World Health Organization

REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2009-2013

MOZAMBIQUE

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ABBREVIATIONS

CCS	Country Cooperation Strategy
CF	Common Funds
EOC	Essential Obstetric Care
GoM	Government of Mozambique
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IHP	International Health Partnership
HHA	Harmonization for Health in Africa
IPTp	Intermittent Preventive Therapy in Pregnancy
ITN	Insecticide Treated Net
MDGs	Millennium Development Goals
MF	Ministry of Finance
MIS	Malaria Indicator Survey
MoH	Ministry of Health
MPD	Ministry of Planning and Development
MTEF	Medium-Term Expenditure Framework
NGO	Nongovernmental Organization
PAP	Programme Aid Partnership
PARPA(PRSP)	Poverty Reduction Strategy Paper
PESS (HSSP)	Health Sector Strategic Plan, 2007-2012
PMTCT	Prevention of Mother-to-Child Transmission
SADC	Southern African Development Community
SWAp	Sector-wide Approach
TB	Tuberculosis
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US$	United States Dollar
WCO	WHO Country Office
WHO	World Health Organization

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The Mozambique Country Cooperation Strategy (CCS) (2009–2013) will be implemented in the context of the WHO's 11th General Programme of Work for 2006–2011 and the Medium-Term Strategic Plan 2008–2013. It also occurs within the advanced process of "Delivering as One" under the UN reform, of which Mozambique is one of the pilot countries.

Within the 11th General Programme of Work, the WHO Country Office (WCO) in Mozambique will focus on the following priorities for the period 2009–2013: (i) strengthening health systems; (ii) reducing the disease burden; (iii) improving mother and child health; (iv) addressing health determinants; (v) leadership, governance and partnership.

The Health System Strengthening priorities aim at improving health services through actions that impact on the pillars of the WHO/AFRO Health Systems Framework: (i) health workforce; (ii) service delivery; (iii) medical products, vaccines and technologies; (iv) health information; and (v) financing.

To accelerate the development of Human Resources for Health (HRH), and strengthen the HRH management and planning capacity, the WCO will continue to provide support for developing and updating HRH-related policies and strategies, improving HR information systems and reinforcing training programmes.

WCO will support the design of integrated packages of health service delivery and promotion of community involvement so as to increase equitable access to health services, and strengthen primary health care management and institutional development.

To ensure improved access to medical products, vaccines and technologies, and their improved quality and use, the WCO will support related regulatory interventions, including improvement of quality assurance, strengthening of the monitoring and evaluation system to avoid unnecessary stock-outs of essential medicines, medical products and technologies, and improve their rational use.

The WCO will provide technical assistance to define and implement a long-term strategic plan for strengthening the HIS nationwide and secure funds and resources for its implementation. It will support the revision of the tools for data collection and flow in the HIS, the supportive supervision system and feedback mechanism, and will update yearly the Service Availability Mapping (SAM), among other approaches.

Within the Financing priority pillar, WHO will support the promotion of evidence-based decision making at all levels of the health system, through enhanced capacity to generate and use financial information, as well as addressing financial barriers related to access to health, in order to reduce unnecessarily catastrophic expenditure on health.

Responding to the disease burden of Communicable and Noncommunicable Diseases (NCD), the WCO will help strengthen the national capacity to reduce morbidity and mortality due to AIDS, tuberculosis and malaria, achieve high-level immunization coverage with all antigens in order to reduce the burden of vaccine-preventable diseases, achieve the eradication of polio, elimination/control of measles and neonatal tetanus, reduce morbidity due to helminthiasis, eliminate leprosy, intensify surveillance and response to epidemic-prone diseases, and reduce/control the burden of NCDs, while paying attention to unhealthy lifestyles.

To improve mother and child health, the WHO support will focus on developing and implementing the Adolescent Health Plan, implementing the Integrated Mother, Newborn and Child Health Strategic Plan, increasing and improving the provision of quality services at the health facility level, ensuring availability of adequate resources, achieving and sustaining high-level routine immunization coverage and all services integrated under the RED (Reach Every District) approach, and introducing Pentavalent and other new vaccines countrywide.

