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FLANDERS MOZAMBIQUE

COUNTRY STRATEGY PAPER FOR DEVELOPMENT COOPERATION 2021 - 2025

TOWARDS GREATER INCLUSIVITY AND QUALITY FOR BETTER HEALTH

COUNTRY STRATEGY PAPER
FOR DEVELOPMENT COOPERATION

FLANDERS MOZAMBIQUE

2021 - 2025

REPUBLIC OF MOZAMBIQUE

Government of Flanders

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LIST OF ABBREVIATIONS

2030 ASD	2030 Agenda for Sustainable Development
APE	Community health workers
ART	Antiretroviral therapy
ASRH	Adolescent sexual and reproductive health
BC	Bilateral consultation
CGE	General State Budget (Conta Geral do Estado)
CNCS	National AIDS Council
CSP	Country Strategy Paper
EU	European Union
DKBUZA	Flanders Department of Chancellery and Foreign Affairs
FRELIMO	Mozambique Liberation Front
GBiz	Special programme for the next generation
GFF	Global Financing Facility
GDI	Gender-related Development Index
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GGHE	Global Government Expenditure on Health
GRN-SDG	National Reference Group for the Sustainable Development Goals (Grupo de refência nacional para os objetivos de desenvolvimento sustentável)
GNP	Gross National Product
HDI	Human Development Index
HDR	Human Development Report
HIV/AIDS	Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome
HPI	Human Poverty Index
HRH	Human Resources for Health
ICRH	International Centre for Reproductive Health
IHP+	International Health Partnership+
INS	National Health Institute
MPI	Multidimensional Poverty Index
ITM	Institute of Tropical Medicine Antwerp
SMME	Small, micro and medium-sized enterprises
MDM	Democratic Movement of Mozambique
MINEC	Ministry of Foreign Affairs and Development Cooperation
MINED	Ministry of Education
MISAU	Ministry of Health
MJD	Ministry of Youth and Sports
MoU	Memorandum of Understanding
MTR	Mid-Term Review
NAIMA+	Network of NGOs Working in Health and HIV/AIDS in Mozambique
NAPA	National Adaptation (to climate change) Programme of Action
ODA	Official Development Assistance
ODAmoz	Official Development Assistance to Mozambique Database
OECD-DAC	Development Assistance Committee of the Organisation for Economic Cooperation and Development
PEPFAR	US President's Emergency Plan for AIDS Relief
PESS	Health Sector Strategic Plan
PFM	Public Financial Management
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PROSAUDE	Health Sector Common Fund
RENAMO	Mozambican National Resistance
RCF	Rapid Credit Facility
HRP-RHR	Special research programme on human reproduction of the Department of Reproductive Health and Research
SADC	Southern Africa Development Community
SDG	Sustainable Development Goal
SGM	Sexual and Gender Minorities
SISTAFE	Financial Management State System
SRHR	Sexual and Reproductive Health and Rights
SWAp	Sector-Wide Approach, used here as a synonym for Health Sector Common Fund
TA	Technical assistance
TB	Tuberculosis
THE	Total Health Expenditure
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

INTRODUCTION

The current Fourth Country Strategy Paper (CSP IV) forms the framework for the multi-annual commitment to development cooperation between the Governments of Flanders and Mozambique for the period 2021-2025. The strategy was established through joint consultation between the two partner governments, organised online as a result of COVID-19. The general principles for future development cooperation were defined during the period July-August 2020 (see Table 3). These principles are mainly based on the recommendations of the Mid-Term Review (MTR) of CSP III (see Table 2) and have been integrated within the present document. They have furthermore been expanded by input derived from consultation with the broader civil society in Flanders, organised in parallel with the government-to-government consultation.

Overall, CSP IV retains the **exclusive thematic focus on "access to health"**. It also builds on the work undertaken by both governments under CSP III on **health system strengthening** and **access to sexual and reproductive health and rights** (SRHR), particularly for **adolescent girls**, as these are deemed a vulnerable group in Mozambique. However, this work revealed that in addition to female adolescents, other groups including **people with disabilities and/or HIV, sexual and gender minorities (SGM), migrants and internally displaced people**, are equally vulnerable in terms of SRHR access. Some of these groups overlap with the original target group of adolescents, as a result of which they experience an even greater, intersectional vulnerability[1]. At the same time, findings show that the (perceived) quality of care impacts both the patient's willingness to seek care and the success of the service delivery. The main projects and programmes will remain devoted to **access to SRHR, however the specific target group of adolescent girls will be extended to include these other vulnerable groups**. There will furthermore be an emphasis on **increasing the quality of care**, through **better educated and coached health personnel and volunteers** and by the introduction of **technological and social innovation**. As such, we seek to ultimately improve both demand creation within the entire community, including vulnerable groups, and the results of the service delivery itself.

Besides ongoing financial and technical assistance (TA), we will maintain a strong component of structural **support for the broader health care sector**. In the interests of efficiency, effectiveness and sustainability, we intend to **integrate** our focus on SRHR and the associated **service delivery** into a more comprehensive vision for strengthening the broader health system as a whole. Moreover, we continue to advocate the **promotion of a science-based health policy and implementation practice**. This vision is also closely aligned with Flanders' desire to bring about **systemic change** through its development cooperation.

The strategy paper aspires to leave no one behind when it comes to access to SRHR.

Both governments are aware of the growing risk of health crises following in rapid succession and on an ever-wider scale and, like COVID-19, eventually growing into a pandemic of global proportions. A strong health system is the most crucial element in the prevention of **an imminent epidemic and its disastrous economic impact** and, when necessary, for combatting it as quickly and effectively as possible.

However, strengthening the health system and delivery of highly specific services via indirect actors alone cannot solve the key problem, which is the limited access to SRHR for vulnerable groups in Mozambican society. Social and economic factors, for the most part beyond the reach of the health sector, continue to largely determine level of access. At the same time, the lack of sexual and relationship training and information sharing through formal and informal education, and of awareness-raising within and by the community, perpetuate the existing and damaging notions of what constitutes a proper male-female-x relationship, as well as discrimination

1 For example: Light for the World & UNICEF, Access to humanitarian aid for women and men, girls and boys with disabilities. Challenges and Recommendations - A review of the access to humanitarian aid for women and men, girls and boys with disabilities affected by Cyclone Idai, Mozambique, 2019.

Behavioural and systemic change presupposes sustainable cooperation between different sectors and actors.

and lack of inclusion for members of other vulnerable groups. As a result, various forms of physical and mental violence are still too often experienced and/or tolerated as "normal" and even "correct". In addition, rigid gender patterns and other social views still curtail the life chances of women and sexual minorities, and of the other vulnerable groups. However, such information and training, as well as specific components of health service delivery, can rarely be convincingly offered to these groups and their environment through the health system alone. Even a broader combination with efforts in the education-sector will not suffice to reach all learning and behavioural change targets. Relevant training and information, coupled with constructive examples from different sources and perspectives, are vital if people are to change their basic attitudes and behaviour towards traditionally vulnerable groups. For this reason, additional channels, such as the sports and culture sectors, the broad media and socially organised groups, communities, organisations and associations, and the education and health systems as a whole, must be deployed. The emphasis must be on a **multisector approach which provides** awareness-raising and very specific service delivery by various sectors and different actors within a **multi-actor partnership**. The multisector approach is a concrete translation of the drive towards systemic change which underlines the aims of Flemish cooperation.

A further challenge is the lack of specific data, sufficiently segmented by gender, age and socio-economic situation, which keeps vulnerable groups out of the spotlight. This makes it impossible for us to prioritise those who thus far have fallen the furthest behind. We will therefore advocate for the collection of more disaggregated and detailed data, within and beyond the scope of the projects, in order to improve and increase the activities and accountability of the Mozambican Government and its partners vis-à-vis these vulnerable groups. At the same time, we will **strengthen** our **rights-based approach** by significantly augmenting the cross-cutting focus on these groups and their equal rights throughout the various aid modalities in which we are engaged. In addition, we undertake to be more thorough and consistent in broadcasting the results of our actions within this rights-based approach among the relevant actors, including local authorities, civil society and other donors.

We have drawn inspiration for our new approach from:

1. **The policy of the Mozambican Government**, as set out in the Five-Year Programme of the Mozambican Government, 2020-2024 (PQG 2020-2024[2]); the Health Sector Strategic Plan 2014-2019 (PESS[3]), as extended until 2024 by decision of the Mozambique Health Coordinating Council, and the Programme for Adolescent Sexual and Reproductive Health (ASRH);
2. The **policy of the Government of Flanders**, as laid down in the Government of Flanders Policy Document on Foreign Policy and Development Cooperation, 2019-24, and the Government of Flanders Coalition Agreement, 2019-2024[4];
3. The **recommendation of the National Reference Group for the Sustainable Development Goals** (GRN-SDG) which has identified inclusive and quality social services as one of the 7 accelerators of development[5];
4. The special emphasis, outlined in the **2030 Agenda for Sustainable Development (2030 ASD)**, on due attention to unmet needs of vulnerable groups from a so-called "leave no one behind approach" and the translation thereof into the first Voluntary National Report on the implementation of the 2030 ASD in Mozambique, the Flemish Vision Paper on Development Cooperation in 2030 and the Flemish Framework Decree on Development Cooperation[6].
5. **An analysis of the ongoing burden of disease and limited average life expectancy** occasioned by gaps in health service delivery for specific vulnerable groups of the Mozambican population, such as adolescents and other groups, whether or not they overlap with the adolescents;
6. The percentage of **individuals from vulnerable groups** within the total Mozambican population[7].

The CSP IV subtitle **"Towards greater inclusivity and quality for better health"** refers to the aforementioned acceleration of development as identified by the GRN-SDG. It also points to joint efforts by both parties to achieve the overarching goal of **strengthening the health system to ensure the health and well-being of all members of the Mozambican population, including vulnerable groups, under all circumstances**.

By adopting the current Country Strategy Paper, the two partner governments are fulfilling part of their **commitment towards** the implementation of the **2030 ASD**, focusing on the interlinked main objectives (SDGs) which are shown schematically below: SDG 1 (No Poverty); SDG 3 (Good Health and Well-Being); SDG 5 (Gender Equality); SDG 10 (Reduced Inequalities); SDG 16 (Peace, Justice and Strong Institutions) and SDG 17 (Partnerships for the Goals).

2 Governo da Moçambique, Programa Quinquenal do Governo: 2020-2024, 2020, p. 8 & pp. 10-13.

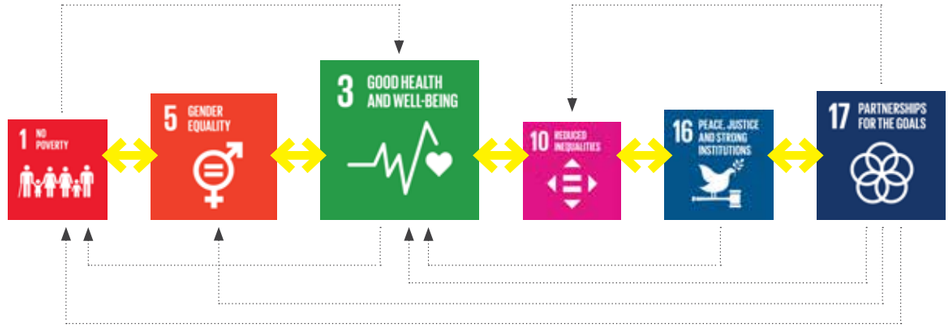
3 MISAU, Plano Estratégico do Sector da Saúde, 2014-2019. O nosso maior valor é a vida, p. 32. (From now on: PESS, 2014-2019).

4 J. Jambon, Beleidsnota 2019-2024 inzake Buitenlands Beleid en Ontwikkelingssamenwerking (Policy Memorandum 2019-2024. Foreign Policy and Development Cooperation), p. 38. Government of Flanders, Government of Flanders Coalition Agreement 2019-2024, pp. 111-112.

5 Mozambique. Voluntary National Review of Agenda 2030 for Sustainable Development. 2020, pp. 24-25. (Hereafter: VNR Mozambique 2020).

6 See: UN, Resolution 70/1, Transforming our World: the 2030 Agenda for Sustainable Development, paragraph 4; VNR Mozambique 2020; Government of Flanders and Flanders Department of Foreign Affairs (today called Flanders Chancellery and Foreign Office), Visienota: De Vlaamse ontwikkelingssamenwerking anno 2030, naar een nieuwe identiteit als partner in ontwikkeling (Vision Paper: Flemish Development Cooperation in 2030. Towards a New Identity as a Partner in Development), p. 7 & Kaderdecreet inzake ontwikkelingssamenwerking (Framework Decree on International Cooperation) of 22 June 2007 as adapted on 1 January 2019, Title III, Chapter I, Art. 4.

7 After initial national research and modelling, the estimate of the proportion of people with disabilities in Mozambican society had to be drastically adjusted upwards from 1.8% in 1999 to 6% or 1.2 million individuals in 2009 (RAVIM & Handicap International Mozambique, People with disabilities in the suburban areas of Maputo and Matola, Maputo, 2010, p. 14).



The general principles of the 2030 ASD and the derivative policy orientations of **specialised multilateral organisations** such as WHO, UNFPA, UNESCO and UNAIDS, assume that partners will:

1. **seek alignment with the objectives and indicators of this global framework**, which is also comprised in Mozambique's national strategy, in order to implement the agenda;
2. consistently place a key focus on a **comprehensive human rights approach**;
3. **actively seek links** to work within other dimensions, sectors and for other objectives in order to promote health and well-being on a broader scale (e.g. education and gender);
4. focus on the **most vulnerable population groups**;
5. **support all levels**, including the local level and individual citizens, in order to reach the most vulnerable and disadvantaged people;
6. work towards a **data revolution**, which will provide policy makers with the necessary tools to formulate, implement and adapt their agenda for sustainable development and their policy for health and well-being;
7. put **universal health coverage** at the forefront when striving to provide increased and better health services for all members of Mozambican society, including the most vulnerable, without placing them under heavy financial obligation;
8. develop and implement a **comprehensive policy focused on health and welfare promotion and health protection**;
9. promote **community-based** and **patient- or people-centred** approaches.

