based on evidence
Δ The conceived interventions took full advantage of a holistic Situation Analysis, based on the systematic empirical evidence from various studies. As such, the interventions are rooted in a deep knowledge of the system and its internal dynamics.
Attribute 4: Risk assessment and proposed mitigation strategies
Δ Chapter 10 includes a detailed risk assessment, followed by a risk matrix (as used by the Australian Agency for International Development, AusAID). It also contains proposals for mitigation measures for these risks and the prioritization of these risks seems quite convincing.
WEAKNESSES
Attribute 1: Strategy based on sound analysis
∇ The Situation Analysis did not emphasize the achievements of the Ministry of Health (MOH) in the area of Reforms. There was (and is) a set of activities already being undertaken by the ministry that has not been taken into account in the "Background" presented in the Plan. ∇ The description of the sector's performance seems to be very critical with respect to MOH. It leaves untouched the role and contribution of other stakeholders. Few of the many positive achievements of the Ministry were duly noted.
Attribute 2: Clear goals, policies, objectives, interventions and expected results.
∇ The PESS III text places more emphasis on the curative than on the preventive component in the provision of health services (the same goes for the curative component's budget, which is higher than that for prevention). Preventive interventions, such as community health, are apparently to be taken care of by civil society, without the necessary leadership and guidance of MOH. This state of affairs is mirrored in the Department of Health Promotion (DEPROS), whose activities are fragmented by a huge variety of programs and stakeholders. ∇ Interventions are greatly influenced by the existing coordination structure and involve various stakeholders. These entities are not explicitly addressed by the PESS. These structures have been in existence for some time and have been functioning in different programs of interest both to MOH and to the other parties. Perhaps they have not been mentioned in the PESS due to their ubiquitous presence. ∇ The Plan addresses in a rather marginal way the collaboration among state and non-state actors, one of the secrets of a multifaceted and complete implementation. There are several areas in which the roles and responsibilities of the parties are not clear, while their limits are not clearly defined. ∇ The Plan does not directly and specifically address the problem of the vertical nature of many of the MOH programs. Given the strong position and influence of these national programs, it is important if the MOH were to include a firm position on their organisation within MOH and the financial flow of their funds
Attribute 3: Interventions are feasible, appropriate, equitable ad based on evidence
∇ The Reform Agenda does not provide many operating details and due to the lack of these elements the feasibility of conducting such reforms cannot be determined in advance. There is a certain level of clarity at the level of intentions but the document still shows a lack of essential elements for action. ∇ The PESS III clearly expresses the intention to address inequity and the needs of the poorest, but does not explain HOW it intends to operationalize this objective. The alleviation of poverty is a national objective and the reason for the involvement of various actors but the persistent challenge is to define forms of concrete action to achieve the desired results.

∇ Another problem not addressed concretely are the financial barriers faced by the poorest when it comes to access to quality services. The Plan does not focus on HOW it wants to remove these barriers so that the poorest do have this access. ∇ There is evidence of rapid private sector development at country level (including the mega-projects), and this is already being strongly felt in healthcare. However, the PESS does not address the (future?) role of the private sector vis-á-vis the provision of health services by the public sector, while some activities and/or programs are already being developed by this sector. ∇ As a first step the PESS III addresses the need for the development of a basic health care package but the idea is not further operationalized.
Attribute 4: Risk assessment and proposed mitigation strategies
∇ While the Plan includes a chapter with risks and mitigation measures, it does not include contingency plans for responding to Emergency situations. This is critical, given the recent history of the country in terms of cyclical natural disasters (such as flooding).
IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION
The Situation Analysis was prepared by making use of various studies and other documented evidence. Once the analysis has identified some gaps in our information, one should take these into account when suggesting solutions for the implementation stage.
SUGGESTED ACTIONS Short term
1. Include a section in the PESS that describes the existing coordination structures at central level within MOH and between MOH and: 1. Other Ministries, 2. Associations and parastatal agencies, 3. Development Partners through various Technical Working Groups (GTTs), 4. Civil society (NGOs, international, national, community-based organizations (OBCs), 5. Private sector (for-profit). 2. Where necessary, review the performance, the TOR and the composition and frequency of meetings of these coordinating /collaborating structures. 3. Chapter 7 on Implementation Mechanisms could benefit from a more detailed account about HOW the PESS will be put in place and what contribution is expected from the various stakeholders at different levels.
SUGGESTED ACTIONS: medium to long- term
4. Develop an operational 'district health system' with its internal and external management and referral systems

2.2 Process

PROCESS Sound and comprehensive processes for the development and approval of the national strategy.
STRENGTHS
Attribute 5: Involvement of multiple partners
Δ The process of elaborating the PESS 2014-2019 involved strong leadership coordinated by the GTT, in which also participated the heads of programs, departments, subordinate MOH institutions, senior staff and technicians of MOH, and with a significant contribution of the six Health Partners Groups (HPG) of the technical and financial partners.

Δ Other stakeholders, including national and local government institutions, public representatives and civil society were involved through a consultation process that occurred in two phases (February and June 2013) in order to enable these stakeholders to contribute to the development of the national strategy. The participation of civil society representatives to these hearings was decided upon by the provinces themselves, however, terms of reference were in place for holding these consultation meetings. Δ Staff working in the health sector and the technical and financial partners of MOH and the government were involved in the systematic development of the PESS, while civil society played a more consultative role in the process of reviewing the interventions the health sector eventually adopted in the PESS document.
Attribute 6: Political Commitment
Δ There exist sectoral and multi-sectoral policies, such as the PQG, the PRSP and the MDG, as well as relevant legislation such as the Constitution of the Republic, which guide the short and medium term targets with respect to the role of the health sector in the national development agenda. They facilitate their implementation, thus showing political commitment at the highest level. The document is expected to be endorsed at the highest level (Coordinating Health Council, CCS) Advisory Council of the Minister of Health and the Council of Ministers).
Attribute 7: Coherence with the relevant highest and lowest level strategies
Δ There is consistency between the PESS 2014-2019 and the programs for specific diseases and other sub-strategies within the health sector. The PESS strategies are consistent with program objectives, goals and are aligned with the political national development strategies (QGP, PRSP, MDG), despite the sector having to commit itself to maintain this realignment in the new cycle of Government planning and programming foreseen at the end of the current mandate (2015).
CHALLENGES
Attribute 5-7 (Crosscutting)
∇ The decision process concerning the priorities of the sector was centralized within MOH and its technical and financial partners, leaving civil society with a mere consultative role. ∇ There was no visible private sector participation throughout the PESS development process.
IMPLICATIONS FOR THE SUCCESS OF IMPLEMENTATION
• Political commitment is not shown by the decision to preferably increase funding of the health sector by the State Budget, as indicated by the projections of the of the Medium-Term Financing (MTEF) scenario of 2014-2016. • The strategy recognizes that it has difficulty implementing the reforms referred to in the PESS, since aspects of its operationalization involve other state sectors, as in the case of aspects linked to decentralization. In other cases, it will be necessary to elaborate regulations or legislative frameworks that enable implementation, such as the role of the private sector in providing health care.
RECOMMENDED SHORT TERM ACTIONS
1. Chapter 7 of the PESS document (Implementation and Operationalization of the PESS), should systematically include the participation of civil society and private service providers in the PESS operational planning process at national, provincial and district level, so as to allow them to participate in the decision-making process concerning prioritization of national strategies. 2. Present the final PESS document to the main stakeholders of the sector (national and local institutions, government, public representatives, civil society including health services providers from the private sector and the technical and financial partners of MOH) before the document is sent for approval at the highest level.

2.3 Cost and Budgetary Framework

Costs and Budgetary Framework Soundness and feasibility
STRENGTHS
Attribute 8: Expenditure Framework including comprehensive budget/costing
Δ The PESS is costed using the tool "OneHealth", a tool providing templates for developing and linking costing, budgeting and financing estimates. The cost estimates of PESS are based on the coverage targets of the plan and inputs required. It estimated the costs of achieving the defined health outcomes for service delivery and the cost of strengthening health systems; Δ The costing exercise was participatory, with consultation of programs and units, based on best available evidence on unit costs and can be considered credible. The costing includes all relevant components such as human resources, infrastructure, medical equipment, medicines, and recurrent costs; Δ The use of the tool OneHealth has provided an opportunity to do, for the first time, a comprehensive costing of a five-year plan, based on detailed calculations of cost for all activities for all programmes and areas, needed to achieve the targets of the PESS, based on current costs and on existing strategic plans and acceleration plans for human resources, infrastructure, HIV/AIDS etc; Δ The initial costing has been scrutinized to reduce costs through rationalizations and by detecting and eliminating duplication of costs. The result was a cost reduction with about USD 700 million or about 10% of the overall estimated PESS costs.
Attribute 9: Realistic budgetary framework and funding projections
Δ The calculation of the expected resource envelope includes government funding, funding of PROSAUDE, and donor contributions on-budget and off-budget, for three funding scenarios; Δ The PESS contains a detailed explanation of the assumptions for each of three funding scenarios. The low scenario (scenario 0) assumes that government financing of the health sector will follow BIP (7-8% annually). The middle scenario (scenario 1) follows the MTEF (CFMP) for government funding, maintains current level of funding for PROSAUDE and agreed disbursements from the Global Fund. The high level scenario (scenario 2) is based on government commitment to the Abuja declaration, allocating 15 of government budget the health sector. All scenarios take into account donor commitments for 2014 and 2015 and for the following years estimates are based on recent trends; Δ The PESS includes a gap analysis under all three funding scenarios.
WEAKNESSES
Attribute 8: Expenditure Framework including comprehensive budget/costing
∇ The scope of costing is limited to public sector services, due to lack of data about the private sector; ∇ There is no multi-year budget attached to the plan. The costing of the plan has a structure that is different from the MOH budget structure, although the tool OneHealth has a module that can be used for transforming the costing to the budget format of MOH; ∇ Assumptions and the details of how costs have been calculated are not explained, but will be explained in a separate report about the costing exercise; ∇ The costing exercise have been done by temporary technical assistants and the method of costing has not been fully institutionalized within the Ministry of Health, although some staff has

received training and several programmes have expressed a desire to use the OneHealth tool for their future planning;

- ∇ The calculation of the costs for health human resources is based on the HR strategic plan. The need for human resources to implement the PESS is in reality greater than what will be achieved under the HR strategic plan and there is no discussion in the PESS on how to close this gap by adding resources to increase training or provide incentives to increase hiring or retention of HR.