Addressing health determinants is another priority of the WHO in the area of Health and Environment. It will support approaches that address the reduction of water-related diseases and optimization of the health benefits of sustainable water and sanitation conditions, and that address improvement of the recognition by decision-makers of the holistic nature of health issues and importance of cross-sectoral synergies as well as involvement of local communities. It will support the strengthening of the gender equality and human rights approach in the Health Sector and the promotion of multisectoral collaboration on the prevention and control of gender-based violence.

Concerning the social and economic determinants of health, the WCO will aim at strengthening the capacity to collect health-relevant socioeconomic data to support evidence-based policies on equity and health by promoting equity-based approaches on health nationwide and supporting the setup of a core number of equity-related indicators.

Chronic Malnutrition, Health Promotion, Knowledge Management and Information Sharing, Emergency Preparedness and Response will be the other main domains to be addressed by the WCO within the health determinants priority.

The WCO also intends to help strengthen leadership, governance and partnership by ensuring the stewardship role of the Ministry of Health, improving knowledge management and informed decision-making in the country, stimulating collaboration and partnership among all actors in health, and supporting public sector reform processes.

The WCO will continue to provide direction and coordination on matters critical to health in Mozambique. It sees the harmonization and promotion of partnerships and alignment with national health strategic plans as one of its key roles.

SECTION 1

INTRODUCTION

The World Health Organization (WHO) has defined a global health agenda in its eleventh General Programme of Work (GPW) for 2006–2013, focused on current health problems and their respective challenges, and recommending adequate responses to them for the near future. To implement the 11th GPW, WHO has formulated a medium-term strategic plan (MTSP) for 2008–2013, organized around 13 strategic objectives, providing orientations with improved reflection of the country needs, and enhancing effective collaboration within WHO at all levels.

The WHO Regional Office for Africa has identified regional priorities for action in its document "Strategic Orientations for WHO Action in the Africa Region 2005–2009", emphasizing the fact that WHO priorities in Africa are in line with global agenda of the GPW and taking into consideration the health-related MDGs, resolutions of WHO governing bodies, the New Partnership for Africa's Development (NEPAD) Health Strategy and resolutions of the African Union Heads of State on health.

These changes in the WHO institutional framework, associated with the new aspects of public health challenges and other recent major technical developments, as well as the ongoing WCO re-profiling exercises, have generated the need for developing a second generation Country Cooperation Strategy (CCS). Mozambique's second generation CCS, covering the period 2009–2013, builds upon the first CCS that spanned the period 2004–2008. It incorporates national, regional and global developments in health that have occurred since the first generation CCS was formulated. It reflects the WHO values, principles and regional strategies for providing better support for addressing the health needs of Mozambique.

The present CCS is the result of a comprehensive analysis of the dynamics in the health sector, including recent national achievements, current and emerging needs and development challenges, government policies and plans, as well as activities of other health development partners. It is aimed at improving the health status of the Mozambican population, through the Primary Health Care approach, but in the context of a major shortage of human resources for health as well as a lack of an adequate and functional health system.

It was developed through a consultative process, which included the sharing and discussion of the document with health partners and national authorities. The endorsement was done at a consensus meeting with the participation of the main health stakeholders.

The second generation CCS is developed at the same time as Mozambique reaches the last stage of the implementation of its second Poverty Reduction Programme (PARPA – *Plano de Acção para a Redução da Pobreza Absoluta*), and as the country prepares to assess its achievements, and review the challenges and constraints relating to the acceleration of interventions for the achievement of the Millennium Development Goals (MDGs). This is also a time when key policy documents and plans are being developed and approved, following the formulation of the Health Sector Strategic Plan 2007–2012. The implementation of the CCS will occur within a less than favourable financial environment at the global level, which will have direct impact on the external contribution to the National Budget.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 SOCIOECONOMIC DEVELOPMENT

With a population of 20.5 million,[1] Mozambique is the seventh largest country in sub-Saharan Africa. Nearly 70% of the population lived in rural areas[2] in 2005. More than 80% of the economically-active population identified agriculture/arboriculture/fisheries as their main activity in 2002/03.[3] The illiteracy rate is 60% (male: 39.4%; female: 71.3%).

Poverty in Mozambique fell significantly between 1997 and 2003, with the percentage of poor people falling from 69.4 to 54.1%, corresponding to a poverty drop of 16.4% in rural areas and 12.3% in urban areas.[4]

The latest national household income and expenditure survey showed evidence of recovery and improved living conditions throughout Mozambique.