Finally, both partner governments acknowledge the need for an adapted work method to reach at-risk groups, characterised by high, often intersectional vulnerability and/or discrimination. This, in turn, requires **diversification and innovation** which can also be very **cost and effort intensive**. For this reason, we will use **qualitative as well as quantitative indicators** to monitor our results within the 'widening access to SRHR' component of CSP IV.

In addition, we will use a **portfolio approach**. In so doing, we strategically complement our **direct support to the Mozambican government** as the main component by support to **civil society, knowledge institutions and international organisations**, while also examining the possible contribution of the **private sector**. This will allow for the deployment of pilot initiatives with new approaches that still need to be tested and, where necessary, direct services to the target group.

MOZAMBIQUE AT A GLANCE[8]

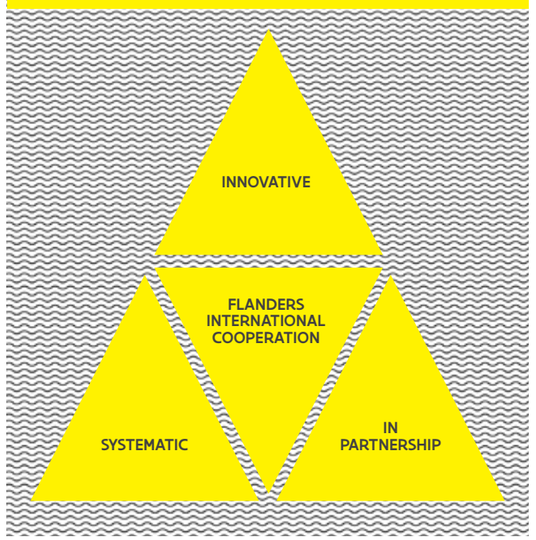
Official name	Republic of Mozambique
Government	Presidential republic, multi-party system
Administrative division	11 provinces, 154 districts
Official language(s)	Portuguese
Currency	Mozambican metical
Total population (2020)	30.066 million inhabitants
Population forecast (2030)	36 million inhabitants
Young age dependency ratio (0-14)	45%
Life expectancy at birth (2016)	60.2 years (women: 63 years; men: 57.1 years)
% Population below poverty line (2014)	63.7%
% Population below national income line	46.1% (53.1% rural; 40.7% urban)
GDP growth (2019)	2.28%
GNI per capita	460 current US$
Inflation (2019)	2.8% (cfr. 2016: 17.5%)
Human Development Index Ranking	180 of 182 Member States (HDI = 0.446)
Gini index (income inequality)	45.6
Gender Inequality Index Ranking (2015)	142 of 162 Member States (GII = 0.569)
Employment rate	78.5
Youth unemployment (% age 15-24)	6.8%
Average years schooling	3.5 (girls: 2.5; boys: 4.6)
Adult literacy rate (% > 15 years)	56%
Internet users (2017)	6.6% (men: 8.1%; women: 5.3%)
Net ODA (% GDP, 2018)	12.6%
Global Corruption Index Ranking	146/180 (score: 26/100)

8 Source: INE Mozambique, World Bank, UN Mozambique, HDR-UNDP, Transparency International.

1
THE DEVELOPMENT COOPERATION BETWEEN FLANDERS AND MOZAMBIQUE

Figure 1

Flanders' international cooperation invests in global, sustainable development, leaving no one behind. To achieve welfare and equitable prosperity within the carrying capacity of our planet. Flanders encourages innovation, makes use of a systems approach and puts partnerships at the centre of its activities. Flanders considers good governance, respect for human rights and equal opportunities for men and women as prerequisites for sustainable global development.



1.1
FLEMISH DEVELOPMENT COOPERATION GENERAL OVERVIEW

Following the worldwide adoption of the 2030 ASD on 25 September 2015, Flanders reviewed its vision on, and approach to, international cooperation and in 2016 adjusted its framework decree accordingly[9]. The current goal of the Government of Flanders' development cooperation policy is to contribute to poverty reduction and the sustainable socio-economic growth of developing countries. Flanders endorsed the Busan Partnership for Effective Development Cooperation (2011) and adopted the New European Consensus on Development (2017). Prior to that, it had already endorsed the Paris Declaration (2005) and the Accra Agenda for Action (2008)[10]. As one of the most prosperous regions in the world, Flanders wants to contribute towards the achievement of the 2030 ASD and its SDGs. The figure below provides a brief summary of the principles and terms of implementation of this new vision.

At present Flanders' aid is geographically concentrated on Southern Africa, more specifically, on its three partner countries: South Africa[11], Mozambique and Malawi. Support goes to 'Access to Health, including SRHR', 'Agriculture and Food Security', 'Opportunities for the Future of Vulnerable Population Groups', 'General Economic Development', 'Climate Change' and 'Humanitarian Action'[12].

9 Government of Flanders and Flanders Department of Foreign Affairs (today called Flanders Chancellery and Foreign Office), Visienota: De Vlaamse ontwikkelingssamenwerking anno 2030, naar een nieuwe identiteit als partner in ontwikkeling (Vision Paper: Flemish Development Cooperation in 2030, Towards a New Identity as a Partner in Development), 2016 & Kaderdecreet inzake ontwikkelingssamenwerking (Framework Decree on International Cooperation) of 22 June 2007 as adapted on 22 February 2016, Title II, Article 3(11).

10 OECD-DAC, The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, 2008 & The Busan Partnership for Effective Development Co-operation, 2011. Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on the New European Consensus on Development 'Our World, Our Dignity, Our Future'.

11 However, in the years following 2020, the relationship with South Africa will be reoriented and diversified away from a relationship that is primarily based on development cooperation. At the same time, another partner country in North or East Africa will be selected to address the root causes of migration.

12 J. Jambon, Beleidsnota 2019-2024. Buitenlands Beleid en Ontwikkelingssamenwerking (Policy Memorandum 2019-2024. Foreign Policy and Development Cooperation), pp. 37-42.

1.2. EVOLUTION OF THE FLEMISH DEVELOPMENT COOPERATION WITH MOZAMBIQUE

In **2002**, Mozambique became the **second official partner country of Flemish Development Cooperation**. The social havoc wreaked by the HIV/AIDS epidemic provided a direct incentive for targeted aid directed mainly at fighting this disease. In **2004**, a **first formal cooperation protocol** was signed between the Governments of Flanders and Mozambique with the focus almost entirely on this important health issue. The **first Country Strategy Paper 2006-2010 (CSP I)** met the legal requirement to provide a framework for Flemish development cooperation with the focus countries[13]. The cooperation was also brought in line with international criteria on efficiency and effectiveness of development cooperation, as set out in the 2005 Paris Declaration. From this point onwards, Flanders would be providing direct support to the Mozambican government at the central level to reinforce its health system via i.a. the sector-wide approach, allowing the Government to make the health sector efficient again and to recruit new health personnel (who often still require additional training). Parallel support was provided to indirect and direct actors in order to continue initiatives for the fight against HIV/AIDS and to retain motivated and well-trained health personnel and community workers in Tete Province. The construction of health infrastructure was also included as a sub-sector. Both partners also worked closely together within the sub-sector of technical and vocational education. The predictability of our collaboration increased significantly thanks to a financial indicative commitment of 25 million euros and an average expenditure rate of 5 million euros per year.

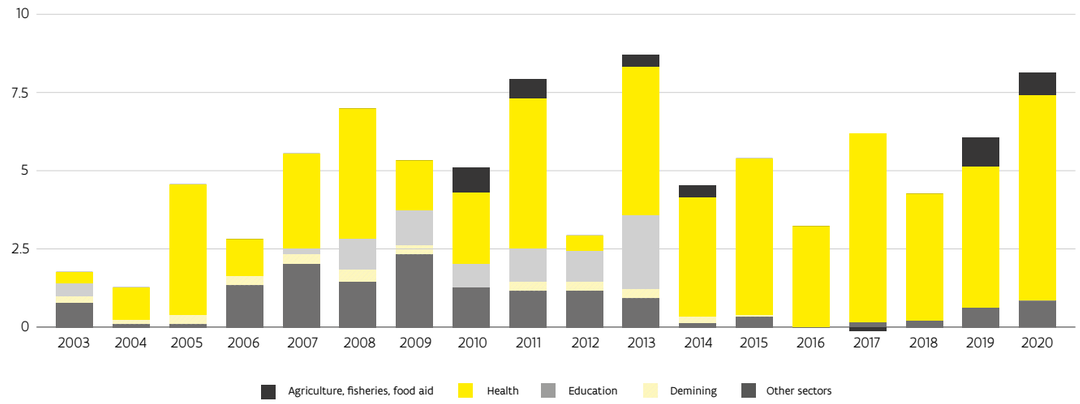
The cooperation between Flanders and Mozambique is characterised by an increasingly considered choice of sectors and target groups.

The (qualitative) growth and increasing diversification of the cooperation, coupled with changes in international consensus on efficient and effective development cooperation, forced both partners to **adapt their general cooperation protocol** in **2009**. Flanders took the decision that intervention sectors would no longer be determined unilaterally. In addition, we adopted the international principles on efficiency and effectiveness of development cooperation of the Paris Declaration and also the Accra Agenda for Action, i.e. (1) country ownership; (2) increasing harmonisation and integration of Flanders' development efforts with the initiatives and monitoring instruments of other donors; (3) results-oriented management and (4) mutual accountability through monitoring and evaluations. This was followed by the incorporation of other principles enshrined in the Flemish Framework Decree for Development Cooperation; the transversal themes of 'gender', 'HIV/AIDS', 'children's rights', 'good governance' and 'sustainable development' (repealed in 2019) on the one hand, and the contribution to achieving the Millennium Development Goals (now SDGs) on the other hand. The portfolio approach (cfr. below) was subsequently also accepted by both parties. Finally, the status of foreign personnel to be employed was clarified, and the positioning of the CSP within the cooperation was defined.

In the **CSP II (2011-2015)**, both partners agreed to further strengthen the sector concentration policy, focusing on one single sector with the highest added value for Flanders, i.e. the health sector. Particular attention was paid to SRHR. This was accompanied by a brief entry into the food security/nutrition sector as the aid sector par excellence within a multisector approach to the theme 'access to health'. Flanders also provided sector expertise to the Ministry of Health and the entire health donor group on both public health finance management and health personnel management. We encouraged upscaling, a programmatic approach and innovation within the cooperation. Flanders maintained the annual level of expenditure (EUR 5 million/year as an indication) and the same cross-cutting issues. We expanded the strategy for results-oriented management and risk management within the broader scope of mutual accountability. We strived to further promote the concept of evidence-based health policy in Mozambique, mainly through capacity building of the National Health Institute. Finally, Flanders initiated efforts to counter the negative impact of climate change in Mozambique and to introduce a more structured form of emergency and humanitarian aid within the CSP.

CSP III (2016-2020) once again retained the almost exclusive focus on broad support for the health sector, complemented by specific attention on SRHR. The more focused approach on access to SRHR for mainly female adolescents brought increased attention to vulnerable groups and this constituted the main innovation to the cooperation. Consequently, the multisector approach, in particular with the education sector, moved centre stage. Training and employment of health personnel were adapted in order to foster a more inviting care environment for adolescents. At the same time, improved collection of health data and health research enabled deeper understanding of the problems of this vulnerable population group.

Figure 2: Bilateral Development Cooperation between Flanders and Mozambique (ODA in million EUR)



13 Kaderdecreet inzake ontwikkelingssamenwerking (Framework Decree on International Cooperation) of 22 June 2007, Chapter VI, Art. 13.

2
COOPERATION PROGRAMME 2021-2025: FOCUS ON INCLUSIVE AND QUALITY HEALTH CARE

2.1 FRAMING THE FOCUS IN PARTNER POLICIES

Following a (by COVID-19 circumstances dictated) virtual consultation in July-August 2020, Flanders and Mozambique agreed to again focus this fourth Country Strategy Paper exclusively on "Access to Health", and in so doing, contribute to **Universal Health Coverage (UHC)** in Mozambique. This is based on our shared commitment to achieve the fundamental right to the **highest attainable standard of health for the Mozambican population** in general, and **vulnerable groups** in particular. The latter include women, adolescents, SGM, people with disabilities, internally displaced people, migrants and their various sub-groups, primarily in Tete Province. According to the 2030 ASD, as of 2016, both partner governments must prioritise those population groups that are furthest behind in their efforts to achieve sustainable development. This will not only contribute to 4 of the so-called 5 Ps in the 2030 ASD, i.e. People, Prosperity, Peace and Partnerships, but also accelerate implementation of several interlinked objectives of the 2030 ASD, viz. SDG 1: No Poverty; SDG 3: Good Health and Well-Being (the most important SDG according to research among the Mozambican population[14]); SDG 5: Gender Equality; SDG 10: Reduced Inequalities; SDG 16: Peace, Justice and Strong Institutions and, finally, SDG 17: Partnerships for the Goals, as outlined in the introduction above.

Within the broader context of health system strengthening, the focus of our cooperation is access to SRHR for multiple vulnerable groups and their intersections.

Within the wider health sector, Mozambique and Flanders wish to maintain the focus on increasing access to quality SRHR services, including for the aforementioned vulnerable groups. The relative added value which the Flemish-Mozambican cooperation is able to offer within the wider donor landscape in Mozambique falls mainly within this sub-sector, largely due to Flemish domestic expertise in this area **and its applicability to development contexts**. A second criterion for this choice is the **pursuit of continuity** within this bilateral cooperation, which has proven to be effective (see MTR recommendations, Table 2). The third criterion is the **objective needs analysis** within the Mozambican population. This sub-sector continues to face enormous challenges but given improved, more extensive and more inclusive services, many health gains are within reach. The strengthening of the health system and expansion of access to SRHR are major points of attention within both the **five-year plan 2020-2024 of the current Mozambican Government**, and the **policy memorandum 2019-2024 of** Jan Jambon, **the current Minister-President of Flanders**, who is responsible for development cooperation.