Attribute 9: Realistic budgetary framework and funding projections

- ∇ Since several donors cannot commit funds for the whole planning period, projections of donor support for the last years are based on historical trends,
- ∇ Funding projections do not include private contributions and locally collected fees, for which there is no comprehensive information of how much is collected. Private sector contributions may be substantial as found by the health sector review (13% of total health sector budget in 2006). A recent study was however conducted on cost recovery in the health system and patient contributions / out-of-pocket expenditure;
- ∇ The opportunity when developing the PESS, to discuss possible innovative financing models like public-private partnerships has not been used;
- ∇ Government funding (OGE) to the health sector has fallen in recent years. Since Government allocation to the health sector is about 9% of government expenditures in 2013 and remains about the same level until 2016 according to the projections in the MTEF, it is currently not likely that scenario 1 and 2 will materialize;
- ∇ There is no prioritization of the plan to show what should/could be achieved with different funding scenarios. There is no discussion on how to ensure that top priorities get priority in funding, or how to adapt the plan to different funding scenarios. The targets for service delivery and coverage are not adjusted in the light of funding availability.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- Costs for implementing the PESS are above all of the three scenarios and implementation of the desired health outputs as expressed in PESS requires a financing of at least scenario 0;
- The fact that the structure used for the costing of PESS has not yet been transformed to the government budget structure will make it difficult to introduce PESS actions and costs in the 2014 health sector planning and budgeting;
- Without closing the gap between available and desired health human resources, the PESS cannot be fully implemented. Priorities have not been defined to adopt PESS to different levels of HR availability;
- Since it is not likely that scenario 1 and 2 will materialize, at least for the next couple of years, and since there is no prioritization of the plan to show what should/could be achieved in scenario 0, the PESS does not give any guidance for prioritization of targets for service delivery and coverage in the light of funding availability for 2014;
- The fact that private financial contributions have not been taken into account in the scenarios of available funding have underestimated the available funding, and the need for prioritization may be less than calculated under the gap analysis.

SUGGESTED ACTIONS (short term)

1. A budget for 2014 should be developed and attached to the plan, using the OneHealth tool;
2. The PESS should include alternatives on how to close the HR gap;
3. Continue to promote dialogue with PROSAUDE partners to ensure that this important funding mechanism for the health sector continues to function;
4. The results from the study on cost recovery in the health system and patient contributions / out-of-pocket expenditure should be taken into account to revise the funding scenarios in the

revised version of the PESS;
SUGGESTED ACTIONS (medium to long-term)
1. The Government should allocate 15% of the government budget to the health sector according to the signed Abuja agreement; 2. A multi-year budget for 2015 – 2019 should be developed and attached to the plan, using the OneHealth budget tool; 3. A detailed explication of assumptions for estimations of unit costs should be added as an annex to PESS; 4. The use of OneHealth as a method of planning, costing and budgeting should be institutionalized within the Ministry of Health; 5. Efforts should be made to improve the reporting on private contributions and locally collected fees, and if possible include these in the funding; 6. Priorities should be defined to ensure that top priority interventions are prioritized in receiving funding. The plan should also be adapted to different funding scenarios. The targets for service delivery and coverage should be adjusted in the light of funding availability. 7. The debate on alternative financing mechanisms of the health sector should continue to ensure sustainability. The description of the health sector's cost recovery elements should be included in the new Health Financing Policy. A future challenge of MOH will be to increase interest and involvement of the for-profit private sector in health sector provision and financing.

2.4 Implementation, Financial Management and Governance

Implementation and Management Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy
STRENGTHS
Attribute 10: Operational plans detail how the strategy will be achieved
Δ MOH develops one overall annual health sector operational plan (PES) at central level, which defines the priority interventions for the implementation of the PESS during that year, supported by the GOM and partners. Similarly in each province, the DPS develops annual provincial PES to guide the implementation of the PESS in the province. Δ Various sub-sector (programmatic / thematic) plans supporting the PESS have been developed, including the Strategic Plan for Human Resources for Health (PNDRHS) for 2008 – 2015 and its sub-plans and operational plans; the recent Strategic Plan for Pharmaceutical Logistics (2013 – 2017); and Acceleration Plans, such as those for HIV and TB. Thematic / programmatic annual operational plans have also been developed for some directorates / departments / institutions. Δ The implementation of the annual PES and of a number of thematic / departmental annual plans is closely monitored by MOH and partners. Performance against these plans serves as milestones for PROSAUDE disbursement (e.g. the Public Financial Management Action Plan, the Pharmaceutical Logistics Action Plan, etc.). Δ Operational plans often include piloting of intervention strategies / approaches / technologies by district authorities and health services with support from technical partners and implementing agencies. Unfortunately these pilots are not always undertaken with prior agreement by district, provincial and central authorities.

Attribute 11: Describes how resources will be deployed to achieve outcomes and improve equity

- Δ The overall organisation of health service provision by the National Health Service is defined and the resources required for the NHS are included in the costing of the PESS.
- Δ Chapter 3 of the PESS document mentions the intention to formulate and implement an essential health package for each level of service provision.
- Δ In the equity section there is mention of the Ministry of Financial provincial allocation formula used for allocation of government resources to provinces.
- Δ The PESS and the Human Resource Strategic Plan and associated plans address issues of inequity of HR distribution over geographic areas and institutions. The PESS mentions the recently implemented incentives system which encourages staff accepting to be allocated in remote rural areas.

Attribute 12: Adequacy of institutional capacity

- Δ The need for strengthening of institutional capacity is well integrated into various sections of the PESS document.
- Δ The PESS includes strong references to capacity issues related to human resources and to the logistics of drugs and medical supplies and identifies of strategies and interventions to address them. The need for strengthening of the HR and Logistics information systems is acknowledged and included as priority intervention.
- Δ The HRH objectives mentioned in PESS are in line with recommendations from the recent mid-term evaluation of the HRH plan (PNDRHS).
- Δ Guidelines for planning and supervision exist for each level (central, provincial and district).
- Δ The PESS document mentions that a technical group of MOH staff focusing on coordination and guiding reforms will be placed within the Health Minister's Cabinet.
- Δ The PESS document identifies some needs for short- and long-term technical assistance.

Attribute 13: Financial management and procurement

- Δ SISTAFE (*Sistema de Administração Financeira do Estado*) and the e-SISTAFE (the IFMIS - Integrated Financial Management Information System) are strong systems, compliant with national and international standard, fully implemented and in general complied with at national level but less at lower levels of government;
- Δ The sector has been subject to several PFM assessment and related exercises, from which an Action Plan to Improve PFM has resulted;
- Δ Actions are being taken to improve the functioning of the PFM systems, with capacity building and staffing, according to action plans, although progress on impact of improving the system is slow. The PESS document refers to the *Plano Acelerado de Reformas Institutionais* (PARI), which defines urgent interventions in 2013 – 2015 for capacity building at central, regional and district levels in areas of administration & finance, planning, HR management, logistics and distribution of drugs and medical supplies (CMAM), procurement (UGEA) and inspection.
- Δ There are several different audits in the health sector, the Tribunal Administrative does the general audit of the government budget, the *Inspecção Geral de Saúde* (IGS) is the MOH auditor, and External audits are conducted by donors, i.e. for PROSAUDE and the funds from GFATM by the Inspector General. Technical assistance is provided to MOH for the same purpose;
- Δ Procurement by MOH is undertaken by 2 institutions. CMAM procures drugs and most of medical supplies, whereas UGEA procures a few medical chirurgical supplies, as well as medical and non-medical equipment, furniture, non-medical supplies and transport facilities. All procurement is undertaken according to international standards. CMAM procurement capacity and issues are well described in the PESS document.