Despite this progress, Mozambique is still one of the poorest countries in the world, with a per capita GDP of US$ 387,[5] and ranking 172nd out of 177 countries (according to available data) in 2005,[2] the lowest within the Southern African Development Community (SADC).

2.2 NATIONAL HEALTH POLICY AND STRATEGIES

The health policy framework for Mozambique is articulated in several documents, namely the Five-Year Government Programme (2005–2009), the Action Plan for Reduction of Absolute Poverty (PARPA II), the Economic and Social Plan (*Plano Económico e Social - PES*), the Health Sector Strategic Plan, 2007–2012 *(Plano Estratégico do Sector Saúde – PESS*) and the Medium-Term Expenditure Framework (MTEF).

The national health policy is based on principles of primary health care (PHC), equity and better quality of care. The objectives for the health sector are laid down in the PESS, 2007–2012. Expected outcomes from the PESS include:

- increased access to health services towards universal coverage principles;
- consolidation of the PHC approach and integrated service delivery;
- strengthened referral system and continuity of care;
- improved quality of services delivered at all levels;
- improved functioning and performance of health care facilities at all levels;
- guaranteed adequate and early response to emergencies and epidemics, strengthened community participation;
- promotion of a collaborative approach with other health providers, and

- improved intersectoral collaboration.

The PESS offers a strategic framework for programme-specific and health systems-related plans.

2.3 HEALTH SYSTEMS AND SERVICES

The National Health Sector Strategy (PESS) emphasizes the need for strengthening health systems and has prioritized the development of human resource capacity, improvement of health care infrastructures, and increased community engagement and expansion of training and deployment of community health workers.

The vision of a sustainable health system ensuring universal access to health care, based on primary health care principles, is further embedded in the Government's decentralization policy. As a result of this process, an increased number of tasks, functions and powers have been transferred to the peripheral level.

Service Delivery Organization

The health system is composed of the public sector, the for-profit private sector and the non-profit private sector. Health care services are provided mainly through the public sector network (NHS), which relies on 1277 health facilities (HF), organized in 4 levels, with a total of 15 877 beds[6] and around 26 000 health workers (Table 4). *Level I* offers essential primary care services through 1224 HF (urban and rural health centres and health posts) representing 96% of all national HF. Of the 53 hospitals, 5 are level-4 hospitals, offering the highest level of specialized care, 7 (provincial) are level 3. *Level II* includes the rural district hospitals (totalling 41), which constitutes the first level of referral care, and are expected to have emergency care facilities and the capacity to perform minor surgeries as well as non-complicated obstetric and trauma surgeries. *Levels III* and *IV* are respectively 7 provincial and 5 central and specialized hospitals, oriented for more specialized curative care and act as referrals from *levels I and II*.

The for-profit private sector is developing gradually, especially in large cities, and provides services mainly to urban residents. On the other hand, the non-profit private sector, which is dominated by international nongovernmental organizations (INGOs) and religious entities, in common agreement with the Ministry of Health (MoH), implements community health programmes: prevention, disease control and information, education and communication. In 2005, there were 145 international NGOs[7] and their numbers keep increasing. Many are active in HIV/AIDS-related programmes, including medical treatment with antiretroviral drugs.

There is also a large, informal, community-based network of lay care and traditional medicine. There is renewed interest in strengthening community involvement and community-based services. A community health workers programme is being revitalized as an intermediate solution to bring health care to remote areas.

Public-private partnerships for financing and provision of health care services have not been sufficiently explored in the country.

The population per primary health unit (first referral hospital and health centres) is 15 800, still far below the WHO recommended ratio of 10 000 inhabitants per primary health unit. Outreach activities are intended to overcome this gap. Many health facilities are in urgent need of renovation and maintenance. Many facilities lack basic commodities such as running water, electricity, transport and communication.[6]

Access to primary health care is further affected by an unequal geographical distribution of health facilities, to the disadvantage of the least-developed rural areas. Only 36% of people have access to a health facility within 30 minutes of their homes.[7]

Health Workforce

The lack of human resource capacity is by far the greatest barrier to overall health sector delivery and has been recognized as a major constraint in attaining the health-related Millennium Development Goals. With 0.03 doctors and 0.21 nurses per 1000 inhabitants,[8] Mozambique has one of the lowest health worker densities in Africa. This is as a result of low pre-service training and recruitment, increased attrition, and rapidly-changing health needs.