14 VNR Mozambique 2020, p. 18.

The cooperation programme is determined by a Theory of Change. This theory describes how and why a desired change is expected to occur in a given context. As Flanders focuses on Mozambique's policy and implementation strategies, this theory of change is linked to the Mozambican Health Sector Strategic Plan, PESS, 2014-2019, as recently extended until 2024. In the first place, we support the mission of Mozambique's Ministry of Health (MISAU), as presented within this PESS:

> "Offer leadership in the **production and provision of increased and improved essential health services**, which are **universally accessible**, through a **decentralised system** that favours **partnerships** to **maximise the health and well-being of all Mozambicans**, so that they can build a productive life which will lead to personal and national development[15]".

We will take into account the following basic principles for health service delivery as set out in the PESS:

1. Primary health care
2. Equality
3. Quality
4. Partnerships
5. Community involvement
6. Research and technological innovation
7. Integrity, transparency and accountability.

The cooperation will furthermore contribute to the realisation of the 7 strategic goals of the PESS16:

1. Increase access and utilisation of health care services
2. Improve quality of services provided (i.a. by offering user-based services)
3. Reduce inequalities in access to health care services due to geographical and social determining factors;
4. Improve efficiency of service provision and utilisation of resources, (i.a. through integration)
5. Strengthen partnerships in the health sector on the basis of mutual respect
6. Increase transparency and accountability regarding the use of public goods
7. Strengthen the Mozambican health system, i.a. by focussing on the decentralisation policy.

In the short term, these principles and strategic goals should ultimately give all Mozambicans access to increased and improved quality services (first pillar of the PESS). In the medium term, the joint efforts of MISAU and all its partners should contribute to a structural reform of the health sector itself, so that the collective health and service gains can be sustained in the long term (second pillar of the PESS).

15 PESS 2014-2019, p. xi.

16 PESS 2014-2019, pp. 39-44.

At the same time, the current CSP seeks to implement the third accelerator of development as identified by the National Reference Group for the implementation of the 2030 ASD in Mozambique: "Inclusive and quality social services in health care and education"[17]. Finally, the purpose of CSP IV is aligned with the role which the European Union and its Member States have defined for themselves in promoting global health through the adoption of the New European Consensus on Development[18].

2.2 CHALLENGES AND OPPORTUNITIES IN THE HEALTH SECTOR

GENERAL

Zooming in on the results in terms of some key health objectives makes it possible to assess progress:

Table 1: Progress on a number of critical health indicators in Mozambique, 1995-2018[19]

Indicator	1995	2000	2009	2014	2018	1995 /2018	
						Abs.	%
Complete vaccination received by children ≤ 1 year	61%	71%	77%	82%	88%	n/a	+ 27 %
Infant mortality rate per 1,000 live births	147	124	90	62	55	n/a	- 62 %
% of HIV-infected pregnant women on treatment	n/a	n/a	24%	61%	87 %	n/a	+ 87%
Modern contraceptive use	5,1%	17%	13,9%	11,6%	25%	n/a	+ 19,9%
Births assisted by medical personnel (%)	42,2	47,7	55	71%	87%	n/a	+ 28,8%
Maternal mortality rate per 100,000 live births	1000	660	520	408	289 (est.)	-711	- 71%

Between 2015 and 2018 the percentage of the population who had contact with the health system rose from 55% to 65.7%. Over the same period, the perception of the quality of health services delivered improved and the number of people indicating that they were satisfied with Government's handling of basic health service delivery also increased by just over 10% (from 42% to 55%)[20].

Despite this progress, the health sector still faces many structural challenges. This translates into a two-fold picture of general progress versus relative backlog in a regional context, obtained by analysing the average life expectancy at birth in Mozambique. At 63 years for women and only 57.1 years for men, it is still relatively low compared to the regional averages of 67 and 61 years respectively. Nevertheless, life expectancy has increased significantly in recent years. On average, Mozambicans who were born in 2007 had a life expectancy of only 49.4 years. There is also great inequality between the life expectancies of socio-economically weaker and stronger groups, with life expectancy for weaker socio-economic groups up to 29.8% lower than that of the strongest groups. Important causes for this phenomenon will be discussed in more detail below, as they relate to specific challenges in the health sector that

17 VNR Mozambique 2020, pp. 24-25.

18 Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on the New European Consensus on Development: 'Our World, Our Dignity, Our Future', paragraph 27.

19 Figures based on: https://aidsinfo.unaids.org/, & WHO, World Health Statistics, passim, consulted on 26/08/2020 & INS, Moçambique, Inquérito de Indicadores de Imunização, Malária e HIV/SIDA, IMASIDA, 2015, 2018, UNICEF Data Warehouse, The World Bank Data, MISAU, Relatório Anual de Balanço do Sector da Saúde, 2019 & VNR MOZAMBIQUE 2020, p. 36 & https://www.who.int/gho/maternal_health/countries/moz.pdf?ua=1.

20 VNR Mozambique 2020, p. 36.

this CSP aims to address. We will also pay particular attention to social determinants that radically determine the severity or frequency of the problem for certain social groups. The combination of these historical factors with the increasing impact of non-communicable, often only chronically treatable diseases for which the health system is still insufficiently prepared[21], only make the challenge to further progress even bigger.

OVERALL ORGANISATION OF THE HEALTH SYSTEM

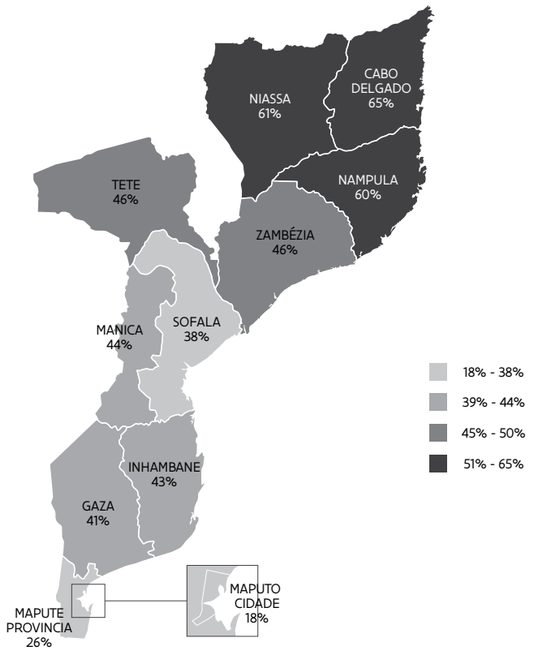
A first challenge is linked to the general organisation of the Mozambican health system which, following the more recent thorough reforms, has moved increasingly towards decentralisation at provincial and district level. The extent to which all authorities in charge of health will be able to cooperate and coordinate with each other in a constructive manner will determine to what degree we will be able to reach individual patients and vulnerable groups with all services concerning SRHR for example. This cooperation is key to the successful delivery of the extensive range of preventive, containment and remedial measures required to deal with (imminent) health crises.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

The challenges in the field of SRHR and the resulting adverse health effects remain significant, especially for (young and poor) women. Modern methods of contraception[22] are used by approximately 30% of women in the richest income quintile and only about 3% of women in the poorest quintile, which actually constitutes a decrease as compared to the 2003 figures[23]. There is also a big discrepancy in modern contraceptive use according to age. Whereas 11.3% of married women of reproductive age use modern contraceptives, for married women in the 15-19 age category, this drops to 5.9%. Moreover, the overall unmet need for modern contraceptives remains high at 22.3%, while the use of long-term contraceptive methods, which are often much easier to use and yield better results, is even negligible.

Mozambique also has a high incidence of early marriage, with 36.6% of adolescent girls already married. Again, there is a big discrepancy between urban (24.5%) and rural (43.7%) environments. As a result, the fertility rate of 5.3 children per woman (compared to 5.9 in 2011) and the number of early age pregnancies and births remain very high. In 2015, 46% of adolescents aged 15 to 19 were pregnant or had already given birth, while in 2014, 193 out of every 1,000 girls in this age group gave birth. With a teen pregnancy rate of 137 per every 1,000 15-to-19-year olds, Mozambique has one of the highest teenage pregnancy rates of sub-Saharan Africa[24] – and this trend continues to rise.

Figure 3: % adolescent girls, 15-19 age group, pregnant or already given birth (2015)[25]



Again, adolescents from the poorest quintile are overrepresented: 47.1% had their first child before their 18th birthday compared to 'only' 27.2% of adolescents from the richest quintile. Unskilled adolescent girls are much more vulnerable: 64% were pregnant or had already given birth, compared to 31% of girls with a secondary or higher education. Moreover, a large discrepancy can again be observed between urban ('only' 35% young mothers) and rural (54% young mothers) areas as well as between the provinces[26].

Such a high number of pregnancies and deliveries at an early age also contributes significantly to the high maternal mortality rate of at least 289 deceased mothers per every 100,000 live births, a long way off from the 2030 ASD target of 70 deaths maximum. There is thus still a great deal of work to be done before all adolescents and members of other vulnerable groups are protected against unwanted, often unhealthy, and even life-threatening pregnancies. This remains imperative if Mozambique is to achieve a demographic transition. Apart from complications following an abortion, the main direct causes of maternal mortality are uterine rupture (29%), severe bleeding (24%) and sepsis (17%). At the same time, AIDS and malaria are the most common indirect causes of maternal mortality, accounting for 54% and 40% respectively, while anaemia is also very common (54%)[27].

At first sight, access to prenatal consultation for pregnant women seems to be high at 90%. However, only 53% have at least 4 consultations per pregnancy, quite a shortfall given the 8 contacts recommended by the WHO28. 87% of all pregnant women give birth in a health institution, a remarkable achievement as compared to only 44% in 1994 and

21 Diabetes, e.g. increased from 2.8% to 7.4% and hypertension from 31% to 39%, while the entire category of NCDs already accounts for one third of burden of disease, an increase of 18% compared to 2010 and even of 45% compared to 2000. A. OLGA MOCUMBI e.a., Doenças Crónicas e Não Transmissíveis em Moçambique. Relatório Nacional, 2018, pp. 13-19.

22 If not referenced otherwise, data on contraception and fertility are derived from: PESS, 2014-2019, p. 18 and MISAU, Avaliação Conjunta Annual do Desempenho do Sector de Saúde, 2014, p.24.

23 J.G. DIAS & I. TIAGO DE OLIVEIRA, Multilevel Effects of Wealth on Women's Contraceptive Use in Mozambique, in: PLoS ONE, 10(3): e0121758, p. 2.

24 VNR Mozambique 2020, p. 32.

25 Copied from IMASIDA: p.69, figure 5.5.

26 IMASIDA, p. 69. & https://www.unfpa.org/data/adolescent-youth/MZ

27 PESS 2014-2019, pp. 8-9

28 MISAU, Relatório Anual de Balanço do Sector da Saúde, 2019, p. 52.

We must not only improve quantity but also quality of services for SRHR to reduce the high burden of morbimortality among vulnerable groups and promote their self-development.

71% in 2014. However, quality remains the issue both in terms of patient orientation and regarding the equipment of health centres (availability of basic medicines and other basic health technologies for standard checks and operations; scarcity of centres able to offer different levels of emergency treatment in the event of complications, etc.[29]). This is all the more true for women with physical or mental disabilities.

Although postpartum care is already widespread, in many cases it is not provided in the first week after birth. And yet, this is the most crucial period for preventing neonatal mortality and avoiding complications after birth[30]. It is therefore not surprising that the new-born mortality rate of 55 deaths per 1,000 live births remains high[31]. It accounts for almost 18% of the under-5 infant mortality rate and is also decreasing much more slowly than the general infant mortality rate[32]. Specific strategies, integrated with maternal care, are therefore needed to further reduce this figure.

The fight against HIV and AIDS in Mozambique is not following all the regional positive trends and there are even small relapses in some areas.. This has to do with i.a. some persistent problems of access to SRHR and thus the general infection rate among Mozambicans between the ages of 15 and 49 has risen from 11.5% in 2014 to the current 12.6%. Apart from South Africa, this is the highest national percentage in sub-Saharan Africa. Adolescent girls and young women remain the groups most vulnerable to HIV infection. More recently the percentage of people living with HIV (PLHIV) on antiretroviral treatment has decreased from 64% in 2016-2017 to 57% in 2018. In addition, the number of pregnant women with HIV on treatment has also decreased from almost 100% in 2017 to 87% in 2018. Treatment is vital in order to prevent infection of the foetus and infant, with mother-to-child transmission remaining high (14.9%) at 18 months due to mothers dropping out from treatment, especially during the breastfeeding period. At the same time significantly fewer men (46%) than women with HIV (67%) are on treatment, suggesting that the testing and care-seeking behaviour of men lags far behind that of women for socio-cultural reasons. AIDS-related mortality rates are dropping, but too slowly. In 2010, 64,000 people died of AIDS with this number dropping only to 54,000 in 2018.

In order to achieve the 90-90-90 objective[33] by 2020, 72% of HIV-infected Mozambicans should have been already cognisant of their positive status, which means a shortfall of 18%. With 56% of these PLHIV on treatment, there is another shortfall of 34%. Owing to a lack of proper monitoring, the percentage of people on treatment who no longer have a detectable viral load and are therefore no longer contagious, is however unknown[34].

29 O. AUGUSTO, E.E. KEYES e.a., Progress in Mozambique: Changes in the Availability, Use, and Quality of Emergency Obstetric and Newborn Care between 2007 and 2012, PLOS ONE, July 2018.