Attribute 14: Governance, accountability, management and coordination mechanisms

- Δ For many years the health sector is used to strong central planning mechanisms, such as the PESS and the PES. Both set the priorities and define the planning and monitoring formats in the Provinces and Districts.
- Δ Responsibilities and accountability between Central, Provincial and District level in the context of the decentralisation process has been defined, as well as the implications for the health sector of the devolution to the municipalities (both funding + planning mechanisms)
- Δ Sector management is undertaken by the six Directorates in MOH. They meet weekly with the Minister or Permanent Secretary (PS) to share information and decide on critical actions.
- Δ There are well established structures for regular consultations and coordination between MOH and its (financial and technical) partners at policy level (CCC and CCS) and at technical level (GTTs). This collaboration has been anchored in the Memorandum of Understanding of 2008 (for the PROSAUDE donors) and the Kaya Kwanga Code of Conduct of 2003 for all those partners that work in the health sector. There are also well established mechanisms that regularly review the performance of the sector (ACA + QAD) and provide follow-up on its recommendations.
- Δ All the major National Programs are completely aligned to the PESS III, both in terms of their budget (including the off-budget donors) and in terms of their monitoring framework (including definition of indicators, baseline and targets).

WEAKNESSES

Attribute 10: Operational plans detail how the strategy will be achieved

- ∇ PESS section 5.2 (describing health sector "support systems") does not include indicators, whereas section 5.1 describing health programmes does include indicators.
- ∇ The PESS document and programmatic / thematic strategies do not always clearly describe who is accountable for activities and who is responsible for implementation.
- ∇ District planning processes are not yet strong: interventions are mainly planned at provincial level and included in annual provincial plans.
- ∇ The current plethora of various health sector sub-sector thematic strategies and operational plans are not always clearly linked to the PESS, and may not always be harmonised with the PESS and other sub-sector plans.
- ∇ There is no mechanism defined in the PESS document for ensuring that best practice and lessons learned from pilot projects and innovation, feed back into central level policy decisions and implementation.
- ∇ Whereas PESS section 6.2 mentions the intention of MOH to develop an integrated infrastructure plan, the chapter 2 situation analysis does not mention the on-going efforts to increase / strengthen health service infrastructure; and section 5.2 does not include any reference to infrastructure development.
- ∇ The 2012 Health Sector Review (RSS) recommended that a National Pharmaceutical Policy be developed, in order to define the national drugs policy and confirm the division of tasks and responsibilities between the various institutions active in the pharmaceutical sector. This recommendation has not been included in the PESS document.
- ∇ The role and responsibility of traditional medicine is not clearly defined in the PESS document.

Attribute 11: Describes how resources will be deployed to achieve outcomes and improve equity

- ∇ Whereas the intention to develop an essential health package for each service level is mentioned in chapter 3, there is not further reference to this issue in chapters 5 and 6.
- ∇ The PESS document only contains a short description of service providers, with no mention of

private for-profit companies.

- ∇ The equity section does not refer to another important effort of MOH to ensure equity of resource allocation, namely the provincial allocation formula of PROSAUDE funds.
- ∇ The PESS document does not include any mention of a mechanism for allocation of newly trained staff to priority technical / programmatic areas / services.
- ∇ There is no mention of the overall aim of the health sector providing medical drugs and supplies, to improve the availability of drugs at the level of the peripheral health facilities and the patient.
- ∇ In the description of drugs and medical supplies in section 5.2.4, the strategies defined for the various programmatic areas are unclear[5]. Furthermore, the text in the Pharmaceutical area only refers to the responsibility of quality control for drugs procured by MOH, instead of referring to responsibility for ensuring quality control of drugs procured by all actors in the sector.
- ∇ Chapter 3 does not formulate objectives or strategies for management and logistics of non-medical supplies, medical and non-medical equipment, and maintenance; nor mention the need to develop a strategic plan for these areas, as currently no plan is available.

Attribute 12: Adequacy of institutional capacity

- ∇ Chapter 2 of the PESS document does not contain any qualitative information on current efforts to train additional health workers, projections and gaps, nor of the need to professionalise management tasks.
- ∇ There is no mention in the PESS of alternative strategies for increasing capacity for service delivery (other than by training and recruiting increased numbers of staff).
- ∇ The PESS does not contain a systematic analysis of Technical Assistance needs.

Attribute 13: Financial management and procurement

- ∇ There is a multitude of flows of funds emanating from Ministry of Finance, Ministry of Health, donors, technical projects and civil society organisations (CSOs), reaching the lower levels from several directions and at different times. The fragmentation of funding from many sources places heavy strains on the system, creating significant weaknesses in the quality of financial management system;
- ∇ Delays in funding disbursement by the Government of Mozambique and by donors (incl. PROSAUDE) are common and repeated. There are no systems in place to ensure more timely disbursements;
- ∇ The lack of staff and capacity, especially at provincial and district level hinders the full compliance with the financial systems rules and regulations;
- ∇ Financial reports produced by MOH on budget execution are comprehensive but do not report according to the structure with activities and results defined in the strategic plan; Reports are issued mostly for donor information rather than for management purposes. Lower levels of the health sectors are poorly captured in the reports;
- ∇ Audit reports from the "*Tribunal Administrativo*" are general audits and do not contain specifics for the health sector. General findings include irregular payments, missing supporting documents and poor registering and management of inventory and fixed assets;
- ∇ IGS lacks capacity both in number of staff and knowledge, and cannot regularly audit the health sector. Audits do not include assessment of value for money;
- ∇ Systems to act on the audit findings and follow up to find out whether audit findings have been

[5] These areas are: the "area farmaceutica", "area logistica de medicamentos" and "area de farmácia hospitalar." The Direcçao Nacional de Farmácia will provide a corrected text to DPC.

corrected are weak;

- ∇ The PESS does not mention the issue of the current absence of a procurement oversight committee, which existed previously.

Attribute 14: Governance, accountability, management and coordination mechanisms

- ∇ Coordination structures for the various intersectoral activities, (such as nutrition, water and sanitation, school health) have not been well defined, thus limiting the process to address the various social determinants of health (highlighted in the Situational Analysis)
- ∇ The performance of the various coordination structures between MOH and the partners (CCC, GTT) varies in outputs and quality. The participation in these structures of I-NGOs is regular and constructive. However, participation by National NGOs and the Private Sector is limited or even non-existent.
- ∇ Time-wise the period of the PESS 2014-2019 is not fully aligned to the Strategic Plan of the Government (PQS) and its Poverty Reduction Plan (PRSP). In addition, half of the year 2013 has already passed and the PES 2014 is currently being prepared;
- ∇ Objectives and challenges of the funding modality of the PROSAUDE donors has not been addressed in the PESS, resulting in stagnation and poor commitment by the partners
- ∇ While Mozambique joined the IHP+ secretariat in 2007, the need to improve Harmonisation and Alignment by MOH and its partners has not specifically been addressed in the PESS.
- ∇ The important Reform Agenda proposed in Chapter 6 (Pillar 2) seems an open-ended unstructured intervention, without Terms of Reference, outputs, timeline and milestones.
- ∇ The National Health Policy, written in 1979, has never been updated or revised since.
- ∇ The issue of Regulation and Control in the sector (accreditation, law enforcement, private sector regulation, drug control) and the role of the various Association (doctors, nurses) and regulatory bodies has not been adequately addressed in the PESS. Developing systems for accreditation and the minimum health care package will be essential inputs when addressing the Reforms (*Pilar* 2) or drafting the health financing policy.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

Implementation

- Successful implementation of the PESS will very much depend on how well provinces and districts are engaged and supported in planning and operationalization of the strategic plan.
- Successful implementation of the PESS will also depend on GOM and partners making the required resources available and on partners aligning their support to GOM strategies and systems at central AND Provincial levels.
- On-going and proposed construction of new health facilities in remote and under-served areas has a multiplier effect on the demands for additional qualified health workers, equipment and operational budgets. This must be taken into account as projections for human resources are computed.

Costing and Financial Management

- The multitude of funds flowing to the provinces and districts, the delays in disbursements and the lack of capacity for financial management - specifically at lower levels, procurement and the capacity for taking actions and follow-up on audits will hamper the implementation of PESS.
- Successful implementation of the PESS will to a large extent depend on improvements in financial management and timely reporting on expenditure of the various funding sources.

Governance

- In the longer run the implementation of the full reform agenda (*Pilar* 2) as detailed in the outputs (Terms of References) described below will contribute substantially to improvements in the quality of service delivery, improve access (geographical and financial) and monitoring.
- Much will depend on an improved working climate and confidence between the partners in the sector, re-installing the trust that characterised the health sector a few years ago. Therefore, the issues of the IHP+ and the Paris / Accra Declaration are still very relevant at this moment.

SUGGESTED ACTIONS in the short term

1. PESS chapter 2 to include:
    - Description on current large infrastructure development efforts.
    - Qualitative information on current efforts to train additional health workers (pre-service training), projections and gaps.
    - Situation analysis for logistics management of medical and non-medical equipment and non-medical supplies.

2. PESS section 5.2 to include objectives, strategies and indicators for:
    - Strengthening of the procurement system for non-medical products, as well as all equipment, furniture and vehicles. Mention that MOH and partners may consider the re-establishment of a Procurement Oversight Committee (*Comité das Compras*).
    - Strengthening of logistics management of medical and non-medical equipment and non-medical supplies.
    - Infrastructure development.
    - MOH and partners may wish to consider developing alternative strategies, or make sufficient additional funding available for further acceleration of HR training and HR contracting with external resources

3. Consider the recommendation from the 2012 Health Sector Review (RSS) that a National Pharmaceutical Policy be developed. When drafting the National Pharmaceutical Policy also address the division of tasks and responsibilities between the various institutions active in the pharmaceutical sector.