Health staff distribution around the country still shows considerable regional asymmetries. The output of training institutions is insufficient to respond to the growing demand for a larger and better-trained workforce.

Performance of health workers is affected by low motivation due to inadequate remuneration, limited career prospects, increasing workload and a difficult working environment.

To address the workforce crisis, the MoH adopted an ambitious and comprehensive National Human Resources for Health Development Plan for 2008–2015[9] to increase the total health workforce by 79% by 2015. The revitalization of the CHW programme (basic polyvalent agencies) foresees a large expansion of basic service delivery at community level.

Health Information System

The Health Information System (HIS) in Mozambique is still facing numerous challenges in terms of quality and use of data, mainly due to insufficient and poorly-trained health workers, scarce financial resources, inadequate tools for data management and inadequate supervision and feedback. The HIS represents a crucial area for development in health, as it provides essential information for decision-makers, and is the source of data for half of the indicators included in the M and E Performance Assessment Framework of the health sector. The HIS was selected by MoH as a priority area for 2010 and a five-year strategic plan has been finalized.

Medical Products, Vaccines and Technologies

It is estimated that more than 75% of the population uses traditional medicine primarily to treat health-related problems.

In 2005, an evaluation confirmed the availability of high quality medicines in all provinces as one of the main achievements and the most important progress made in the pharmaceutical sector. However, despite this positive result, the evaluation report pointed out several issues and challenges (i.e., slow and inefficient procurement system, inefficient and centralized drug warehousing and distribution system, ineffective drug regulation and weak registration system, shortage of qualified human resources for the sector, irrational use of medicines, etc.), which remained to be tackled in order to improve the performance of the pharmaceutical sector in Mozambique. Procurement, supply, warehousing and distribution of vaccines and essential health commodities also needed to be improved.

In 2006, an external evaluation of the pharmaceutical sector[10] provided a clear assessment and made recommendations on the various components of the sector and designed a roadmap for improving the pharmaceutical sector in Mozambique.

Mozambique has recently adopted a new national essential medicines list. In addition, the National Regulatory Authority is gradually functioning. The procurement system has been improved with the inclusion of a pre-qualified list of suppliers and the launching of a database on all suppliers, importers and products on the national market.

Financing

Total health expenditure per capita is estimated at around US$ 13 (2007/2008), far below the target of US$ 34 recommended by the WHO Commission on Macroeconomics and Health to provide a basic package of services in low-income countries. According to the Medium-Term Expenditure Framework projections, health expenditure per capita is expected to reach US$ 15 by 2011. As of 2006/2007,[11] government total expenditure on health as a percentage of government expenditure was about 9%, far below the Abuja target of 15%. However, this ratio had achieved levels of 13% and 14% in 2002 and 2003 respectively.

The Ministry of Health initiated a debate on the need for the development of a health sector financing strategy. Such a strategy will also explore other financial mechanisms so that individual contributions to health care do not lead to further impoverishment of the poor. A study on the impact of the abolition of health service user fees, which include an estimate of the respective lost revenue, will contribute to the policy dialogue on the need to remove financial barriers to facilitate access to health for the most vulnerable groups. The recently completed National Health Accounts is an equally important source of information.

2.4 HEALTH DETERMINANTS

Inequities in Mother and Child Health

Access to skilled birth attendance is one measure of inequity in maternal health. Differences in socioeconomic aspects account for about two-thirds (61%) of inequalities in skilled birth attendance, of which household wealth accounts for 24%, mother's education 16% and living in rural areas 12%.[12]

When examining the relationship between utilization patterns and offer of skilled care during delivery, women who did not receive valid antenatal care (at least four visits to a health professional during pregnancy) were more likely to deliver without professional care. Factors associated with utilization of maternal health services account for 16% of inequities in skilled birth attendance. Of this, 12% of inequities could be attributed to perceived barriers to access, especially distance to facility. Quality of case management, approximated by antenatal care quality, contributed to another 23% of inequities in obtaining skilled birth attendance.