30 Analysis of pre-, intra- and postpartum care is mainly based on PESS, 2014-2019, pp. 17-19.

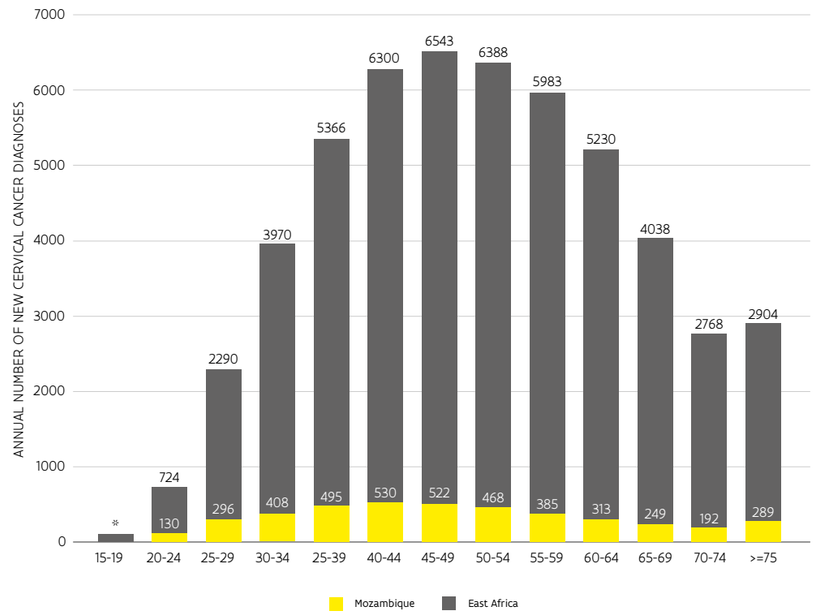
31 The World Bank Data.

32 WHO, GHO data consulted on 28 September 2020.

33 In order to be able to end HIV and AIDS as a global health threat by 2020, 90% of all people living with HIV need to know their status, 90% need to be on treatment and 90% of those on treatment need to have an undetectable viral load, see: https://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf.

34 UNAIDS, Performance Monitoring Report, Regional and Country Report, 2020, pp. 29-31 & Evidence Review, Implementation of the 2016-2021 Strategy: On the Fast-Track to End AIDS, 2020, p.19 combined with VNR Mozambique 2020, p.36 & https://www.unaids.org/en/regionscountries/countries/mozambique, consulted on 21 September 2020.

Figure 3: Annual number of new cases of cervical cancer in Mozambique/East Africa



Cervical cancer is not only the most common, but also by far the deadliest form of cancer in women in Mozambique. In 2018, the country reported 4,300 new diagnoses and 3,400 deaths from cervical cancer. With 27.5 cases of cervical cancer per 100,000 women per year, Mozambique has remarkably more new cases than the average for East Africa, which stands at 24.1. There needs to be greater awareness about this cancer among the general population. In addition, different forms of cervical cancer prevention and treatment should be increasingly integrated into existing programmes and strategies for disease prevention found within the health system[35].

According to the World Malaria Report 2018, Mozambique has the third highest number of malaria cases in the world (approximately 10 million cases, 5% of the global burden of disease in 2017). Ranked at 29%, malaria remains the main cause of death and affects mainly children under 5 (over 50% of them), young people between 6 and 14 years old (49%) and (anaemic) pregnant women and their newborns. Consequently the progress achieved prior to 2017 has largely been undone, while the major negative impact of COVID-19 on the fight against malaria has yet to be analysed. The occurrence of the parasite in the Mozambican population is once again very high (40% are carriers). The increased mobility of people constantly renews the reservoir, destroying any progress made locally. At the same time, the resistance of the vector to the most commonly used insecticides and medicines, other than artemisinin, is growing rapidly. At the end of 2018, a new approach, initiated by the President himself, was therefore adopted in order to be able to turn the tide as quickly as possible and to make the life of pregnant women, their newborns and their environment, amongst others, safe again[36].

35 MISAU, Plano Nacional de Controlo do Cancro, 2019-2029, 2019, pp. 13-15.

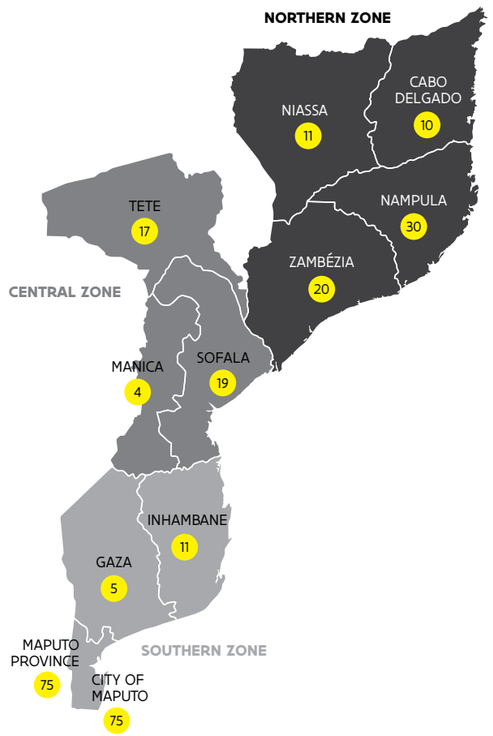
36 WHO, World Malaria Report 2018, passim, https://www.who.int/news-room/feature-stories/detail/mozambique-signals-urgency-on-malaria-as-researchers-seek-fresh-hope & https://www.severemalaria.org/countries/mozambique.

In terms of TB, the main and deadliest coinfection with HIV and AIDS, it is estimated that about 34,000 PLHIV have an active TB infection, while resistant and even multi-resistant TB is becoming an increasing problem. This is due to the so-called treatment cascade by which a significant number of patients drop off between successive phases of testing, notification, initiation of treatment and long-term treatment. The same phenomenon still occurs in the context of the life-long treatment of PLHIV themselves.

HUMAN RESOURES FOR HEALTH

In terms of health personnel, Mozambique continues to be confronted with one of the most serious crises worldwide, despite the great progress made over the past two decades. Only 758 specialists are employed within the public health system. In 2019, there were on average only 39 health personnel employed in the health sector, among whom 9 doctors and 30 nurses, per 100,000 inhabitants[37]. This is a far cry from the minimum of 230 per 100,000 inhabitants recommended by WHO guidelines. The further increase in health care personnel will still need to overcome structural obstacles. The endogenous growth of nursing personnel, mainly in the area of maternal and child-care (SMI), over the past few years is encouraging. In 2019, 2,425 (of which 61% female) and in 2018 even 3,339 nurses graduated. It is partly due to this growth that a ratio of 68 specialist nurses for every 100,000 women of childbearing age and children aged 0-5 years has been reached.

Figure 4: Number of surgeons per province (2015)[38]



37 MISAU, Relatorio anual do Balanço do Sector da Saúde, 2019, Maputo, 2020, p. 34.

38 Copied from A. OLGA MOCUMBI e.a., Doenças Crónicas e Não Transmissíveis em Moçambique, Relatório Nacional - 2018, p. 10.

Still, personnel retention remains problematic in a public health sector facing tough competition from the for-profit and not-for-profit private sectors in particular, as well as the many donor-funded health projects and programmes. This is even more evident with higher level personnel. The universities only produce about 200 doctors a year, while in 2018 a mere 64 specialists graduated in all medical disciplines[39]! At the same time, many medical graduates can wait up to two years before being recruited.

It is necessary to train many more nurses and other personnel in the health sector to the highest possible level of education, while improving the quality and practice orientation of their training. This in turn has an important impact on the care-seeking behaviour of the general population. When looking at the more vulnerable groups, this impact is only growing. Already in 2010 Ricardo Moresse, chairman of the Forum of Mozambican Associations for People with Disabilities (FAMOD), stated that:

> "to tangibly improve access to services, we need to start by changing the attitudes and practices of service providers, more than policies and laws."[40]

Several passages in the VNR Mozambique 2020 indicate that, in addition to elderly people and children, people with disabilities are still in an extremely vulnerable position when it comes to basic social service delivery. This shows that, even after 2010, little progress has been achieved for them in this respect[41]. The same goes for adolescents in the many districts that have not yet been reached. Health service delivery for migrants, internally displaced people and PLHIV also suffers greatly from a lack of well-trained health personnel.

At the same time, the absorption capacity of the health system needs to be structurally improved. Currently it stands at only 1,000 to 1,500 health personnel a year, and there is insufficient predictable public funding available to increase that capacity in a sustainable manner. The fact that the majority of health personnel continues to be highly concentrated around the country's main population centres is a major problem. Attempts are being made to address this through mandatory distribution of personnel across the country. However, progress is slow due to the fact that many of the previously marginalised regions in the country have to start from very low personnel numbers. The best indicator of the gravity of this situation is the mean distance to a primary health facility in the different provinces. In Tete this distance of 15.4 km remains the largest compared to the average national distance of 12.4 km and the smallest of 1.6km in Maputo (city)[42]. This puts enormous pressure on the referral system as a whole, which cannot possibly work effectively in a context of such huge scarcity at the first line level.

Moreover, said referral system is generally still very poorly represented at the higher echelons. The primary level can still count on 1,609 health centres and health posts, albeit with widely varying capacities (96%). At the secondary level, however, there are only 51 rural and district hospitals and 5 general hospitals (3%). With 10 provincial hospitals, the tertiary level is barely represented at provincial niveau, while the quaternary level offering the highest specialisation is only served by 4 central hospitals and 1 psychiatric hospital. Another strategy to respond to the limitations resulting from a shortage of low-skilled health personnel and a health infrastructure which is insufficiently widespread is to increasingly shift tasks to community workers, so-called multipurpose community workers (APEs), or to (self-organising) community groups. These are already involved in activities such as ARV distribution, family planning and malaria. The Mozambican Ministry of Health has also developed a strategy to involve traditional healers, given their widespread presence, their position as confidants in the community and their proven healing skills. In addition to the APEs they are also used as intermediaries for the distribution of contraceptives (condoms)[43].

39 Club of Mozambique, Mozambique gets 64 new doctors, 20/12/2018.

40 Cited in RAVIM & Handicap International Mozambique, People with disabilities in the suburban areas of Maputo and Matola, Maputo, 2010, p. 10.

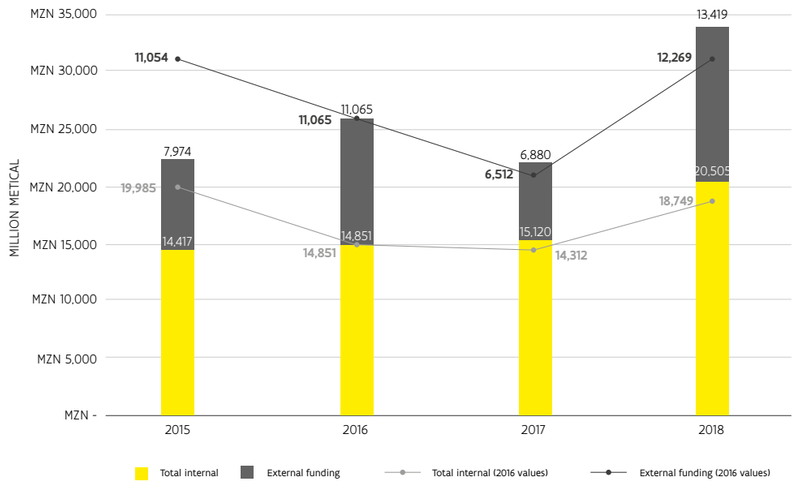
41 VNR Mozambique 2020, pp. 3, 21, 26, 32, 34, 37, 40, 53, 61, 78, 82, 97 and mainly p. 36.

42 MISAU, Relatorio anual do Balanço do Sector da Saúde, 2019, Maputo, 2020, p. 28.

43 PESS 2014-2019, pp. 23-24.

FINANCING OF THE HEALTH SECTOR

Figure 6: Evolution in the health budget in real and nominal values (billion MZN, internal/external)



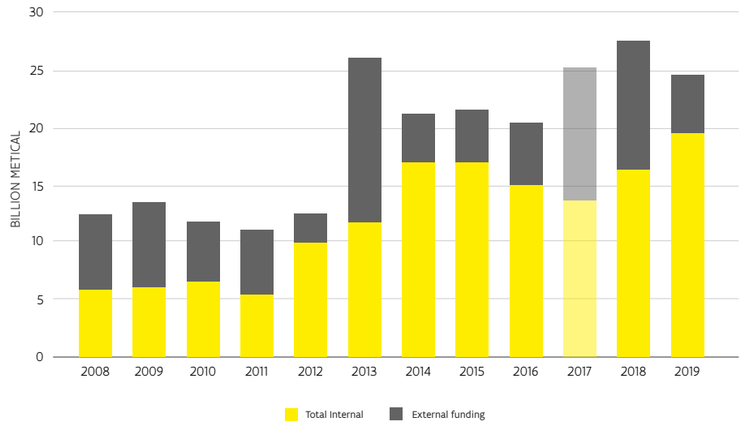
There are also still many challenges regarding financing of the health sector[44]. It is clear that the Mozambican Government, with the support of external partners, made a major effort in 2018 to channel more resources from the state budget to the health sector. Mozambique set aside a record 8.8% of the state budget - 12.7% excluding expenditure on financial operations and debt repayments - from its own resources for health. Eventually, 21.2 billion MZN were assigned to the health sector from internal resources, while external partners contributed 17.6 billion MZN, or 45% of the total. Ultimately, the system successfully implemented 87% of the total of 33.9 billion MZN (60% internal, 40% external). In 2019, the Mozambican Government (59%) and its international partners (41%) provided 33.5 billion MZN for the health sector. With this, the Mozambican state allocated 7.4% or 9.8%, excluding national debt repayment, to the health sector from the internal resources of the state budget. 88% of the internal and external total was implemented (29.4 billion MZN). In nominal terms, the budget used for 2019 decreased by 5%. However, when calculating in real terms, the health budget decreased sharply in the period 2016-17, only to return to the level of 2015 in 2018. After that, it decreased sharply again in 2019.

Based on a calculation of the real financial requirements to implement the PESS – estimated at 750 million US$ per year - we can see that, even at the highest investment of 2018 valued at 580 million US$, full financing of the sector falls short by almost 30%. Also, even when using the higher percentages for the health sector share, by excluding the cost of debt repayments, Mozambique still fails to deliver on the continental agreed commitment in the Abuja Declaration. This would require Mozambique to spend at least 15% of the state budget on health.