Governance: Short Term

1. Include the attainment of Universal Health Coverage (UHC) in the PESS as the overarching aim for its long-term objectives / targets (20 years?).
2. Include a description of the existing coordinating structures at central and Provincial levels between the various stakeholders within government (with other ministries, parliament), within MOH itself (CCC and others) and with the technical (various GTTs) and financial partners (CCS, PROSAUDE). Revise (where relevant) for each, its objectives, expected outputs, chair and composition and frequency of meetings.
3. Align the PESS III to the period of the next Five Year Plan of the Government, by changing its start to 2014 and by adding one more year to its duration. In this way PESS III will cover the period between January 2014 - December 2019. Include the need for an external Mid Term Review (MTR) in the middle of 2016 that should assess its progress in *Pilar* 1 and *Pilar* 2 and review the preliminary targets for 2017 - 2019. Recommendations of the Mid-Term Review should be included in the PES 2017.
4. Elaborate as part of *Pilar* 2, Terms of Reference with timeframe, roadmap and milestones for the

main Reform related interventions; outputs to become as follows:

- Minimal health service package defined by level and district health system defined, including referral systems,
- Health Financing Policy / Strategy drafted
- Integrated Plan for Infrastructure Development (PIS) finalised
- National Pharmaceutical Policy defined / drafted
- Relation with the Private Sector (collaboration, control, regulation / accreditation) clarified
- Sub-plans in the various programs harmonised with the PESS (time frame, content, budget and M&E)
- Hospital Reform Plan defined together with the new roles and responsibilities of DNAM
- Admin and financial autonomy of CMAM defined
- Adequate architecture for the various information systems, such as SIS, LMIS, HRIS finalised

5. Consider the establishment of a "Reform Unit", with full time staff coming from different levels / corners of the sector that will be part of the Organogram of MOH and directly under the leadership of the Minister. The main task of this "Reform Unit" is to move / propel the Reforms ahead in the coming two years (2014-2015).

SUGGESTED ACTIONS in the medium to long term

Costing: Medium to long term (in PES 2014 and PES 2015)

1. PFM strengthening plans - including strengthening of procurement - should be fully implemented;
2. As part of strengthening the PFM system, attention should be given to rationalizing and simplifying the flow of funds and the timeliness of disbursements;
3. The IGS should be strengthened by capacity building and additional allocation of staff at the various levels; “Value for money” audits should be introduced;
4. The system for attending to and follow-up on audit findings should be strengthened;
5. The alternative of out-sourcing procurement should be explored, taking into account advantages and disadvantages.

Governance: Medium to long term

6. Once the PESS has been approved, develop (i) a communication strategy defining how the PESS will inform and guide the various stakeholders in the sector at national, provincial and district / facility levels and (ii) a simplified short version of the PESS for use by others that are not directly involved in its implementation (district / provincial governments, political parties, media etc)
7. Initiate the process to develop a new National Health Policy

2.5 Monitoring, Evaluation and Review

Monitoring, Evaluation and Review Soundness of review and evaluation mechanisms and how their results are used
STRENGTHS
Attribute 15: The plan for M&E is sound, reflects the strategy and includes core indicators, sources of information, methods and responsibilities for data collection, management, analysis and quality assurance
Δ The PESS and the accompanying M&E strategic plan describe a comprehensive framework that permits the monitoring of the performance of the national strategy. A comprehensive list of indicators for impact and strategic objectives of the plan exist. The majority of the indicators have baseline data, mostly from the 2011 DHS, and from specific population based surveys. In the Pillar One section of the PESS, nine out of 36 indicators reflect performance in health systems strengthening (human resources, infrastructure, budget, equity); the remaining 75% are programme-based impact and strategic objective-based indicators. This seems a reasonable balance. It is noted that indicators for Reforms (*Pilar* 2) are hardly present in the document. Δ The indicators that reflect programme performance are almost totally aligned with programme strategic plans, although the periods covered in the plans are not always the same. Δ The Ministry of Health and its Directorate for Planning and Cooperation have embarked since a few years on a process of using information technology for data management of the HMIS. The vision, the plan and the progress made to-date was not well described in the PESS.
Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action
Δ A series of procedures and interventions is in place since 2011 to review progress, to validate data for indicators used to measure performance of the strategic plans. Quarterly '*balanços*', annual reviews including visits for data verification to the provinces are fully operational. These reviews include the participation of the major development partners (bilateral and multilateral donors), and to a lesser extent representatives of civil society. The results of these reviews are disseminated to the major stakeholders. Reportedly the results are used to adjust activities and budget allocations. The intervention is deemed very useful by MOH and partners alike.
WEAKNESSES
Attribute 15: The plan for M&E is sound, reflects the strategy and includes core indicators, sources of information, methods and responsibilities for data collection, management, analysis and quality assurance
∇ The list of impact and strategy indicators presented in the summary of the PESS does not completely present the sources of information to be collected in future monitoring interventions. Most sources are population-based surveys. The timing of these surveys may not always coincide with PESS milestones (mid-term, end-term). Some programme indicators, and most clinical service 'programmes' do not have relevant (SMART) indicators. Support systems (like Human Resources and non-medical logistics) were not described in operational terms, making it difficult to monitor its performance. Strategic programme indicators do not present a balanced view of all programmes: over 50% belong to Sexual and Reproductive Health and Infant Health programmes, while for instance there is no strategic indicator to measure the performance of the Health Promotion Programme. ∇ The Government of Mozambique has already committed itself to some aspirational targets, for

instance to reduce the Maternal Mortality Ratio from 408 (in 2011) to 190 per 100,000 live births (in 2017). It has committed itself to increase the proportion of HIV+ persons receiving Anti-Retro Viral Treatment from 54% to 80% in three years. These targets seem difficult to achieve in the short period of time.

∇ With the proposed change in duration to Jan 2014 – Dec 2019, new targets need to be set for the end of the plan period. This will pose challenges for the various programmes and services.

Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action

∇ Although a successful system for periodic performance review is operational, and firmly planned to continue during the strategic plan period, due to the relative vertical nature of some major programmes, the flow of information is not well integrated, nor does the plan outline steps to improve integrated information management.

IMPLICATIONS FOR SUCCESSFUL IMPLEMENTATION

- The monitoring framework needs to be improved before the start of PESS. Improvements include the completion of the expected sources of data, the update on base line data, mid-term targets where feasible and end-of-period (2019) targets. A more balanced set of indicators reflecting MOH priorities is highly desirable.
- Expanding the M&E framework to include the Health Reform Agenda is dependent on the inclusion of a roadmap for the reforms.
- A continued joint intervention for monitoring is an essential part of the implementation of the M&E interventions.

SUGGESTED ACTIONS Short term.

4. To balance the list of programme indicators so that the priorities defined in the PESS are better reflected in the indicators list.
5. To review and complete the list of sources of information, baselines and targets needed to assess performance.
6. Review end-of-PESS targets for the new final year of the plan (2019).
7. Expand the plans and desired end results for the transition to HMIS data management using information technology.
8. Substitute the indicator “Tuberculosis mortality” (not measurable in Mozambique), for the “Proportion of deaths in annual tuberculosis case cohorts” (routinely collected by National Tuberculosis Control Programme).

SUGGESTED ACTIONS Medium to long term

1. Review the feasibility of targets, within the limitations of commitments already made.
2. Elaborate a plan to integrate the information flows for the different programmes and services.

3. Annexes

Annex 3.1. TOR for the JANS mission to Mozambique

Joint assessment of Mozambique's Strategic PESS III 2014-2019

Background
Mozambique has, to date, implemented the Government Five-Year Development Plans *("Programa Quinquenal do Governo - PQG)*", currently approved for 2010-2015, Action Plan for Reduction of Poverty (*"Plano de Acção para Redução da Pobreza (PARP)" 2011-2014 - PARPA II*), the annual Economic and Social Plan *(Plano Economico e Social – PES)*, the Medium Term Expenditure Framework (MTEF), and the Health Sector Strategic Plan *(Plano Estratégico do Sector Saude -PESS II 2007-2012)*. Besides the sector strategic plan, Mozambique also has several disease specific & health program and systems related strategic plans such as the Integrated MDG 4 & 5 plan, Strategic plan for Tuberculosis, Human Resources Development Plan 2008-2015, Strategic plan for Health Information Systems, HIV strategic plan .

The current PESS which guides the development of annual plans namely PES (economic and social plans) ends in December 2012 but, for practical reasons will be extended till July 2013 to give more time for finalizing the next strategic plan and go through the appropriate approval process. The MoH of Mozambique initiated the preparation of PESS III (2014-2019) in August 2012 with the setting up of a Technical Working Group (GTT) made up of MOH managers, representation of cooperating partners HPG, and consultants. The GTT is directly accountable to the Director of Planning who is responsible for leading the process of writing the new sector plan.

A key reference for the elaboration of PESS III is the report of the recently conducted health sector review which presents an analysis of the current situation as well as the trends covering the past 5 to 10 years of the systems pillars and the disease specific and health programs. The final report was delivered in October 2012.

Also key to the production of a plan that has ownership with all players in the health sector is the decision to have wide and participatory consultation process with development partners, key government sectors and ministries, professional associations, civil society and other stakeholders.

To make the PESS III more robust and to encourage more buy-in from a wide range of stakeholders, the Ministry has decided to subject it to the "Joint Assessment of National Strategies (JANS)" process. It has received technical assistance from WHO (10-14 Sept 2012) to give orientation on JANS purpose, process and tools to senior health managers and health development partners. This "introductory phase of JANS" was also used to assess the current PESS against the JANS tools.