Childhood malnutrition is another measure for existing inequalities. Prevalence of malnutrition in children under three is 41% in rural areas, compared to 26% in urban areas. It is 43% for children whose mothers have no education, compared to 12% for children whose mothers have secondary or higher education. The analysis illustrates that underlying social and economic factors contribute to 70% of the existing inequality in childhood malnutrition. The three largest contributors in this category are source of drinking water (18%), household wealth (17%) and mother's occupation (13%).[12]

Ninety percent of the agricultural labour is done by women in Mozambique, yet they are vulnerable to food insecurity. The main contributing factors are limited access to education, especially in rural and peri-urban areas, and limited access to the labour market. As a result, they cannot ensure adequate nutritional intake for themselves and their families.[13]

Health and Environment

According to a recent WHO report[14], roughly 16.2% of all deaths in Mozambique can be attributed to inadequate water, sanitation and hygiene practices. In 2006, only 44% of the population had access to an improved water source (71% coverage in urban areas and only 26% in rural areas) and 36% used improved sanitation (53% in urban areas and 19% in rural areas).[15]

The intersectoral coordination of activities and information sharing between governmental and other institutions is limited. The enhancement of synergies between different policy sectors is vital to introduce environmental health issues into the national development agenda.

Gender

Gender-based violence, maternal mortality and feminization of certain conditions such as STI/HIV/AIDS are the main issues of gender inequality in the country.

The importance of gender equality is reflected in the Government's Five-Year Plan, which focuses on implementation of the National Gender Policy.[16] The development of a strategy for gender equality in the health sector[17] and the national strategy for violence against women are important responses to the commitment of gender mainstreaming.

The limited expertise in gender mainstreaming skills, the lack of capacity in gender-sensitive policy formulation and programme analysis, the feminization of certain conditions such as STI/HIV/AIDS and the poor integration of initiatives against gender-based violence are some of the challenges to overcome.

Human Rights and Health

Although Mozambique has ratified several major international and regional human rights treaties that address the right to health and a number of rights related to conditions necessary for health, the issue of human rights is not well applied and focused on the main health programmes and initiatives.[18]

The protection and promotion of human rights, including the right to health, is enshrined in the Constitution of Mozambique (2004). The rights-based approach is also reflected in other important strategic documents such as the Poverty Reduction Strategy Paper (PARPA II) and the National Health Policy Declaration.

Health Promotion

Household knowledge about health in general remains low. However, poor hygiene practices, poor sanitation conditions, early and unsafe sex practice, unhealthy diet, lack of physical activity, high alcohol and tobacco consumption and several harmful cultural practices are some of the common high-risk behaviours among the general population.

A sound national health promotion (HP) policy and strategy will be an essential step forward in overcoming the main challenges in health promotion. These strategies include strengthening the coordination with the mass media and building partnerships with civil society associations, while accommodating the more than 20 local languages.

2.5 DISEASE PROFILE

The common causes of death and illness are malaria, tuberculosis, AIDS, acute respiratory tract infections and diarrhoeal diseases. The main epidemic-prone disease is cholera. The leading contributing factors are high levels of poverty and malnutrition, and inadequate access to clean water and sanitation.

Approximately, six million cases of malaria are reported each year. It is estimated that around 24% of deaths among children under-five are due to malaria.[19] Many of the high numbers of maternal deaths registered in Mozambique are directly or indirectly caused by malaria infection. Despite a downward trend, the mortality rate of malaria remains high, contributing to nearly 26% of hospital deaths. The malaria indicator survey (2007)[26] showed that 15.8% of households had at least one insecticide-treated bed-net (ITN), but only 7.3% of pregnant women and 6.7% of children under-five had slept under an ITN the previous night. Fifty-two percent of those houses targeted for indoor residual spraying (IRS) had actually been sprayed and only one out of six pregnant women (16%) had received two or more doses of malaria-preventive treatment (IPTp).

Mozambique has an estimated incidence rate of 431 cases of *tuberculosis* per 100 000 people (all forms) and ranks 19th among the 22 high-burden countries in the world. The case detection rate (49%) and the DOTS treatment success rate (83%) for registered new smear-positive TB cases are still below the global TB outcome targets.[20] TB-HIV co-infections are rising. In 2007, 47% of TB patients tested positive for HIV. The preliminary results of the Anti-TB Drug Resistance Survey indicate that the prevalence of multi-drug resistant TB is 3.4% among new cases and 12.5% among re-treatment cases.