It is important to note that current distribution of resources for deployment in the field is still moving too slowly towards far-reaching decentralisation. In the context of moving towards UHC, a larger allocation seems to be called for at provincial level (11%) and at district level, which is responsible for the important basic and secondary health care (22%), as well as for tertiary care (6%), relative to the central level (51%).

44 The health financing analysis was made on the basis of: MISAU, Relatorio anual do Balanço do Sector da Saúde, 2018, Maputo, 2019, pp. 28-29 & Idem, Relatorio anual do Balanço do Sector da Saúde, 2019, Maputo, 2020, p. 39. Also relevant to this is UNICEF, Budget Brief Health, Mozambique 2018, 2019 & UNICEF, Budget Brief Health Mozambique 2019, 2020.

Figure 7: Evolution in internal versus external health sector investments in real terms (billion MZN)[45]



In the context of sharp increases in health expenditure and heightened fragility caused by the COVID-19 crisis, the continued importance of external funding should certainly not be underestimated. External funds are largely used to absorb the investment costs, whereas internal funds are used primarily to cover recurring personnel and other costs. The external funding modalities for that year were distributed relatively evenly between the PROSAUDE sector fund (28%), bilateral and/or vertical projects and programmes (29%), appropriations (26%, mainly GFF sharing much common ground with CSP[46]) and, albeit with a slightly smaller share, donations in kind (17%).

These figures do not include the bulk of external financing. The amounts that are not channelled through, or at least captured by, the government sector budget are extremely difficult to trace and verify. This appears to be true primarily for the significant investments of USAID/PEPFAR in the health sector. In 2019 alone, the Americans, according to their own figures, invested US$ 103 million towards the fight against HIV and AIDS; US$ 60 million towards basic health care and US$ 18 million for maternal and child care, including contraception, in Mozambique[47]. More generally, in 2018, OECD donors declared that another 818.5 million US$ had been spent in the "Population and Health" sector in the country, thus comprising up to 45% of total ODA for Mozambique[48].

Particularly worrying in this context is the rapid decline in investment through the PROSAUDE sector fund. For the past three years, this accounted for around a quarter of the traditional investment prior to 2016. This in itself encumbers predictability and the ability for alignment with efforts made within the government-led sector strategy, as well as meticulous donor coordination. Furthermore, PROSAUDE funds are the only resources (80%) that are largely destined for decentralised investment by the provinces and districts.

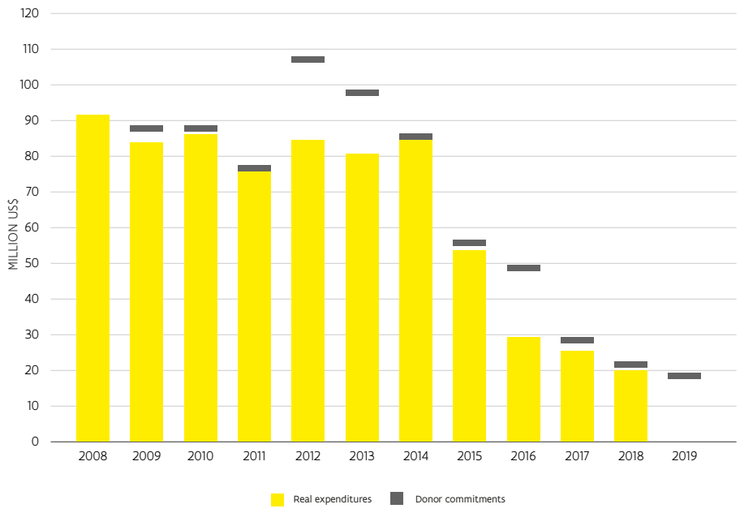
45 UNICEF, Budget Brief Health Mozambique 2019, 2020, p.6, figure 3B.

46 Cfr.: https://www.globalfinancingfacility.org/mozambique.

47 See: https://results.usaid.gov/results/country/mozambique.

48 See: OECD-DAC: Aid at a Glance by Recipient, 2018.

Figure 8: Evolution in investment in PROSAUDE sector fund (US$ million)[49]



The decline of PROSAUDE funding implies that the decentralised authorities are de facto losing a major part of their operating funding, which seriously jeopardises the decentralisation process. Moreover, donors are transferring their PROSAUDE funds at an increasingly later stage, i.e. in the third and even fourth quarter, making carefully planned spending impossible.

THE COMBINED IMPACT OF THE HEALTH, SECURITY AND CLIMATE CRISES

A number of external factors exacerbate the impact of the aforementioned weaknesses within the Mozambican health system. First, there is Mozambique's high exposure to climate change due to its geographical location and the increase in extreme cyclical events (droughts, floods and cyclones) that have become more frequent in recent years. In 2019, with the rapid succession of hurricanes Idai and Kenneth, this phenomenon reached a sad climax. In addition, the hurricanes came at a time when the country saw its peacebuilding and conflict prevention efforts thwarted by some new or resurgent armed conflicts in the north and the centre of the country, respectively. These were driven, on the one hand, by shadowy groups linked to Muslim terrorism and, on the other hand, by a movement claiming an (unclear) association with RENAMO[50]. The combined impact of the climate and security crises also explains the sudden increase of 537,000 **internally displaced people in the 2019 year of disaster**. Although many of these displaced populations were able to return relatively quickly to their often severely affected, native communities or to resettle in safer areas, the negative impact on health services still had equally serious and long-lasting implications for them[51].

Those same weaknesses also affect the capacity of Mozambique to adequately respond to threatening epidemics and pandemics. The possibility of (sudden) outbreaks of new or antibiotic resistant infectious diseases, fuelled by climate change, the increased disturbance of natural habitats and the further globalisation of the economy, make for a very problematic situation as has been recently borne out by the COVID-19 pandemic. Although the full impact of this COVID-19 pandemic on Mozambican society in the long-term is currently still uncertain, the short-term impact is enormous. In order to prevent the spread of this pandemic, the country was forced to close its borders and declare a state of emergency (April 2020). Schools, most industrial plants, businesses and commercial facilities were closed, while social distancing rules and travel restrictions were imposed. Within the health sector itself, key actions were also taken, such as screening and testing suspected cases and isolating and quarantining confirmed cases. This took up a lot of financial and human resources. Restrictions on mobility and social distancing had a big impact on income and businesses. This affects the most vulnerable households in particular by further deteriorating their living conditions, significantly constraining the country's development agenda.

49 UNICEF, Budget Brief Health Mozambique 2019, 2020, p.7, figure 4.

50 All Africa, Mozambique: Defence Forces On 'Maximum Patrol' in Cabo Delgado & Mozambique: Peace in Mozambique - Third Time Lucky?

51 iDMC&IOM, Eight Months after Idai: Chronology of Displacement, Humanitarian Needs and Challenges Going Forward In Mozambique, 2019 & https://www.internal-displacement.org/countries/mozambique.

2.3. STRATEGIC CHOICES FOR THE COOPERATION PROGRAMME

The governments of Mozambique and Flanders have opted for consistent development cooperation and continuity with the previous CSP, notwithstanding a number of new accents and focus areas, in line with emerging opportunities. The general focus of the collaboration remains on the further development of the health sector, one of the priorities of the Mozambican Government's Five Year Plan, 2019-2024. The strategic choices for this cooperation programme are based on the results of the Mid-Term Review of the CSP III and on the experiences and added value of Flanders within the sector.

LESSONS LEARNED FROM THE MID-TERM REVIEW

In 2019, a Mid-Term Review of the CSP III, the so-called MTR III, was carried out. This MTR was generally positive about the contribution of Flanders to the development of the health sector in Mozambique. The MTR III made the following recommendations for future development cooperation between Flanders and Mozambique:

Table 2: recommendations from MTR III

Responsible actor		Summary of recommendations
Government of Flanders	1	Consider taking up the presidency of the health sector fund, PROSAUDE.
	2	Step up efforts to further reduce portfolio fragmentation.
	3	Look for more coherence in the composition of the portfolio and thereby avoid proposals that are less aligned with the objectives.
	4	Strive for greater coherence with the projects financed outside the CSP in Mozambique.
	5	Consider providing direct support to the provincial government.
	6	Organise annual consultation with all projects and each province to promote synergy and exchange.
	7	Increase the occupancy of the country office in Maputo, especially if Flanders takes up the presidency of PROSAUDE.
	8	Intensify cooperation with other similar projects and programmes that are not supported by the Government of Flanders.
	9	Intensify dialogue with other sectors, especially those which play a role in the prevention of gender-based violence, as part of a strategy to improve respect for sexual and reproductive rights.
	10	Increase commitment to the collective activation of resources through PROSAUDE.
Mozambican Government (National)	11	Strengthen multi-sector coordination of SRHR initiatives with all relevant provincial directorates.
Mozambican Government (Provincial)	12	Improve the overview and coordination of the various health initiatives within the province.
	13	Modify the terms of reference for the remit of technical assistant to the provincial directorate so that the assignment is clearly defined, with specific tasks that generate the greatest added value for the directorate.
	14	Consider the establishment of a Steering Committee to oversee the implementation of the Fourth Country Strategy Paper.
Flemish + Mozambican Governments	15	Consider a national evaluation of the approach to the different initiatives and strategies to promote SRHR among adolescents.

GUIDING PRINCIPLES

As a basis for the CSP IV, both partners identified the following 15 guiding principles:

Table 3: Guiding Principles of CSP IV for development cooperation between Flanders and Mozambique

1	Maintain the focus of Flemish Development Cooperation on one sector, i.e. Health, for CSP IV.
2	Continue to promote access to SRHR in Mozambique and the fight against harmful cultural practices and gender-based violence within an overall objective of strengthening the health system and promoting Universal Health Coverage (UHC), as defined by the World Health Organisation.
3	Strengthen the rights aspect of this cooperation by increasing focus on policy influencing and monitoring through support to relevant non-governmental actors and research institutions and the conduct of mutual policy dialogue.
4	Continue to pay consistent attention to vulnerable groups with both preventive and curative health services. These groups include adolescents, mainly girls and young women; sexual minorities; people living with disabilities and/or HIV and AIDS; (potential) victims of harmful cultural practices related to sexuality, reproduction and marriage; and people belonging to several of these groups.
5	Maintain a systems approach to the cooperation by (1) continuing to support the development of the health system through the PROSAUDE sector fund and consider taking up the presidency of PROSAUDE in 2021.
6	Maintain a systems approach to the cooperation by (2) continuing to provide technical assistance via (international) advisors from the central and decentralised governments (Tete Province and possibly Maputo Province).
7	Maintain a systems approach to the cooperation in the area of Health by (3) even more actively promoting multi-sector cooperation between the relevant sector ministries and the explicit inclusion thereof in project calls.
8	Continue to focus on (1) the further development of high-performing and motivated health personnel and skilled health volunteers in particular, and (2) the quality aspect of health service delivery more generally, in order to effectively increase the appropriateness and acceptability of the specific service delivery.
9	Continue the geographical twin-track approach, whereby support to the central level is substantially complemented by support to and within the Provinces of Tete and Maputo. This allows for further monitoring of the advanced decentralisation of the health system in Mozambique.
10	Strengthen the attention to the promotion of an evidence-based health policy by (1) actively differentiating collected health data, as a minimum on the basis of gender and age and (2) continuing to support specialised actors, including Flemish players with internationally recognised expertise.
11	Pay continuous attention to promoting coherence and economies of scale in development cooperation with Mozambique, without losing innovation capacity, amongst other things via pilot projects.
12	Pay sufficient attention to the exchange of material and experiences with other donors and actors and with programmes that have similar or strategically complementary objectives, mainly in the Provinces of Tete and Maputo, but also beyond, and to the potential for joint support of programmes.
13	Capitalise on the experience of the joint call for projects, continue this practice and explore additional ways to further guarantee the ownership and involvement of the Mozambican government in the formulation and implementation of CSP IV.
14	Consistently examine the possibility of adopting Flemish initiatives for international cooperation and development cooperation which have (fundamentally) different objectives than cooperation for Health and which therefore fall outside the framework of CSP IV. One of the reasons for this is that the budget of the current CSP cannot be reported as climate finance.
15	Incorporate improvement of health crisis preparedness of Mozambique in the most appropriate way in the CSP IV.

THEORY OF CHANGE

DESIRED CHANGE

Flanders contributes to the development and implementation of a high-quality and inclusive health policy at the national level and in the province of Tete, as described in the PESS. This policy leaves no one behind, allows for sufficient and diversified attention to be paid to SRHR for all and helps to provide an effective response to epidemics and pandemics. This will enhance the opportunities for all Mozambicans, including members of vulnerable groups such as adolescents, members of sexual and gender minorities, people with disabilities and/or HIV, internally displaced people and migrants, to participate in Mozambican society, while significantly contributing to the country's sustainable development.

BENEFICIARIES

The beneficiaries of this CSP are Mozambicans with various unmet SRHR needs as well as broader health needs, with a special focus on members of vulnerable groups such as adolescents, sexual and gender minorities, people with disabilities and/or HIV, internally displaced people and migrants.

AREAS OF CHANGE

Essential areas of change have been identified based on the current state of the health sector. The areas of cooperation, points of attention and working methods deemed to be priorities within this programme of cooperation, follow the strategic choices mentioned above.

1 THE NATIONAL GOVERNMENT OF MOZAMBIQUE AND THE PROVINCIAL GOVERNMENT OF TETE DEVELOP AND IMPLEMENT A HEALTH POLICY THAT ESTABLISHES AN INCLUSIVE, QUALITY HEALTH SYSTEM AND THAT PROMOTES RESILIENCE TO HEALTH CRISES

Flanders, along with other donors, opts for direct support to the Ministry of Health, through funding of the PROSAUDE sector fund for health, thus contributing to the coordinated implementation of the national health plan. Via this fund, donor efforts are aligned with the strategy and budget of the Mozambican government, which coordinates the administrative and technical implementation of this sector-wide programme. This approach is in line with the commitment of the EU and its Member States to: *"[…] continue to support partner countries in their efforts to build strong, good-quality and resilient health systems, by providing equitable access to health services and universal health coverage*[52]*."*

Flanders provides a significant contribution of at least EUR 2 million per year to PROSAUDE. In addition, it will continue to offer technical support to working groups and the government and will assume its responsibility for the rotating presidency of PROSAUDE. Flanders hopes to thus contribute towards re-establishing a positive trend in terms of the funding for PROSAUDE, which is, after all, uniquely placed to translate the principles of the Paris Declaration, the Accra Agenda for Action and IHP+ for the health sector.