Related expectations are that the assessment and any subsequent revision will increase confidence in

the plan, help bring more partners on-plan and on-budget, and reduce at least some of the burden of separate appraisals or proposal preparations (transaction costs). The independent element is desired in order to provide a fresh, systematic perspective on the plan.

Status of PESS III development in Mozambique

Development of PESS III has made significant progress. It started in August 2012 with the setting up of the Technical Working Group and has currently (mid-November) started writing the first draft of the document. A final draft version will be subjected to the JANS in July 2013. A final draft that has incorporated the recommendations of the independent assessment will be presented for approval by the Conselho do Ministro in August 2013.

The timing of the JANS mission for July 2013 allows for an advanced draft of PESS III to be ready for the in-depth review, as well as give the Directorate of Planning and Coordination time to incorporate the JANS recommendations and finalise the strategic plan by the agreed deadline of August 2013.

Organization of JANS

The PIMA working group, which is joint working group of senior managerial and technical staff of the Department of Planning (DPC) and Coordination of the MoH and health development partners, including civil society representatives, is overseeing the organization of the JANS process. The PIMA group is chaired by the Director of Planning and Coordination. The JANS mission will report to this group at the beginning and end of the mission. The mission will present its findings and discuss recommendations with the MoH and the health partners group (HPG) during the validation meeting at the end of the mission. The mission will submit its final report to Director of the Directorate of Planning and Coordination who will share the report with the PIMA partners and subsequently make it available for the HPG and other stakeholders. The Director of Planning will oversee the incorporation of the recommendations into the draft PESS.

Joint assessment mission objectives

The overall objective of the mission is:
To assess, the draft PESS III, using the JANS tool and guidelines, in order to identify its strengths and weaknesses, and to recommend improvements where necessary.

Specifically, the mission will develop a profile of the strengths and weaknesses of five sets of attributes:

- The situation analysis, and coherence of the PESS III and its strategies with that analysis;
- The process through which the national plan and its strategies have been developed,

including its alignment with national policies and multi-sectoral strategies, and the role of key stakeholders;

- The adequacy of financing projections and strategies, and financing and auditing arrangements;
- Implementation and management arrangements, including those for procurement; and
- The results, monitoring, and review mechanisms including risk management and mitigation plan

It is understood that while it is not the task of the joint assessment team to make any recommendations for funding, it is envisaged that individual agencies will be able to use the findings of the assessment to inform their decisions and, ideally, in some cases to use these instead of carrying out separate missions.

Team composition

It is envisaged that the team will comprise a mix of international and local members all of whom may be seen as "independent" to the process of developing the PESS III; i.e. "not involved in development of the strategy and/or not associated with the government or other major stakeholders responsible for developing the strategy".

A Team Leader, who has previous experience in conducting a JANS, will be identified and will be supported by independent consultants drawn both from within and outside Mozambique in order to ensure a strong mix of local knowledge and international experience. The Team leader will be responsible for bringing team members to a common understanding of the JANS purpose, process and tools at the beginning of the assignment.

As the aim is to subject the PESS III to a general assessment, the core expertise required is in the fields of a) public health/health systems b) economics/financing and c) monitoring and evaluation. It is envisaged that the team will have 4-5 members (including the team-leader) and will include both a local and international independent member in these areas. The team leader should be fluent in reading, writing and communicating in Portuguese. It is an added advantage for other team members to communicate well in Portuguese. Experience in the Africa region and understanding of aid effectiveness and partner coordination is an advantage.

The independent team will be supported during their time in-country by the GTT in terms of making transport and other logistical arrangements, arranging appointments, and serve as key-informants with relevant professional and local knowledge to facilitate the work of the team.

Methodology

The assessment will involve both a preparation and an in-country phase. It will be undertaken through the following:

- Teleconferences between MOH and team leader to agree details of the mission;
- Desk review of the draft PESS III and other relevant documents;
- Briefing with MISAU and partners at the beginning of the mission
- Interviews with key persons from MOH and agencies, civil society organisations, development partners, and other government ministries, departments and agencies (e.g. Ministry of Planning and Development);
- A validation meeting to discuss recommendations will be held with key stakeholders at the end of the assignment.

Deliverables

The Team Leader will ensure the following outputs:

- Presentations for the validation meeting
- A concise report of the findings and recommendations within one week after the mission ends. The report should be in Portuguese and not more than 20 pages plus annexes.

Timeframe

The JANS mission will start on 15 July 2013 subject to the availability of team members and the draft PESS 2014-2019. It is envisaged that the team will need 10 working days in Mozambique. Document review may start earlier.

Budget

A) Consultancy fees and DSA : 12 days (this includes 1 desk work before arriving in-country and 1 additional writing days for "finalising" individual reports/section

B) Air Travel International (to/from Mozambique)
C) Local travel and transport
D) GTT expenses including stationery, supplies and printing
E) Dissemination workshop

Specific terms of reference for team leader and team members

Team Leader/Health System

The team leader should be a health systems expert with previous experience in conducting a JANS. S/he is expected to combine work in this field with the role of team leader. Experience with health sector reforms /decentralisation is an essential.

- Review existing documents and conduct consultations with key informants, or assign team members to do so;
- At the start of the assignment, give orientation to team members on the key principles, methods, tools and terminology of JANS.
- Guide and oversee the team's work
- Work with team to apply the JANS tools and process to PESS 2014-2019;
- Carry out his/her other assignments in area of expertise including examining whether the sections of reforms provide enough justification and detail with regard to decentralisation and its expected benefits to the health sector.
- Ensure that agreed outputs are presented on time
- Coordinate inputs from different team members and the GTT into the report.
- Report results of assessment at the validation workshop;
- Prepare final report.

Throughout the assignment the team leader is expected to liaise with the MoH, GTT and the focal health partner, for logistic support and regular update.

Public Health and Monitoring and Evaluation

Previous experience in conducting a JANS is an advantage.

- Review existing documents on assigned area
- Work with team to apply the JANS tools and process to PESS 2014-2019;
- Interview key informants
- Submit reports and other assigned outputs to team leader as agreed within team
- Participate in team meetings and other meetings as required

Financial management/Health economics

Previous experience in conducting a JANS is an advantage.

- Review existing documents on assigned area
- Work with team to apply the JANS tools and process to PESS 2014-2019
- Interview key informants
- Submit reports and other assigned outputs to team leader as agreed within team
- Participate in team meetings and other meetings as required

Annex 3.2. Work Program

DATE and HOUR	Institution to meet	Con-firm.	Objective	JANS team	Participants	Local
Day 0 - Sunday, 14 July						
16.00 – 20.00	Internal team meeting	V	Attributes, methodology, division of tasks	Entire team		Hotel Terminus
Day 1 - Monday, 15 July						
08.00 - 10.00	JANS organizing committee (Elias, Celia, Leopoldina, Daniel, etc)	V	Discuss ToR, Program and Logistics	Entire team	Organizing committee	MISAU (6th floor)
10.30 - 12.00	Meeting with the PESS elaboration team	V	Processo / desen-volvimento PESS	Entire team	GTT, Organizing committee	MISAU
15.00 – 16.30	Meeting JANS team	V		Team		Hotel
Day 2 - Tuesday 16 July						
07.30 - 08.30	MISAU DPC National Planning Director / Vice-Director	V	Planning	JC, HN, CO, HE	Dr. Célia, Dr. Mazivila	MISAU
08.00 - 09.30	GTAF (Administration & Financing Working Group) (partners)	V		BA, NT	Irish Aid, USAID, CIDA, SDC, Itali-an Coop, Danida	Irish Embassy, Av. J. Nyerere
10.00 - 11.30	ICSM (Health Sciences Institute)	V		NT		Central Hospital
10.00 - 11.30	ANEMO (Nurses Association)	V		JC, HN		MISAU
11.30 - 13.00	AMM (Medical Practitioners Association)	V		HN		MISAU
11.30 - 13.00	GT Programs and Services (partners)	V		JC, HE, NT	SDC, CDC, MSF	SDC
14.00 - 15.30	MPD Planning Department	V		JC, HN	Mrs. Marisa Alves Mrs. Zita Zoaquim	Head Planning Dep. /MPD
14.00 - 15.30	MISAU DPC Budget Department	V	Planning, budgeting, costing	BA, NT,CO	Vania, Laia, Ibraimo, Manuel	MISAU
14:00 – 15:30	MISAU DPC Department M&A	V		HE	Dr. Leopoldina, Eduardo, Silvia	MISAU 6th floor
16.00 - 17.30	GT RH (Human Resources) (partners)	V	RHS	JC, NT, BA, HN	Partners	WHO, USAID, BTC. JPIEGO
17.30 – 18.30	JANS Team Meeting	V		Team		Hotel
Day 3 - Wednesday 17 July						
08.00 - 09.30	GT NGOs (NGO Working Group)	V	Civil society	JC, NT, HN	Secretariat and members of NAIMA+	NAIMA+, above Mimmos
09.00 - 10.00	MF – National Directorate of Public Accounting	V		BA, HE, CO	Manuel Mucavel, Mrs Lurdes, Mr. Bento	Av. Marginal (Baixa)
10.00 - 11.30	DEPROS (Health Promotion Department)	V		JC, HN,	Dr. Laura	MISAU