In 2007, the most recent surveillance round[21] revealed a *HIV* seroprevalence of 16%, which shows a slight increase from the 2001 HIV seroprevalence of 14%. In 2008, an estimated 1 800 000 people were living with HIV and more than 370 000 were in need of antiretroviral treatment. Access to treatment has increased significantly from 6226 people on antiretroviral treatment (ART) in 2004, to more than 128 000 people in 2008. Among people on ART, 7.3% were HIV-positive children (ART data 2008, Mozambique). The number of public health facilities providing ART increased from 20 sites in 2004 to more than 210 sites in 2008. Although this is encouraging progress, it only covered the need of 24% of AIDS patients eligible for treatment. The number of drop-outs and lost to follow-up are becoming the major concerns of the HIV programme. There is an urgent need to guarantee quality interventions and prevent the emergence of HIV drug resistance.

Neglected tropical diseases are common. The prevalence of schistosomiasis haematobium varies from 12.3% to 81.3%. School children are the most affected population group. Lymphatic filariasis is endemic at national level and helminthiasis is widespread.

Mozambique has achieved the elimination of *leprosy* as a public health problem at the national level. Thirty-one out of 144 districts (22%) have not yet reached the elimination prevalence rate, but appropriate action is being taken.

Noncommunicable diseases such as cardiovascular diseases and high blood pressure, diabetes, chronic respiratory tract diseases and malignancies are on the rise and constitute

an important public health problem. Common risk factors are high alcohol and tobacco consumption, with a prevalence of 77.2% and 18.7% respectively.[22] High blood pressure has a prevalence of 33.2% and constitutes a major risk factor for cardiovascular incidents.

Oral health, blindness and other eye conditions are prevalent, but are not receiving sufficient attention.

Acts of *violence and injuries* are on the rise. A nationwide study reveals an injury prevalence of 3% with road traffic accidents as the leading cause of injury-related deaths.[23] Violence against women and children, including sexual abuse, is common and widespread. More than half (54%) of Mozambican women have experienced some kind of violence in their life.[24]

An estimated 2% of the population is *physically disabled* as a result of congenital defects, birth trauma and injury. The prevalence and range of *mental health disorders* is poorly documented. The increase in substance abuse and easy access to alcohol and drugs is alarming and calls for action.

2.6 MOTHER AND CHILD HEALTH

Mozambique has made steady progress in all *child health* indicators over the past two decades (Table 1). Neonatal mortality rate improved but 48 newborns out of every 1000 still die before they reach the 28th day of life. The leading causes of child mortality are preventable and treatable diseases such as malaria, respiratory illnesses, diarrhoea and AIDS-related illnesses. Chronic malnutrition affects 41% of children under-five and the trend is increasing. Further decline in infant and child mortality can be achieved through stepping up the integrated management of childhood illnesses in all health facilities and increasing the coverage of key interventions for child survival. Oral rehydration salt (ORS) treatment is only offered to 47% of children under-five with diarrhoea, and the exclusive breastfeeding rate up to six months is estimated at 30%.[25] Only 6.7% of children under-five sleep under an insecticide-treated mosquito net and only 4.5% of this age group at risk who had an episode of fever had received correct and early treatment with artemisine combination therapy (ACT) within 24 hours of the onset of symptoms.[26] The weak involvement of communities is a missed opportunity for improved child survival overall.

The *maternal mortality* ratio has dropped by two-thirds over the past ten years. The prospect of attaining the MDG target of 250 maternal deaths per 100 000 live births could be affected by the low rate of skilled birth attendant (55% in 2008) and the unsatisfactory coverage of emergency obstetric care (EmOC). The index of access to EmOC was 1.13 health facilities per 500 000 in 2007[27].

Despite the fact that the *contraceptive prevalence rate* globally increased from 1995 up to 2005, (table 1) at the national level, the rate of unmet needs for family planning remains high (53%), with disparities among rural (60%) and urban areas (41%).

According to the DHS 2003, 84.2% of pregnant women had at least one *ante-natal* visit, but slightly more than half (53.1%) had four ante-natal visits or more, with significant differences between urban (71%) and rural (45%) areas. The *post-natal* visit coverage has progressively increased from 37% in 1997 to 54.7% in 2003, and 69.9% in 2007.[28] However, the challenge is to increase the coverage in the first week, following delivery, for both the newborn and the mother.