At the same time, in a country as vast and diverse as Mozambique, a dual approach - combining sector support at the national level with direct targeted provincial support – continues to be a prerequisite if the health system is to be brought as close to the end-users as possible and adapted to the local context and to the urgent health needs of vulnerable groups[53], amongst others. After years of preparation and testing decentralisation in the health sector, it appears that the necessary reforms are finally taking shape. Flanders will support the provincial authorities by strengthening their technical and financial competences so that the final steps in this reform can be implemented as successfully as possible. The cooperation between Flanders and Mozambique will remain focused on collaboration with the province of Tete. This pertains to the support for provincial government institutions, specific research tasks, NGOs and other societal actors, as well as to joint financing of programmes with other donors. As such, (1) we guarantee continuity and (2) the predictability of our support, (3) we capitalise on the lessons already learned in the cooperation with this province, and (4), we provide additional support to different administrative levels within our strategic portfolio approach for the Flemish-Mozambican cooperation. At the same time, a needs analysis indicates certain persistent vulnerabilities[54] particular to the health system in Tete.

In terms of initiatives outside the province of Tete, the approval criteria include the possibility of cross-fertilisation of projects in different provinces, the (numerical) presence of specific vulnerable groups and the monitoring capacity of the Representation of Flanders.

Finally, the strengthening of national and provincial capacities to help prevent and fight local outbreaks of epidemics and pandemics, and the organisation and coordination of relevant sectors to this end, will feature strongly in the new plans.

52 Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on the New European Consensus on Development: 'Our World, Our Dignity, Our Future', paragraph 27.

53 It is no coincidence that within PESS 2014-2019 decentralisation was already the starting point for the aspired structural and far-reaching reforms. See: PESS 2014-2019, pp. 47-48.

54 Distance to a primary level health facility remains greatest in Tete, at 15.4 km compared to the average national distance of 12.4 km (MISAU, Relatório Anual de Balanço do Sector da Saúde. 2019, Maputo, 2020. p. 28).

2 THE DELIVERY OF A COMPREHENSIVE PACKAGE OF QUALITY AND TAILORED SRHR SERVICES ENSURES THEIR UNIVERSAL AND CONTINUOUS USE AND BETTER HEALTH RESULTS

The Development Cooperation between Flanders and Mozambique remains committed to more inclusive access to SRHR in Mozambique, but takes it a step further through the specific focus on promoting access to vulnerable groups.

Both partners agree that SRHR will be defined in CSP IV as the realisation of all services that, regardless of the provider, contribute to better results in the prevention of morbimortality associated with human sexuality and reproduction, including pre-, peri- and postnatal care, and/or promote the mental and physical well-being of each affected individual.

This will be achieved by:

1. increasing the quality of service delivery;
2. using a more diverse, multi-sector approach;
3. promoting social innovation (e.g. patient self-care interventions[55]);
4. using technological innovation (e.g. through digital applications for both service providers and service consumers);
5. guaranteeing sustained access to SRHR services for all, also in the context of health crises.

The pursuit of improved inclusivity will be taken up in the monitoring and evaluation of the overall performance of the health system. Achieving greater inclusivity also requires more socio-anthropological and/or implementation-oriented research, in addition to greater efforts to segment data down to social characteristics such as gender and age, and possibly also the existence of (multiple) disabilities, including their nature and severity[56]. Potential multilateral and indirect programmes that receive support in this area must base their operations on the relevant national plans and strategies, or must at least propose convincing and innovative pilot projects. In addition, they will share their best practices and the results of any action-oriented research and pilot projects with the government. This will allow the promotion of more detailed exchange of data by and with the health services of the Mozambican Government. In this way, all stakeholders should gain better insight into the vulnerability and specific SRHR needs within the various sections of the Mozambican population and how to successfully respond.

Further integration of such SRHR initiatives into the promotional, preventive and curative health services for major infectious diseases, including HIV and AIDS, non-communicable diseases and parasitic diseases, and certainly also into general basic health care and the implementation of vaccination schemes for newborns/children and their mothers, remains an important target. A target we cannot lose sight of if we are to increase the efficiency, effectiveness and sustainability of our efforts.[57]

Finally, both partners reaffirm their analysis that the promotion of health and well-being, and certainly of SRHR therein, requires a multisector approach. Although more complex and demanding, this approach yields better and more sustainable results. As such, the PESS 2014-2019 recognises the fact that sectors outside health need to be involved in order to increase the health impact of our efforts and effectively reach the targeted vulnerable groups[58]. The EU and its Member States consider this multisector approach as a good practice in health cooperation with developing countries, while the WHO also emphasise a so-called "Health in All Policies" approach as a requisite component of health promotion[59]. The UN Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) likewise depends on multisector action for successful implementation[60]. Finally, both the UN's new 2030 ASD and the new Vision on Flemish Development Cooperation[61] stress the importance of stimulating such multisector approaches in order to capitalise on the important inter-linkages between the different goals and dimensions of sustainable development All of this explains the emphasis placed by the National Reference Group for the SDGs on identifying and implementing so-called development accelerators given that these accelerators have a multisector character and therefore greater impact potential[62]. Finally, in this context both partners also endorse the need for implementing the strategy for 'Health at School, of Adolescents and Youth' of the Mozambican Government.

55 Relating to self-care for SHRH, see e.g. https://www.bmj.com/selfcare-srhr.

56 As mentioned by the PESS, 2014-2019, on pp. 51-53, p. 53, pp. 56-57 & p. 62 respectively.

57 For this strategic need for integration, see African Union Commission, Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights, 2016-2030, Maputo, 2016. And also: PESS, pp. 43, 45, 64, 68 & 86.

58 PESS 2014-2019, pp. 35-38.

59 Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on The New European Consensus on Development: 'Our World, Our Dignity, Our Future', paragraph 27. For WHO, see for instance: WHO & Ministry of Social Affairs and Health Finland, The Helsinki Statement on Health in all Policies, 2013.

60 Every Woman Every Child, The Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030, Survive, Thrive, Transform, 2016, pp. 62-63.

61 Government of Flanders & Flanders Department of Foreign Affairs (today called Flanders Chancellery and Foreign Office), Visienota: De Vlaamse ontwikkelingssamenwerking anno 2030, naar een nieuwe identiteit als partner in ontwikkeling (Vision Paper: Flemish Development Cooperation in 2030, Towards a New Identity as a Partner in Development), p. 8.

62 VNR Mozambique 2020, pp. 24-25.

This multisector approach, in which sectors such as Education, Media, Culture, Sports, Agriculture, Water and Sanitation and Public Works may potentially be involved, will address one or more of the following SRHR objectives[63]:

1. Comprehensive sexual and relationship education;
2. The fight against HIV and AIDS and other sexually transmitted diseases;
3. Provision of the best modern methods of family planning through tailored service delivery for vulnerable groups;
4. Improvement of gender relations and the fight against gender-based violence (GBV), including the fight against harmful traditional practices such as child marriages, early marriages and forced marriages;
5. Adjustment of (traditional) views on, and proper (medical) treatment for, people with disabilities within both communities and the government;
6. Promotion of health and well-being of internally displaced people and migrants, including their SRHR.

63 For the need for integration, see inter alia: http://data.unaids.org/pub/BaseDocument/2010/20100604_26thpcbthematicbackground_final_en.pdf. Note that the fight against HIV/AIDS, children's rights and gender are transversal themes for the general Flemish-Mozambican cooperation.

3 GOOD BASIC AND FURTHER TRAINING AND PATIENT-CENTRED CARE BY HEALTH PERSONNEL CONTRIBUTE TO THE INCLUSIVITY AND QUALITY OF HEALTH SERVICE DELIVERY

To address the various issues around training and deployment of human resources for health, both partners will place emphasis on the objective and subjective quality of service delivery at the various levels of cooperation. This also includes strengthening capacity and motivation of health personnel to better approach and treat patients with vulnerable backgrounds. This can be done through both basic and further training and by monitoring health personnel more closely in the workplace. Personnel must have ongoing access to properly equipped infrastructure and sufficient digital and other health technology in order to receive and care for vulnerable groups in a more appealing and appropriate way, even sometimes remotely and/or in more difficult to reach areas. Finally, specific training for health personnel is important for their flexible and safe deployment in crisis situations. These efforts will help make the service delivery in all circumstances more user-friendly and accessible for all Mozambicans.

4 THE PROMOTION OF EVIDENCE-BASED HEALTH POLICY AND THE IMPLEMENTATION AND MONITORING THEREOF INCREASE THE EFFICIENCY AND EFFECTIVENESS OF SAID POLICY, INCLUDING IN THE CONTEXT OF HEALTH CRISES

The proper collection of medical data, epidemiological monitoring and accurate and ethically conducted health research are indispensable. These allow the government to (1) correctly prioritise scarce health resources, (2) select the most appropriate treatment methods and strategies and (3) deal with an (imminent) epidemic or pandemic[64].

This aspect of the Flemish-Mozambican cooperation will therefore be aimed at supporting the actors able to provide most of the following services most efficiently and effectively:

1. Collecting, managing and disseminating health data of strategic importance for policy and sufficiently segmented by gender, age and elements of vulnerability;
2. (Monitoring) the quality control of new vaccines, medicines, (short-term) tests and health services and following up on antimicrobial resistance;
3. Managing medical reference laboratories;
4. Ensuring rapid diagnoses in case of diseases and the outbreak of epidemics or pandemics;
5. Training researchers and research assistants for the laboratories and the deployment of rapid tests;
6. Disseminating targeted health information to the population, including vulnerable groups, within the framework of overall health promotion and disaster preparedness and response;
7. Monitoring the health status within the national territory or part thereof, with due attention to the health of vulnerable groups.

The first task will be to look into the relevance of extending and/or reorienting Flanders' support to the National Health Institute (INS) as a priority partner in the field of health research and monitoring.

64 PESS 2014-2019, pp. 55-56.

2.4. STRATEGIC APPROACH FOR THE IMPLEMENTATION OF THE THEORY OF CHANGE

CORE VALUES: GENDER, GOOD GOVERNANCE AND HUMAN RIGHTS

When programming and implementing their cooperation, the partners will attach particular importance to (1) the promotion of good governance, (2) human rights and (3) equal opportunities for men, women and vulnerable groups, with specific attention to people with disabilities, PLHIV, SGM, migrants and internally displaced people, as the basic conditions for development.

Flanders follows EU guidelines (amongst others the Gender Action Plan III, 2020), in order to monitor whether those conditions are translated into funding and activities. As such, the following targets must be met: a minimum of 85% of supported initiatives are required to:

- score 1 or 2 on the gender equality marker, GG, as defined by OECD-DAC
- score 1 or 2 on the participatory development/good governance marker, PD/GG, as defined by OECD-DAC, and integrate elements of participation, good governance and human rights[65].

In addition, at least 10% of funding will be allocated to initiatives that have at least one of these basic conditions as their main theme.

Finally, project calls for non-state actors will include the requirement to deliver at least 1 result within one or more of the following action areas:

- to actively investigate or monitor the efficiency, quality, effectiveness and, in particular, inclusivity of the government health policy and service delivery towards vulnerable groups in order to uncover and make known prevailing inequalities within the right to the highest attainable standard of health
- to actively investigate or monitor the application of other principles of good governance such as transparency, careful budget planning and execution and accountability, within the Mozambican health sector, authorities and government
- to propose or actively defend alternative policies for greater inclusivity and quality within health service delivery as regards national and/or provincial authorities, or parliament and the government
- to demonstrate how the right of access to the highest standard of health and correct and complete information can also be guaranteed during the prevention and control of epidemics and pandemics.

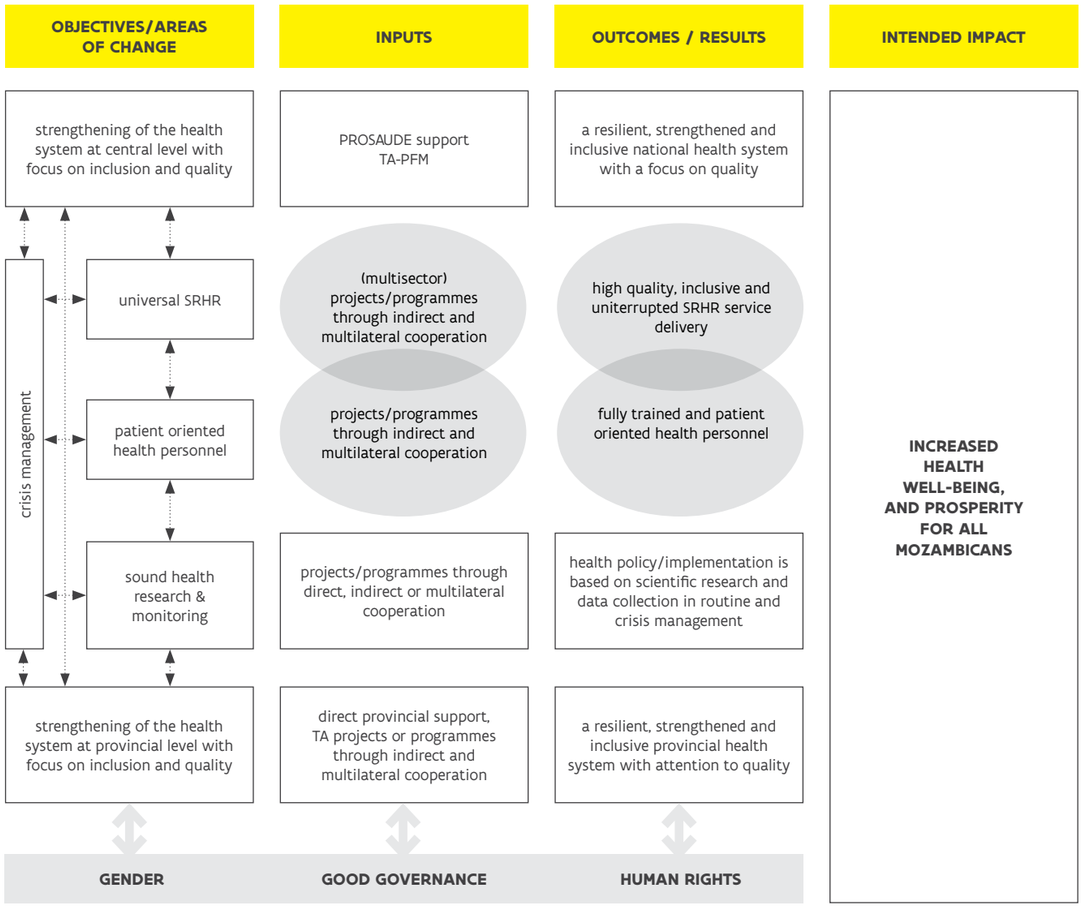
INTEGRATION OF ADAPTATION TO CLIMATE CHANGE

The current high disease burden in Mozambique is strongly characterised by climate-sensitive diseases that disproportionately affect the rural population, women and children. Recurrent outbreaks of traditional and new climate-sensitive diseases in Mozambique, such as malaria, cholera and chikungunya, put even more pressure on the already overwhelmed health services. Climate models predict that Mozambique will face higher temperatures, a delayed start of the rainy season in some regions and an increase in the frequency and intensity of extreme weather events, all of which will exacerbate the existing challenges within the national health system.