DATE and HOUR	Institution to meet	Con-firm.	Objective	JANS team	Participants	Local
10.00: 11.00	Technical Advisor PFM of Danida	V		BA		MISAU
10.00 – 11.00	Technical Advisor RH			NT	Marcelle Claquin	MISAU
11.30 - 13.00	GT PIMA (Working Group Plan, Invest, M&A) (partners)	V		JC, HE	WHO, EU, UNFPA, CIDA	WHO
11.30 - 13.00	CMAM		Procurement & distribution of medicines	NT, BA	Dr. Paulo Nha-ducue & team	MISAU
13.00 – 14.00	MISAU DPC Budgeting	V	Costing	BA,CO	Vania, Laia,Simione, Afisa, Manuel	MISAU 6th floor
14.00 - 15.30	ITS/HIV/SIDA Programme	V		NT, HE, BA	Dr. Aleny	MISAU (2th floor)
16.00 - 17:15	HPG (Health Partners Group) Focal Partner Team	V		Entire team	UNICEF, Irish Aid, DFID	UNICEF, Av. Zimbabwe
17.30 – 18.30	JANS Team Meeting	V		Team		Hotel
Day 4 - Thursday 18 July						
08.00 - 09.30	MISAU Tropical & Neglected Diseases Program, Non-transmittable Diseases Program (DNT)			JC, HE		MISAU
10.00 - 11.30	MISAU DAF (Administration & Financing Directorate)			BA, NT	Ligia Vilanculo, Alirio Chrizindza	MISAU (ground floor)
10.00 – 11.30	MISAU DNSP (Public Health Directorate)			JC, HN, HE	Dr. Mouzinho Saide (Dir)	MISAU (3d floor)
11.30 - 13.00	MISAU Nutrition, SMI, PAV			JC, HE, HN	Dr. Nazir, Dr. Benigna, Dr. Edna	MISAU
11.30 – 13.00	MISAU DAF			BA	Dr. Mariam Bibi, Danida TA	
14.00 - 14.30	MISAU DPC Infrastructure			JC, NT	Dr. Mazivila	MISAU
14.00 - 15.30	MISAU TB Programme			HE	Dr. Ivan	MISAU
15.30 – 17.00	JANS Team Meeting	V		Team		Hotel
Day 5 - Friday 19 July						
08.00 - 13.00	MISAU and IGS (Procurement / Audits)	V		BA	Dr. Ndlala & team	MISAU ground floor
08.00 - 09.30	MISAU Prog. Malária			HE	Dr. Graça e equipa	MISAU (3d floor)
08.00 - 09.30	MISAU Logistics Department /Supply Center	V		NT	Dr. Fortunato / Dr. Acásio	MISAU 6th floor
08.00 -09.00	MISAU Legislation			CO	Dr. Dalmazia Cossa, Dr. Malaica	
10.00- 10.30	MISAU Permanent Secretary	V		JC	Organizing Committee	MISAU
10.00 – 11.30	GT medicines (partners)	V		NT	BM Saul Walker	Word Bank

DATE and HOUR	Institution to meet	Con-firm.	Objective	JANS team	Participants	Local
10.00 – 11.30	Partners supporting decentralization	V		JC, HN, HE	Danida, SDC, USG	Danish Embassy, Av. J. Nyerere
11.30 - 13.00	MISAU DRH (Human Resources Directorate)	V		JC, NT	Dr. Dgedge and team	MISAU 2th floor
14.00 - 15.30	MISAU National Directorate Pharmacy	V		NT	Dr. Felicidade	MISAU
14.00 - 15.30	MISAU DNAM (Medical Assistance Directorate)	V		JC, HE	Dr. Assane	MISAU 4th floor
16.00 – 17.00	JANS Team Meeting	V		Team		Hotel
Day 6 – Saturday 20 July						
Whole day	Consultants prepare slides for presentation	V		JANS Team		Hotel
Day 7 – Sunday 21 July						
13.30 – 18.00	Team meeting to prepare presentation	V		JANS Team		?
Day 8 - Monday 22 July						
08.00 - 12.30	DPC + GTT	V	Informal debriefing + next steps	JANs Team	Dr. Celia, Dr. Mazivila + GTT	MISAU
14.00 – 15.00	Ministry of Finance, Budget Directorate	V		BA, CO	Amilcar Tivane, Paula Bila, Xamila Ali	MF
14.00 – 16.00	JANS Team Meeting	V		Team		Hotel
Day 9 - Tuesday 23 July						
09.00 - 12.00	**MISAU Directors, partners**	**V**	**Presentation of conclusions by JANS**	**Team**	**Celia, GTT, HPG, NGOs**	**MISAU-Amphitheatre**
12.00 – 13.00	JANS Team Meeting	*V*		Team		
Day 10 – Wednesday 24 July. Return of JANS team						
Wednesday 31 July	Head of JANS to send Draft of report to GTT coordinator			JC		
Friday 2 August	Report clarification meeting at DPC			JC, CO	Dr. Celia, GTT	DPC
Friday, 9 August	Translation of JANS report from English into Portuguese			WHO		
Friday 16 August	Submission of final Report to the DPC					
XXX	Presentation of the PESS at the CCS (High Level Meeting)		Prioritization and recommendations of JANS			

Annex 3.3. List of persons contacted/interviewed

NAME	ORGANIZATION
1st Day Monday 15 July	
Dr. Célia Goncalves	MISAU DPC
Dr. Moses Mazivila	MISAU DPC
Dr. Daniel Simone Nhachengo	MISAU DPC
Dr. Elias Cuambe	USAID / GTT PESS
Dr. Hilde De Graeve	WHO Mozambique
Dr. Daniel Kertesz	WHO Mozambique
2nd Day Tuesday 16 July	
GTAF (Admin. & Financing Working Group)	
Viriato Chevane	CDC
Nicole McHugh	Irish Aid
Eliane Moser	ACDI Canada
Dr. Guilio Borgnolo	Italian Cooperation
Ana Bodipo-Memba	USAID
Leo Näscher	Swiss Cooperation
Kirsten Havemann	Danida
Dr. Jonas Chambule	Irish Aid
Ignácio Mondlane	Health Sciences Institute of Maputo (ICSM)
Lagina Mausse	ICSM
Silvestre Langa	ICSM
Jaime Chore	ANEMO
José Davuce	ANEMO
Zita Joaquim	MPD
Marisa Alves	MPD
GT Programs & Services Working Group	
Benedito Toalha	SDC
Leo Näscher	SDC
Rebekka Ott	SDC
Jean-Luc Anglade	Doctors Without Borders / NAIMA+
Dr. Charity Ndalama	CDC
Dr. Leopoldina Ferreira Massingue	MISAU DPC – Monitoring and Evaluation Department
Mrs. Silvia Bignamini	AT at MISAU DPC (FORSSAS / Deloitte)
Mrs. Eduarda	MISAU DPC – Information Systems Department
Dr. Cidália Baloi	MISAU DPC – Information Systems Department
Dr. Eduardo Celades	AT at DPC (WHO)
Laia Cirera i Crivillé	MISAU DPC
Vânia Tembe	MISAU DPC
Ibrahimo Momade	MISAU DPC
Manuel Mahase	MISAU DPC

NAME	ORGANIZATION
GTRH (Human Resources Working Group)	
Dr. Hilde De Graeve	WHO
Dr. Eric Korsten	Belgian Technical Cooperation (BTC), AT at MISAU DRH
Dr. Angel Mendoza	JPIEGO
Ana Bodipo-Memba	USAID
Mrs. Emanuele Capobianco	UNICEF Health and Nutrition
Mrs. Etelvina Mahanjane	DFID
Mrs. Monica Zaccarelli Davoli	UNICEF
Mrs. Adelaide Matisa Alves	MPD Planning Department
Mrs. Zita Chipemba	MPD Planning Department
3d Day Wednesday 17 July	
GT ONGs (NGO Working Group)	
Sally Griffin	NAIMA+
Rita Chico	Malaria Consortium
Rachida Melo	Medicus Mundi
José Luis de Peray	Medicus Mundi
Jorge Matine	Pathfinder International
Mathias Nzaramba	Friends for Global Health
Alcides Tumidas	Kulima
Joelma Joaquim	International Center for Reproductive Health
Malicas de Melo	CUAMM Doctors with Africa
Cláudio Machalile	Ariel Glaser Foundation
Marcelle Claquin	AT at MISAU DRH (JPIEGO)
Dr. Paulo Nhaducue	MISAU CMAM
Joao Grachane	MISAU CMAM
Dr. Aleny Couto	MISAU National ITS/HIV/AIDS programme
Delane	MISAU National ITS/HIV/AIDS programme
Tatiana Borchova	AT at MISAU National ITS/HIV/AIDS programme (HAI)
Joseph Lara	AT at MISAU National ITS/HIV/AIDS programme (HAI)
Laura Mavota	MISAU DEPROS
Natércia Matule	MISAU DEPROS
Teresa Mapasse	MISAU DEPROS
GT PIMA (Planning, Investment and M&A Working Group)	
Dr. Geert Haghebaert	European Union
Fernanda Maússe	ACDI
Dr. Pilar de la Corte Molina	FNUAP
Focal Partners, Health Partners Group	
Dr. Emmanuele Capobianci	Co-Chairwoman HPG, UNICEF