There is still a gap in addressing *adolescent health* needs. Apart from the risk of contracting HIV/AIDS, adolescent childbearing contributes significantly to the risk of maternal death. Thirty-two percent of all maternal deaths[32] occur among adolescents. Although adolescent health-friendly services are provided in all provinces, there is still room for improvement at district level.

Table 1: Progress towards the achievement of MDG 4 and 5

MDG Indicator	1990	1995	2000	2005	2008	2015 MDG targets
Children 1-year-old immunized against measles	59%*	61%	71%	77%	_	95%
Infant mortality rate/1000 live births	158*	147	124	100	_	67
Under-five mortality rate/1000 live births	235*	219	178	145	_	108
Contraceptive prevalence rate		5.1%	17%	11.8%	_	34%
Births attended by skilled health personnel		44.2%	47.7%	48%	55%	66%
Maternal Mortality ratio/100 000 live births	1500*	1000	408	520**	_	250

Source: MDG Progress Report, MoH 2007

* Other sources, MoH data.

*** According to the Maternal Death UN Report 2005,[29] the estimate for Mozambique is 520. Range 360–680 maternal deaths/100 000 live births.*

AIDS-related illnesses are a major threat to mother and child health. Only one-third of pregnant women were enrolled in a programme for prevention of mother-to-child transmission (PMTCT) (coverage 29.8% in 2007), despite a rapid increase in the number of PMTCT sites, from 222 in 2006 to 504 by the end of 2008. Intermittent preventive therapy in pregnancy (IPTp) and PMTCT are gradually being integrated into routine mother and child health services.

The *expanded programme on immunization* (EPI) was introduced 20 years ago, and offered six traditional vaccines. Hepatitis B vaccine was introduced in 2001. From 2009, the MoH is immunizing children under one with a pentavalent vaccine, which includes DPT (diphtheria, whooping cough and tetanus), hepatitis B and haemophillus influenza type B, in addition to the oral polio vaccine and the measles vaccine. In 2012, the country will introduce pneumococcus vaccine.

Between 1997 and 2005, the proportion of one-year old children fully immunized increased from 47% to 64.4%[29] (community based surveys). Seventy-five percent of children under one were immunized against measles (2005). Two consecutive national measles immunization campaigns successfully immunized more than eight million children < 15 years in 2005 and 3.5 million children < 5 years in 2008.

Despite the progress made, routine programme performance indicators need to improve. For instance, less than 50% of districts have achieved 80% coverage in all antigens. Both acute flaccid paralysis (AFP) and measles surveillance indicators are unsatisfactory. The annual notification rate of non-polio AFP has never reached the minimal requirement of 2/100 000 children < 15 years and even decreased from 1.6% in 2006 to 1.2% in 2008. Measles case-based surveillance has improved in general, but the proportion of districts reporting at least 1 case per 100 000 inhabitants investigated with blood sample is 48%, and there are still significant discrepancies at the sub-national level.

Surveillance of paediatric bacterial meningitis (PBMS) is only done at one site and results are unsatisfactory. In 2008, 131 cases were recorded but many more cases are not notified. PBMS surveillance sites should expand to other regions to facilitate monitoring of the impact of the haemophillus influenza B vaccination programme countrywide. Neonatal tetanus surveillance remains a challenge. Since its inception in 2005, very few cases have been reported, and virtually none of them was investigated properly.

Overall, the organizational, logistical and functional challenges of the EPI programme are considerable. They are further compounded by the existing weaknesses of the EPI programme such as poor data collection, vaccine stock control and insufficient cold chain capacity and management[30]. Stepping up the RED (reach each district) approach and addressing chronic health system bottlenecks are essential measures to sustain the advances made in fighting traditional childhood killer diseases.

2.7 EPIDEMICS AND EMERGENCIES: SURVEILLANCE, PREPAREDNESS AND RESPONSE

The country is prone to various natural disasters, as indicated in the risk profile of natural disasters from 1980–2008, including floods, storms and droughts. The local current capacity to mitigate and respond to disasters is weak. Consequently, about 104 000 avoidable deaths occurred during the above-mentioned period. This exposes the population to water-borne and drought-related disease outbreaks, such as cholera and dysentery and an increase in malnutrition.