Flanders and Mozambique will integrate adaptation to climate change as much as possible into their cooperation. At policy level and within its cooperation with governmental actors, Flanders will promote and monitor the integration of the impact of climate change on health policies. In terms of implementation, we will provide appropriate climate risk management measures for vulnerable projects and programmes. Given the large scale of efforts required to combat climate change, Flanders will also support this theme via regional initiatives outside the scope of the present CSP IV (cf. infra).

SCHEMATIC REPRESENTATION OF THE IMPLEMENTATION

The following diagram illustrates the desired change combined with identified areas of change and components of the strategic approach.



65 giz, The Policy Marker System, DAC Markers / BMZ Markers, Guidelines, 2014, pp. 4-6 (gender) & pp. 7-8 (participatory development/good governance). For instance, a score of GG 1 means that gender equality is a significant objective (i.e. although it is important, it is not deemed to be one of the principal reasons for undertaking the development initiative), while a score of GG 2 signifies that gender equality is the principal objective of the development cooperation measure (i.e. it is the crucial reason for its implementation).

BASIC ASSUMPTIONS

The following assumptions are crucial for progress in the objectives and results of this programme:

GENERAL

1. CSP 2021-2025 develops a positive dynamic of cooperation and co-creation between the Governments and all stakeholders from other development partners, multilateral organisations, knowledge institutions, the private sector, (international) NGOs and civil society organisations active in the health sector, to members of the target groups of the programmes and activities.

STRENGTHENING OF THE HEALTH SYSTEM (CENTRAL/PROVINCIAL)

1. The cooperation between the Governments and authorities of Mozambique and Flanders remains constructive and all partners contribute to the joint objectives set out in the present CSP.
2. The Government of Mozambique and the donor community align their visions and investments with an effective and consistent implementation of the existing health policy, determined in a participatory manner by the Government of Mozambique.
3. Both the Government of Mozambique and its development partners strengthen their efforts to invest in Mozambique's national health priorities and health system, as stipulated in the PESS. In that respect, Mozambique shall increase its public resources for the health sector and Flanders shall respect its commitment to PROSAUDE and the provincial authorities in Tete.
4. The impact of climate change and the possible occurrence of health crises remains manageable for the (strengthened) health system.

SRHR FOR ALL

1. Access to SRHR for all Mozambicans remains an important policy priority for the Governments of Mozambique and Flanders and the parliaments of both administrative entities, as well as for other international institutions, donors, civil society organisations and (international) NGOs.
2. Sufficient quantitative and qualitative results are achieved in policy implementation in general and for vulnerable groups in particular.

HIGH-QUALITY AND PATIENT-ORIENTED HEALTH PERSONNEL

1. Together with their international partners, national and provincial authorities step up efforts to train high-quality, patient-oriented health personnel and volunteers, on the basis of a revised and more practice-oriented curriculum.
2. Together with their international partners, the national and provincial authorities increase their efforts to deploy said personnel in a sustainable and sufficiently equipped manner, combined with effective guidance and monitoring of existing and newly recruited personnel in the workplace itself.
3. The personnel is deployed geographically and manages to put inclusivity training into practice and to attract and care for patients from vulnerable groups in an effective and professional manner.

SOUND HEALTH RESEARCH AND MONITORING

1. The Mozambican Government demonstrates increased interest and capacity in terms of developing health policy, including in the context of health crisis preparedness, which is based on scientific research and sufficiently segmented data collection.

VERTICAL COMPONENTS: GENDER, GOOD GOVERNANCE AND HUMAN RIGHTS

1. Civil society continues to be given the space to actively participate in health policy, to defend the health interests of vulnerable groups in Mozambican society and to demand accountability from the government.

3
INDICATIVE BUDGET FOR THE CSP IV

The following indicative table outlines an initial and rough distribution of resources as proposed by the partners for the successful implementation of CSP IV. Taking the total resources available to implement CSP IV as a starting point, a distribution was made based on a general estimate of the financing needs and absorption capacity within the various objectives. This distribution is purely indicative and should under no circumstances be used as a definitive allocation of resources between the various objectives.

Indicative financing of the Flemish-Mozambican cooperation for CSP IV, 2021-2025

Year	2021-2025
To contribute to the development and implementation of a high-quality and inclusive health policy at central level that addresses the health needs of vulnerable groups and is prepared for the prevention of, and fight against, epidemics and pandemics*	12,000,000
To provide support to Tete Province for the development and implementation of a high-quality and inclusive health policy that addresses the health needs of vulnerable groups and can make an effective contribution to the prevention of, and the fight against, epidemics and pandemics	2,500,000
To contribute to increasing access to sexual and reproductive health and rights for all Mozambicans, with specific attention to vulnerable groups	6,000,000
To contribute to the further development of well-trained and motivated health personnel and volunteers at national level and in Tete Province, with a view to increasing access to, and the quality and attractiveness of, health services, including for vulnerable population groups	2,500,000
To contribute to sound health research and monitoring of diseases, epidemics and pandemics with, where relevant, due attention to vulnerable groups and to promoting national crisis response capacities under the International Health Regulations	2,000,000
total	**25,000,000**

* of which, if properly managed, at least EUR 2 million per year for the common health fund, PROSAUDE

4
MANAGEMENT OF THE PROGRAMME

This section describes the overall strategy for the management of the CSP. The success of the programme will depend on effective cooperation between the governments and the freedom to adopt a multi-actor approach in which all parties take responsibility for their specific tasks, commitments and use of resources.

4.1 GOVERNANCE

The Government of Mozambique and the Government of Flanders are jointly responsible for the results of CSP 2021-2025. The Government of Flanders has commissioned the Flanders Chancellery and Foreign Office (DKBUZA) to implement its development cooperation policy. DKBUZA is accountable to the Flemish Minister for Development Cooperation for the financing and management of development cooperation programmes, and will monitor their implementation. The Government of Mozambique has appointed the Ministry of Foreign Affairs and Cooperation (MINEC) as the main coordinator of national economic and development planning and as the facilitator of international development cooperation. The Mozambican Ministry of Health (MISAU) is the main government partner for the implementation of this cooperation strategy, but the cooperation may also include other Ministries, depending on the areas of change specified.

DKBUZA conducts policy dialogues and supports policy reforms and implementation processes relevant to the themes of this CSP. It participates in the relevant dialogue forums with the Mozambican Government and other donors in Mozambique. Good governance and public finance management are also incorporated. This means that mutual accountability and shared responsibility for the success of this cooperation strategy are also monitored.

4.2 IMPLEMENTATION

PORTFOLIO APPROACH

A portfolio approach will be used for the implementation of the present Country Strategy Paper. This approach includes support to:

- different financing or implementation modalities
- different administrative levels of implementation (cf. provincial level)
- different categories of implementing actors (direct, indirect, multilateral, local civil society, private sector actors, etc.).

In so doing, the programme will strive to facilitate and strengthen cooperation between projects and between implementing actors as much as possible in order to accelerate the desired change. This portfolio approach guarantees the necessary flexibility for spending of resources and, to a certain extent, spreading the risks. All projects and programmes funded under this CSP will, independently of funding or implementation modalities or the implementing actor, contribute to the four aforementioned areas of change. The indicators at project level will contribute to the indicators at objectives level. In this way, all programmes are aligned with the objectives set out in the plans of the Mozambican Government.

Flanders will inform the Mozambican Government on any funding provided by non-government actors and will organise calls for subsidies together with the Government whenever possible.

A focused approach is proposed in order to strengthen the efficiency and result-orientation of the programme. This means that a limited number of programmes and projects is selected on the basis of criteria such as the actual needs of a specific area, the relevance and effectiveness of the implementing partners, the potential for coordinated action with the implementing partner, the proposed budget, and the risks involved.

The implementing actors can be bilateral partners, multilateral organisations, international or local NGOs, civil society organisations, research institutions or the private sector. In addition, exchanges or collaborations are possible with Flemish institutions or organisations with specific expertise to improve the quality of programme implementation.

IDENTIFICATION OF PROGRAMMES AND PROJECTS

The designated representatives of DKBUZA and the relevant Mozambican authorities can each identify development initiatives.

Flanders can offer direct support to the Government of Mozambique via bilateral projects, joint financing, or indirect cooperation, whether or not by organising a call for proposals. Delegated cooperation with donor agencies can also be considered. All proposals will be measured against the priorities of this CSP and the Mozambican policy.

Where there is a need for in-house capacity building for local organisations, also with regard to administrative or financial aspects, this can be included in the project proposal and budget.

Flanders and Mozambique undertake to use transparent selection processes for the selection of implementing institutions or organisations. The implementing partners will be assessed on their implementation capacity and must meet certain minimum requirements with regard to financial management, technical competencies and good governance.

Proposals for projects or programmes will be assessed according to the in-house procedures of DKBUZA and then submitted for approval to the Flemish Minister for Development Cooperation. The Government of Flanders must give its final approval to each individual funding request.

The administrative burden will be kept to a minimum by making use of existing formats and procedures of funded organisations whenever possible, and withing the constraints of risk management regulations.

IMPLEMENTATION OF PROGRAMMES AND PROJECTS

The implementation of the programmes or projects is the responsibility of the implementing institutions and organisations.

Detailed information about the implementation of the programme or project and the administrative requirements are specified in a project document and a project agreement.

Flanders will strive to comply as far as possible with local rules and procedures of both government institutions and individual organisations.

In order to limit the financial risks, additional requirements may be imposed, e.g. concerning accountability. In the case of joint financing by several donors and budget sector financing, Flanders will endorse jointly negotiated project and programme proposals and agreements.

REPORTING BY THE IMPLEMENTING PARTNERS

In order to reduce the administrative burden of the implementing organisations, DKBUZA adheres, as far as possible, to existing local reporting systems and procedures, or systems and procedures drawn up and agreed upon in a joint donor context. These reports must meet the required quality and the minimum reporting requirements of DKBUZA. DKBUZA can provide the implementing partner with relevant content and financial reporting templates if necessary. The reporting requirements will also be aligned as closely as possible with the PESS and with other national or local monitoring and data needs of the Government of Mozambique. Reporting comprises both substantive progress reports and financial reporting.

4.3 FUNDING AND BUDGET

Within the time frame of the cooperation programme (2021-2025), Flanders undertakes to pay 25 million euros, with an average of 5 million euros per year. This commitment provides funding for projects and programmes approved by the Government of Flanders in the framework of the CSP 2021-2025. The exact budgets available will be communicated annually by DKBUZA to the Government of Mozambique. DKBUZA will always provide an overview of commitments and funds spent whenever the bilateral consultations take place. The committed and spent funds will be included in ODAMOZ.

The financing of direct bilateral cooperation, both at national and decentralised level, will follow national procedures and must pass a thorough financial risk assessment. In the case of indirect cooperation, the funds will be transferred directly to the implementing parties. Any expenditure deemed to be ineligible will be recovered by the Government of Flanders.

A maximum of 5% of the CSP budget may be used for the identification and formulation of processes and projects, for monitoring, evaluation and learning, for policy research related to CSP themes and for ad hoc technical assistance within programmes and projects. If consultants are contracted externally by DKBUZA, Belgian procurement law shall apply. These funds will be managed by DKBUZA or may be included in project budgets.

4.4. MONITORING, EVALUATION AND LEARNING

MONITORING AND EVALUATION AT POLICY LEVEL

As regards the monitoring and evaluation of sector support to MISAU, Flanders will participate in the existing **policy dialogue** with MISAU and the other donors. Coordination by the lead donor will furthermore be respected, whilst following the principle that relevant monitoring and evaluation should be collective exercises. If possible, Flanders will therefore participate in joint evaluation exercises and work together with the other donors in order to ensure that positions and proposals in respect of MISAU are as coherent and consistent as possible. Flanders can also use technical assistance to support MISAU or the provincial government in their policy tasks, but new instruments can also be explored and used for this purpose. The results of the decentralised, indirect and innovative initiatives are fed back at the SWAp policy level.

A results framework, based on the objectives of this CSP and the PESS, has been developed as a general instrument for monitoring the progress of the CSP, (see below, annex 1). Results achieved will be monitored by using existing national indicators. The programmes and projects funded through this CSP will include or contribute directly to the relevant indicators of this results framework and will be required to report on these indicators.