NAME	ORGANIZATION
Monica Davoli	UNICEF
Etelvina Mahanjane	DFID
4th Day Thursday 18 July	
Rebeca Lígia Vilanculo	MISAU DAF
Alírio Ozas José Chirindza	AT at MISAU DAF (FORSSAS)
Mariam Umarji	AT at MISAU DAF (DANIDA)
Moisés Mazivila	MISAU DPC
Dr. Mouzinho Saíde	MISAU - DNSP
Dr. Carla Silva Matos	MISAU – DNSP DNT
Dr. Olga Nelson	MISAU – DNSP DTN
Dr. Edna Germack Possolo	MISAU – DNSP Nutrition Department
Dr. Nazir Amade Ibrahimo	MISAU – DNSP Women and Children Department
Dr. Maria Benigna	MISAU – DNSP EPI
Dr. Ivan Manhiça	MISAU – DNSP NTCP
Dalmazia Cossa	MISAU – Legal Advisor
Humberto Muquingue	MISAU-DPC-GTT – Consultation Coordinator for the Provinces
5th Day Friday 19 July	
Dr. Marcelino Lucas	Permanent Secretary (SP)
Dr. Graça Matsinha	MISAU – DNSP Malaria Programme
Fortunato Rafael de Oliveira	MISAU DAF – Logistics Department
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Laria Helene Catarina Abdul	MISAU IGS
Iolanda Matsimbe Malace	MISAU IGS
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Saul Walker	World Bank
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Adelaide Mbebe	MISAU DRH
Natalia Santanu	MISAU DRH
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Isabel Buffalo	MISAU DRH / BTC

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Dr. Paula Lurdes Raimundo	MISAU National Directorate Pharmacy – National Medicine Quality Control Laboratory (LNCQM)
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Dr. Celia Goncalves	DPC
Dr. Moses Mazivila	DPC
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9th Day Tuesday 23 July	
Dr. Marcelino Lucas	MISAU Permanent Secretary (SP)
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Dr. Elias Cuambe	USAID / GTT
Dr. Hilde De Graeve	WHO - Mozambique / PIMA
National Directors and many staff from various MISAU Directorates and Departments	
Technical and Financial Partners	
Civil Society	

Annex 3.4. Consulted documents

AUTHOR / YEAR	TITLE
Situation Analysis	
Carrachás, 2011	Situation Analysis of Human Resources Management Practices in the Health Sector in Mozambique BDC
MISAU, 2012	Report on Health Sector Review
Process	
Government of Mozambique, 2010	Mozambican Government Five Year Plan_2010-14.pdf
MISAU, 2013	PESS pre-final version – 10 July 2013
MISAU, 2013	Annexes PESS 2013
MISAU, 2013	Detailed matrix of PESS indicators
MISAU, 2013	Consolidated comments of partners_ PESS version 26-05-13
HPG, 2013	Donor coordination HPG 2013-14-130605
GTT, 2013	GTT final response, comments, consolidated partners V2
MISAU, 2012-3	Various Minutes of PROSAUDE
HPG2012-3	Various Minutes of the Health Partners Group
MISAU, 2012	PESS 2013-2017 Consultation Guide for the Provices
MISAU, 2013	Feedback from Provincial Consultations
MISAU, 2013	Consultations: Annotated Summary with Actions
MISAU, 2013	PES DPS-GAZA
MISAU, 2012	MPD Proposal PES 2013
MISAU, 2012	CCC Minutes 2012
MISAU, 2012	CCS Minutes 2012
MISAU, 2011 - 2013	ACA, Reports
Costs and financing	
Ernst & Young, 2010	Reports of the PROSAUDE fund, Global Fund, Medicines Fund and the Provincial Common Fund l
Fiscus Public Finance Consultants e SAL & Caldeira – Advogados e Consultores. 2009	Evaluation of the Public Finance & Procurement Management Systems in the Mozambican Health Sector, 2008
Intellica, 2013	Study on Sources and Revenie Potential in the Health Sector
MB Consulting, 2011	Public Expenditure and Financial Accountability – PEFA, Evaluation in Mozambique 2010
Ministry of Finance, 2013	Medium Term Fiscal Scenarios (CFMP), 2014-2016
MISAU, 2011	Report on Health Sector Review
MISAU, GTAF, 2011	Analysis from Partner's viewpoint Report on Budget and Financial Execution
MISAU, 2012	Action Plan for the Strengthening of the Financial Management of the Health Sector in Mozambique
MISAU, Intellica, 2013	Manual of Proceedings for the Collection and Management of Revenue in the Health Sector
MISAU, DAF, 2013	Status Report of July 2013 on the "10 Priorities in Managing Public Finances 2013"
MISAU DAF, 2013	Manual of Financial Management Proceedings. Version 01, May 2013.
General Inspection, Fundo Global, 2012	Audit of Donations by the Global Fundo Global to the Republic of Mozambique

AUTHOR / YEAR	TITLE
Implementation	
Human Resources	
MISAU,2008	National Plan for the Development of Human Resources in Health 2008-2015
MISAU,2008	HRH Plan 2008-2015
MISAU, 2011	Strategy for Permanent Education in Health
MISAU,2012	Annual Report DRH 2011 Final
MISAU, 2012	Mid-term evaluation (2008-2011) of the National Plan for the Development of Human Resources in Health 2008-2015. May 2012
Programmes	
MISAU, without data	Health promotion strategy
HIV/AIDS	
MISAU, 2010	National Strategic Plan for Responding to HIV and AIDS, 2010-2014
MISAU	MISAU; M&A Plan for HIV 2012-2014
MISAU	MISAU; Response Acceleration Plan for HIV and AIDS 2013-2015
Malaria	
MISAU, 2012	MISAU; PNCM – Strategic Malaria Plan 2012-2016
MISAU, 2012	MISAU; PNCM – Monitoring Plan 2012-2016
MISAU,	Adolescent Health *Geração BIZ* _ Moz
MISAU, 2009	PAV 2009-2013 Mozambique – MULTIANNUAL PLAN
MISAU, 2011	Multisectoral Malnutrition Plan - final English
MISAU, 2010	APEs Programme 2010 approved
Tuberculosis	
MISAU, 2013	NTCP: Strategic Plan TB 2013-2017 Draft
Logistics and Pharmacy	
MISAU, 2012	Procurement Assessment, May 2012-Port
MISAU 2012	Strategic Pharmaceutical Logistics Plan, December 2012
MISAU 2013	Pharmaceutic Department – Strategic Map 2013 – 2017
Governance	
MISAU, 2013	Institutional Reform Acceleration Plan (PARI) 2013 – 2015. Narrative of May 2015 & Excel Matrix Monitoring 2013.
FORSASS, 2012	Performance Monitoring Plan
GFATM, 2011	OIG_GFOIG11018 Audit Mozambique Report English
MISAU, 2012	Several Minutes of the HPG 2012.
MISAU, 2011/13	QADs 2011-2013
M&A	
MISAU, 2013	Plan for the Strengthening of the Monitoring and Evaluation System _27_Mar_2013_final
MISAU, 2013	National Monitoring and Evaluation Plan and Annexes
OMS, 2010	Development of the comprehensive M&A Mozambique – Report CHeSS
MISAU, 2013	Detailed matrix targets indicators PESS2013_2017 v06
MISAU, 2009	Strategic Plan SIS 2009-2014 Approved

Annex 3.5. Recommendations by JANS with comments from MOH-PIMA

A. Suggestions for Actions by JANS (Short Term[6])	A. Comments from MOH-PIMA
A. General	
Include the concept of "Universal Health Coverage" as a general PESS objective.	Universal coverage of "services" is included in the motto – It will be substituted by universal health coverage. The protection against financial risks is a political commitment not controlled by PIMA (vision). Equity and quality can be achieved by the sector (mission) and there are already indicators for their strategic objectives. PIMA decision: Include the concept of universal health coverage in the vision and describe the steps the sector will follow in the next 6 years, in particular funding strategy, resource allocation mechanisms (criteria), basic package, (....).
Include a description of the existing coordination mechanisms at central and provincial, inter- and intra-sectoral levels (CCC GT-SWAP*, CCS, PROSAUDE ...) These are coordination groups within the SWAP (Aid Effectiveness) and some technical groups led by the Ministry.	The GTT will include the main coordination structures in the governance section (e.g. SWAP), with civil society at all levels and intersectoral working committees. The situation analysis will describe the coordination structures. Chapter 5.2 describes the main challenges. Mechanisms to strengthen coordination structures are described in the reforms.
Align the PESS with the next Five Year Plan of the Government by changing the start date to 2014 and adding another year of duration. PESS III will run from January 2014 to December 2019. The mid-term review should be scheduled in 2016.	This recommendation has been accepted. The goals and costs are to be aligned with the new time period.
Within the scope of Pillar elaborate the Terms of Reference with timeline and key actions / results of institutional reforms (see point G1 below) Consider the creation of a Reform Unit with full-time staff from different levels / sector areas that are part of the organic MISAU personnel and are under the direct leadership of the Minister.	The PIMA/MISAU welcomes the recommendation to develop ToR for the reforms based on the PESS vision and principles, including the creation of the Reform Unit, key actions and results (milestones) and a timeline. However the ToR will focus on the process and should not be too prescriptive.
Strengthen the dialogue with the PROSAUDE partners in order to ensure that the problems faced by this important funding mechanism are resolved. MISAU should show strong leadership and credibility to	The PIMA/MISAU agree with the recommendation to maintain the dialogue and recognizes the need to adapt the coordination mechanisms of the SWAP (will be included in the chapter on reforms). The revision of the Memorandum of Understanding of PROSAUDE is urgent

[6] Prior to the CCS and to be included in the PES 2014

A. Suggestions for Actions by JANS (Short Term[6])	A. Comments from MOH-PIMA
overcome the current situation of PROSAUDE and/or find alternatives in the medium and long term.	and will be included in Chapter 5.2.
Review the list of program indicators to better reflector the priorities defined in the PES.	This is already being done. The SMI indicators show the priority of the sector but will be balanced with other indicators (health promotion and medical assistance).
Define targets for the last PESS year (2019).	This is already being done. The goals and costs are to be extrapolated to 2019. **NOTE: the goals for 2018 - 2019 are provisional and will be reviewed after the mid-term evaluation (MTR) in 2016**
Expand the plans and expected results for the transition from SIS, using new information technologies	Agreed (this is already being done). Half a page will be produced to integrate the content in chapter 5.1
The internal PES 2014** should be aligned to priorities, strategic objectives, indicators and targets of the new PESS. **Rephrase the sentence: PES 2014 should be aligned to the new PESS.	Agreed. This is already being done (PES internal, to be completed in November 2013).
B. Análise de Situação	
Include a section in SEP that describes the existing coordination structures at central level within MISUA and between MISAU and: • Other Ministries • Associations and para-statal agencies, • Development Partners through the various Working Groups (GTTs)* • Civil society (international and national NGOs, community-based organizations (CBOs), • Private sector (for profit). * These are coordination groups within the SWAP (Aid Effectiveness) and some technical groups led by the Ministry.	Agreed. See recommendation 2 (examples: GITEV, SETSAN,…)
Where necessary, review performance, ToR, composition and frequency of meetings of these structures.	The PIMA/MISAU agree with the recommendation, and suggest that the debate be transferred to the long-term (to be included in the PES 2015)
Chapter 7 on Implementation Mechanisms could benefit from a more detailed account about **HOW** PESS will be put in place and what contribution is expected from the various stakeholders.	Agreed. Implementation mechanisms will be elaborated in more detail. The PESS document is also an instrument for the mobilization of funds, therefore, the current approach showing the financial gap seems more appropriate.
C. Process	
Include (Chapter 7) the process of hearing civil society in a systematic manner in the strategic and operational planning processes (see also A2)	Agreed. The document will detail the current mechanisms for civil society participation in operational planning.
D. Costs and Budget Framework	
The Government should allocate 15% of the state Budget to the health sector in order to comply with the agreement signed in Abuja.	Agreed, but we suggest a review of the wording in order to strengthen the dialogue with MPD/MF. This is one of the assumptions of Scenario 2 (optimistic scenario) of the resource envelope and it will be

A. Suggestions for Actions by JANS (Short Term[6])	A. Comments from MOH-PIMA
	included in the funding strategy.
A multi-annual budget for 2014-2015 should be drawn up, using the OneHealth instrument. A detailed justification with the assumptions of estimated unit costs should be included as an annex to the PESS.	The PIMA/MISAU agree with the recommendation, and suggest to transfer the issue to the long-term, because the classification of OneHealth is different from that of the Government (this will take time, can be made from the PES 2015 onwards) We agree. The Annex is being elaborated.
It is necessary to define priorities in the allocation of available funds. The goals of interventions and coverage should be adapted to the availability of funds.	The costing chapter will show how the cost pattern reflects the priorities of the sector and the distribution of costs by level of attendance. The targets will be reviewed and adjusted annually and in the mid-term review.
The PESS should present alternatives to closing the RHS gap.	We agree. This action is part of the actions planned under PESS-Pillar 2.
E. Implementation	
Chapter 2 of the PESS should include (i) a description of the progress in the area of large infrastructure; (ii) information about efforts to train additional RHS, determine the needs and fill the gaps; and (iii) an analysis of the management and logistics of medical and non-medical products including equipment and consumables.	We agree. This is part of the situation analysis and will be included.
Section 5.2 of the PESS should include objectives, strategies and indicators for infrastructure development.	We agree. This will be reflected in the infrastructure development plan that will be developed in the next year (2014), after the situation analysis (inventory of health infrastructure), but the current interventions will appear as an attachment to the chapter on financing.
Section 5.2 should consider the design of alternative strategies or guarantee the availability of additional funds in order to accelerate the training of RHS and/or the hiring of RHS using external funds.	Agreed. See recommendation D5.
Include the recommendation of the Health Sector Review (SSR) on the development of the National Pharmaceutical Policy.	Agreed. Will be included in Pillar 2.
F. Financial Management and Procurement	
The plan for strengthening Public Finance Management should be implemented. As part of the system of Public Finance Management it should pay attention to rationing and simplification of the flow of funds and disbursements.	***Can JANS clarify this recommendation?*** At present the PARI (plan for the acceleration of institutional reforms) is the document that replaced the "Plan for Strengthening the Public Finance Management". The state budget has no problems with the flow of funds at present. ***Clarify whether this is a recommendation on PROSAUDE***.
Section 5.2 of the PESS should include the objectives, strategies and indicators to strengthen the system for the sourcing of non-medical products, as well as of all equipment, furniture and vehicles (see E1).	Agreed. Is being done.
G. Governance	
Develop, as part of Pillar 2, the Terms of Reference with	See recommendation A4

A. Suggestions for Actions by JANS (Short Term[6])	A. Comments from MOH-PIMA
a timeline, milestones and key actions and results for major interventions in the reforms; expected results are: • Definition of the minimum package of medical services by level and district health system, including referral systems, • Policy / Strategy Outline for Health Financing, • Completion of the Integrated Plan for Infrastructure Development, • Definition of the National Pharmaceutical Policy, • Clarify the relationship with the Private Sector (collaboration, control, regulation / accreditation), • Harmonization of sub-plans of the various programs with the PESS (timeline, content, budget and M & A), • Definition of the Hospital Reform Plan in conjunction with the new responsibilities of the DNAM, • Definition of the administrative and financial autonomy. • Finalize the architecture suitable for different information systems, such as SIS, LMIS, HRIS.	

B. Suggestions of Actions by JANS (Medium and Long Term[7])	B. Comentários do MOH-PIMA
B. Situation Analysis	
Develop a 'district health system' operating with its internal and external management and referral system.	We agree. We will further develop this in the chapter on Reforms (health services) and include it in the ToR.
D. Costs and Budget Framework	
A multi-annual budget should be developed using the OneHealth tool and attached to the plan.	We agree.
The debate on alternative mechanisms for financing the sector should continue, ensuring sustainability. The descriptions of cost recovery elements should be better developed in the new strategy for financing health. A future approach of MISAU will be increasing the interest and involvement of the for profit private sector in the provision and financing of the health sector.	We agree. Will be part of the financing strategy.
The use of OneHealth as a tool for planning, costing and budgeting should be institutionalized within the Ministry of Health; the plan should be adapted to the different funding scenarios.	We agree. The institutionalization of OneHealth is on the agenda.
Efforts should be made to improve the reporting of private sector contributions and of the fees collected at local level, and, if possible, include these in funding.	We agree, this will be based on the study about identification, classification and quantification of provisional revenue collected in the sector.

[7] To be included in the PES 2015 and elsewhere.

B. Suggestions of Actions by JANS (Medium and Long Term[7])	B. Comentários do MOH-PIMA
Priorities should be set to ensure that the key interventions are prioritized for funding. The plan should also be adapted to the various funding scenarios. Targets concerning service provision and coverage rates should be adjusted depending on the funds available.	The PESS document is also an instrument for the mobilization of funds; thus the current approach showing the financial gap seems more appropriate.
F. Financial Management and Procurement	
Plans for strengthening Public Finance Management - including strengthening procurement should be implemented.	We agree, but this is PARI. See recommendation F1
Within the scope of the Public Finance Management system attention should be paid to rationing and simplification of the flow of funds and disbursements.	We agree, but this is PARI. See recommendation F1
IGS audits should be strengthened through staff training, the introduction of "value for money" audits and the strengthening of systems attending and following up audit results.	We agree. Is already included in the PARI.
The system attending and following up audit results should be strengthened.	We agree. Is already included in the PARI.
One should explore the alternative of outsourcing demand, taking into account advantages and disadvantages.	Agreed. Will be discussed within the scope of the reforms, including the PARI.
G. Governance	
Once the PESS is approved, develop a communication strategy and a simplified, shorter PESS version.	We agree. To be included in the PES 2014
Start the process to develop a New National Health Policy.	We agree. We will include this as a key action in the reforms.
H. Monitoring, Evaluation and Review	
Replace the indicator "Mortality in Tuberculosis" (not measurable in Mozambique) to "Proportion of deaths in the annual cohort of tuberculosis patients" (collected regularly by the National Tuberculosis Control Program).	The indicator is recommended by the WHO but the Program will report the % of deaths among TB cases because the indicator "tuberculosis mortality" is not measurable.
Review the feasibility of the targets, with the limitations of the commitments already made.	A review of the targets in relation to the commitments will be evaluated annually by the monitoring mechanisms and in the existing dialogue.
Prepare a plan for the integration of information flows for the various programs and services.	We agree. Already being included in the PESS as a long-term action.