In 2024 an **external mid-term review** (MTR) of CSP IV will be carried out to assess progress in the implementation of the CSP, while making recommendations for future cooperation. The terms of reference for this review will be approved by the Governments of Flanders and Mozambique. The conclusions of this external review will be jointly discussed and be part of the input to make future cooperation more effective, efficient and sustainable.

A **bilateral consultation** between the Governments of Mozambique and Flanders will take place at least every two years, alternating between Mozambique and Flanders, to discuss policy developments in the health sector, both in general and with regard to CSP areas of change. In addition, (1) the health results achieved within the aforementioned areas of change and (2) the desired future results within these areas will be explained. This consultation will also provide opportunity to report on the progress of the CSP and to share lessons learned within the cooperation framework and based on mutual accountability and the common commitment to continuous improvement. If necessary, measures can be taken in mutual consultation in order to speed up certain processes and/or shift priorities. DKBUZA will provide an overview of the commitments and funds spent. Representatives of MISAU, MINEC and DKBUZA, and, where relevant, other ministries and implementing partners involved, will participate in the bilateral consultations.

The first bilateral consultation (2021) will discuss the start-up and overall programming for the CSP. The second consultation (2023) will discuss the first results and the outlines for the mid-term review. During the third and final bilateral consultation under this CSP (2025), the results of the mid-term review and of the supported initiatives will be covered as a whole, including as the basis for future cooperation.

MONITORING AND EVALUATION AT IMPLEMENTATION LEVEL

The overall responsibility for implementing the programme and reporting on progress and results lies with the implementing partners. DKBUZA will track this process by means of work plans, meetings, progress results, evaluations and site visits. The monitoring is part of a learning process to improve project implementation and organisational capacity and will, where possible, be carried out together with the Government of Mozambique. A steering committee for programmes at provincial level can be set up to increase transparency and mutual accountability. The indicators used for monitoring the progress of projects will be linked to the results framework and thus also to the PESS. These indicators will pertain to the impact on beneficiaries and on the core values 'gender', 'good governance' and 'human rights'.

As a general rule, all programmes or projects will be evaluated externally. This evaluation will be budgeted for within the project budgets. The project or programme agreement will include the modalities for monitoring and evaluation. Evaluations can also take place at the request of DKBUZA. When financing joint programmes, DKBUZA will participate in the joint monitoring and evaluations. This applies in particular to PROSAUDE, where the monitoring mechanisms are laid down in the Memorandum of Understanding and the Manual of Procedures.

The indicators for monitoring direct bilateral cooperation at national and provincial levels (area of change 1) and at the level of areas of change 2 (SRHR), 3 (HRH) and 4 (health research) are the indicators used within the general monitoring framework of the Health-SWAp or within the aforementioned relevant specific programmes. These will in turn feed into the CSP IV results framework (see below, annex 1).

In principle, each project or programme is subject to a regular financial process or compliance audit which applies international standards. The types of audits can vary and are financed by DKBUZA. When participating in joint programmes, especially in PROSAUDE, Flanders will participate in joint audits with other donors. For financing to government partners, the results of the audits conducted by the Mozambican Government's Administrative Tribunal will also be taken into account.

4.5. RISK MANAGEMENT

Multiple risks may affect the achievement of the results of the CSP 2021-2025. Flanders and Mozambique are jointly responsible for risk management and risk mitigation. In the event of risks taking place during implementation of the CSP, Flanders and Mozambique may need to take a number of measures to ensure the proper management of the projects and funds. Even were implementation of the cooperation strategy to change, the most disadvantaged population groups of Mozambique will always remain the end beneficiaries.

Should this CSP increase its focus on decentralisation and implementation in the provinces, in particular Tete and Maputo, it is possible that the Governments of Flanders and Mozambique will have to take additional risk mitigation measures.

Risk management is applied on the basis of the following principles:

- Adherence to the principles of the Paris Declaration applicable to the Governments of both Mozambique and Flanders when considering changes to the modalities of support.
- Flanders will, together with other donors where necessary, closely monitor the risks of the cooperation programmes and, where required, will develop risk mitigating measures and try to find solutions in dialogue with the Government of Mozambique.
- Risk identification (organisational capacity, financial policy, HR policy, ethical policy, etc.), analysis, risk management and monitoring will be part of all initiatives resulting from this CSP.
- Flanders will adopt a portfolio approach, using a mix of implementing partners, of directly supported administrative levels and of financing modalities.
- In the event of decreasing performance or increased risk to the funds committed to the central or provincial level, Flanders may redirect said committed resources to local authorities or non-governmental and multilateral organisations, in accordance with the objectives and target groups outlined in this CSP. The Mozambican Government will be informed of such decisions.
- DKBUZA will reclaim from all implementing partners, any expenses falling outside the agreed budgets and plans, or identified as unlawful expenses by its own or external audits.
- Human rights, attention to gender and good governance, including the management of public finances, remain the basic requirements for development cooperation between Flanders and Mozambique.
- In the event of serious governance problems in Mozambique, Flanders will have to assess whether Mozambique's absorption capacity has been affected. In extreme cases, support may have to be reduced or frozen. Whenever possible, this will be decided in consultation with the Government of Mozambique on the basis of the assessment by the international donor community and, in particular, by the European Union.

5
THE FLEMISH-MOZAMBICAN COOPERATION OUTSIDE THE SCOPE OF THE CSP 2021-2025

5.1 GENERAL

Flanders supports several initiatives in Mozambique that fall outside the framework of this CSP as additional effort to concretise its commitment in the new partnership for global development, as described in the 2030 ASD. This may comprise initiatives providing direct support to Mozambique, or regional initiatives that include neighbouring countries as well as Mozambique. These initiatives are aimed at combating the climate crisis, strengthening agriculture and food security, and increasing the resilience of the population to natural disasters or private entrepreneurship. As the investment priorities of the Government of Flanders may shift, the following overview is time-bound. Further information on these initiatives can be found on this site (Dutch only).

5.2 REGIONALLY ORGANISED INITIATIVES

STRENGTHENING OF HEALTH COOPERATION THROUGH MULTILATERAL INITIATIVES

Flanders prefers supporting multilateral organisations as a complement to its bilateral cooperation with the partner countries and regions. Flanders is one of the most important donors of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP), based within the WHO's Department of Sexual and Reproductive Health and Research (SRH). A second example is the support to UNAIDS within the framework of the fourth cooperation agreement with Flanders. UNAIDS is considered to be the leading institution in terms of an integrated response to the HIV hyper-epidemic and furthermore places strong emphasis on prevention through behavioural change. UNAIDS also plays a vital role in the multisector fight against this epidemic by working to remove the barriers to prevention and treatment embedded in national legislation, as well as the deep-rooted social attitudes that discriminate against members of groups most vulnerable to this disease, such as men having sex with men, drug users and also, in the context of Southern Africa, adolescents and young women. During the bilateral consultations, Flanders undertakes to provide further information on the development and results of its multilateral cooperation relevant to Mozambique.

FIGHT AGAINST CLIMATE CHANGE, DISASTER PREVENTION AND CONTROL, AND REHABILITATION

Mozambique is ranked third most vulnerable country in Africa to multiple weather-related risks. It indeed regularly faces massive flooding, cyclones and droughts, which are only becoming more frequent and severe due to the impact of climate change. For this reason, Flanders supports various initiatives that are working to increase the resilience of partner country Mozambique against the impact of climate change. These efforts will ensure that essential functions of the health system and the food and water sectors are less vulnerable to climate and that, despite unstable climate conditions, sustainable improvements for the population are still achieved in those sectors.

As part of its efforts to make its humanitarian aid as sustainable as possible, Flanders will allocate part of these resources towards a structural approach to disaster prevention in the partner countries, including Mozambique. In the event of an actual disaster, Flanders will furthermore increase efforts to provide emergency aid and to release money for rehabilitation.

SUPPORT FOR ECONOMIC PROSPERITY

The private sector plays a crucial role in the partnerships to the implementation of the 2030 ASD. A strong economic fabric, supported by, among others, high-performing companies, is indispensable for the successful diversification and sustainable development of Mozambique and its economy. However, in order to be able to take up this role, the Mozambican business community must be enabled to actually follow the rules of sustainable practice.

To achieve this, Mozambique will have to embrace better business practices as well as social and technological innovations. For this reason, Flanders continues to support actors that are able to strengthen the relevant capacities of Mozambican entrepreneurs. Examples include grants provided for training on port-related matters and the bilateral cooperation between the Antwerp Port and the port of Maputo. In addition, cooperation takes place with specialised organisations in Flanders. Another channel is the promotion of labour standards and health in the workplace through cooperation with the ILO. Finally, we are also considering opportunities for technology transfer geared to environmentally friendly production, amongst other things.

CULTURE AND SCIENCE

The international deployment of science and technology is highly relevant when it comes to resolving the myriad of social and environmental problems. This makes it possible to jointly promote sustainable development and to realise the 2030 ASD in a more effective and broader way. This applies equally to the mutual appreciation for, and further promotion of, cultural events in Mozambique and Flanders. In addition to providing direct financial support to Flemish and Mozambican knowledge institutions and partnerships, Flanders can also count on UNESCO to realise this cultural, scientific and technological component within its international cooperation.

ANNEXE

INDICATIVE RESULTS FRAMEWORK

This framework may be supplemented by other indicators from programmes, projects or Mozambican policy plans and implementation strategies.

Indicator	Baseline	Sources for verification	Source of the indicator
Impact 1: Increased health, well-being and prosperity for all Mozambicans			
Couple-years of protection by contraception	3,146,606	World Bank	Relatorio Balanço anual 2019
Provincial (Tete)	270,962		
Broken down for vulnerable groups	?	Own figures	Own projects and programmes
Perception of increased accessibility and quality of the Mozambican health system	65.7%/55% (2018)	Surveys of general population and at points of service Afrobarometer	VNR MOZ 2020
Number of health units - National	1,674	World Bank	Relatorio Balanço anual 2019
Number of health units - Provincial (Tete)	135		
Average number of inhabitants per health post - National	17,514		
Average number of inhabitants per health post - Provincial (Tete)	20.839		
Average distance to health post - National	12.4 km		
Average distance to health post - Provincial (Tete)	15.5 km		

Indicator	Baseline	Sources for verification	Source of the indicator
Area of change 1: The national Government of Mozambique and the provincial government of Tete develop and implement a policy that creates an inclusive and quality-oriented health system for all Mozambicans, and that increases national and local resilience to health crises.			
Budgetary allocation for health of the GoM in %	7.4% (internal)	Analysis GTAF / UNICEF	Relatorio Balanço anual 2019
	10.7% (internal+external)	Published State Budget/ PES	
In metical (nominal)	19,769,000,000 MZN (internal)		
	33,495,000,000 MZN (internal+external)		
In US$	580,000,000 US$		
Implementation rate	88% (internal + external)		
Flanders pays its contribution to PROSAUDE on time, once conditions for payment have been met and deemed sufficient by the donor group		Own administration	Communication MISAU – PROSAUDE-donors
Coverage by at least 4th prenatal contact - National	53%	Relatorio Balanço anual	Relatorio Balanço anual 2019
Coverage by at least 4th prenatal contact - Provincial (Tete)	55%	Relatorio Balanço anual	Relatorio Balanço anual 2019
Number/ Coverage APEs	6,673	Relatorio Balanço anual	Relatorio Balanço anual 2019
Number/ Coverage Health Committees	572	Relatorio Balanço anual	Relatorio Balanço anual 2018
% Health personnel of at least an average level of employment - General	59% (16% higher level)	Relatorio Balanço anual	Relatorio Balanço anual 2019
% Health personnel of at least an average level of employment - Primary/secondary level	63% (4% higher level)		
Patient loyalty of pregnant women to their antiretroviral treatment (> 12 months)	65%	Relatorio Balanço anual	Relatorio Balanço anual 2019

Indicator	Baseline	Sources for verification	Source of the indicator
Area of change 2: The increased quality of a complete package of flexible SRHR services together with awareness-raising through various sectors and innovations ensures a wider-spread and more continuous use and better results.			
Coverage of new users of modern methods of contraception after consultation - National	41%	Relatorio Balanço anual	Relatorio Balanço anual 2019
Coverage of new users of modern methods of contraception after consultation - Provincial (Tete)	41%		
Number of individuals from vulnerable groups starting to use modern methods of contraception	0	Own projects and programmes	Own figures
Number of maternity hospital beds per 1,000 women of childbearing age - National	1,29	Relatorio Balanço anual	Relatorio Balanço anual 2019
Number of maternity hospital beds per 1,000 women of childbearing age National - Provincial (Tete)	1	Relatorio Balanço anual	Relatorio Balanço anual 2019
% schools, secondary schools and technical and vocational institutions, providing sexual health services - National	100	Relatorio Balanço anual	Relatorio Balanço anual 2019
% schools, secondary schools and technical and vocational institutions, providing sexual health services - Provincial (Tete)	100%	Relatorio Balanço anual	Relatorio Balanço anual 2019
Area of change 3: Good basic and further training and patient-centred deployment of health personnel contributes to inclusiveness and quality of health services delivery			
Differentiated care for vulnerable groups included in standard training for health personnel	To be determined	Sistema de Informação da Formação Contínua SIFo	Study carried out by Flanders
Perception of quality of service delivery	To be determined	Independent surveys after contact with service provider	Programmes and projects of the Flemish Development Cooperation
Area of change 4: The promotion of evidence-based health policies and their implementation and monitoring increases the efficiency and effectiveness of policies, including in the context of health crises.			
Number of policy-oriented research initiatives completed		List of initiated investigations of the partner	Internal monitoring partner(s)
Number of publications or updated policy influencing data sets relevant to CSP IV	To be determined	Partner publication list Digital and/or hard copy	Internal monitoring partner(s)
Core values: gender, human rights and good governance			
% expenditure from CSP IV according to GI/GII marker, breakdown and total		FIMED-Databank or equivalent	Flanders' standard monitoring
% expenditure from CSP IV according to M1/M2 participatory development/good governance, breakdown and total		FIMED-Databank or equivalent	Flanders' standard monitoring

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