A well-functioning epidemiological surveillance system is of utmost importance for averting or containing the health consequences of an emerging disaster or epidemic. The key Integrated Disease Surveillance and Response (IDSR) core indicators such as early notification of outbreaks of epidemic-prone diseases and case fatality rates for outbreaks of priority diseases are too low to ensure early alertness and response. Health system bottlenecks such as the lack of a reference laboratory for the diagnosis of outbreak-prone diseases and poorly-equipped and poorly staffed laboratory services at all levels as well as the use of outdated national technical guidelines are some of the factors that will hamper the successful implementation of the recently-adopted International Health Regulations. By subscribing to these regulations, Mozambique commits itself to ensure maximum public health security.

2.8 SUMMARY OF HEALTH AND DEVELOPMENT CHALLENGES

Mozambique needs more investment in its health system structures and functions. Stronger support for the primary health care approach is essential for the success and sustainability of disease-specific programmes. This should be followed by improvements in quality of care in every aspect of service delivery and at every level. Scaling-up the health workforce and expansion of the health facility network precede increased coverage and access to services.

Despite promising progress towards the achievement of the health-related MDG targets, health outcomes are still unsatisfactory. Malaria continues to claim too many lives. HIV prevention activities have been inadequate to curb the HIV prevalence trend. Dual TB/HIV infections and the threat of increasing multi-drug TB resistance complicate the national TB programme response. The individual and public health consequences of chronic noncommunicable diseases, neglected tropical diseases, injuries and the hidden tragedy of domestic violence need to be addressed more adequately through the public health system.

Frequent outbreaks of cholera and the risk of newly-emerging epidemic prone diseases underline the importance of institutionalizing rapid emergency and preparedness responses, including the strengthening of surveillance systems and implementation of the International Health Regulations.

Increasing access to emergency obstetrical care, ensuring that all women deliver with the assistance of a skilled birth attendant, in response to the high unmet family planning needs, and refocusing on the health needs of adolescents are interventions that need to be vigorously pursued. Greater attention should be paid to newborns as only very few of them benefit from effective neonatal resuscitation and postnatal care. Early initiation of breastfeeding and exclusion of any other milk substitutes up to 6 months should be part of an intensified health-promotion campaign and community involvement. Strengthening immunization services, improving correct management of diarrhoea with oral rehydration and zinc, encouraging care-seeking behaviour for respiratory tract infections and pneumonia are necessary for improved child health outcomes.

The determinants of health related to nutrition and food security, access to safe water and sanitation, gender inequality, illiteracy and poverty reduction require recognition by decision-makers and planners of the holistic nature of health issues and the importance of cross-sectoral cooperation. The human right to health envisages a more active involvement of local communities and requires reorientation of the approach of health professionals towards care seekers. Health promotion should be stepped up in order to inform and encourage communities to adopt healthy lifestyles.

Fostering leadership and national ownership through institutional capacity building remains a priority and effective implementation of priority interventions a challenge. Adequate government funding, predictability of external funding and commitment of partners to support country priorities should dominate the policy dialogue between development partners and the Government.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIP

3.1 DEVELOPMENT PARTNERS

The cooperation of the MoH and its development partners is based on a well-structured Sector-Wide Approach Programme (SWAp), which has been in place since 2000. The SWAp is organized around a set of common principles, objectives and working arrangements. It consists of the following key elements:

- support for implementation of the National Health Sector Strategic Plan (PESS 2007–2012);
- the SWAp Code of Conduct, which defines the principles and norms on which the coordination is based;
- the Memorandum of Understanding between the MoH and development partners supporting the health sector, through the common fund (Prosaude);
- the HIV and AIDS Partners' Forum Code of Conduct between the Government of Mozambique and partners supporting HIV/AIDS;
- the Code of Conduct between the MoH and NGOs, signed in 2008 and which signalled an important step forward in the engagement of the MoH and Nongovernmental actors in health;
- the annual review of the sector's performance (ACA), which is done jointly by partners and the MoH. Recommendations emerging from the review and identification of priorities for the following year are approved at the high-level Sector Coordination Meeting (CCS) in March each year;
- the Performance Assessment Framework (PAF), which is the monitoring framework for the sector, consisting of 38 indicators and annual targets.

Mozambique has 28 development partners supporting the health sector (Annex I). They channel their financial support through four types of funding modality, namely general and/or sector budget support, direct project support and off-budget funds.

Fifteen partners have signed a specific memorandum of understanding for support, through pooled funding (Prosaude) to the sector. By opting for this funding modality, the Prosaude partners are aligning fully with country priorities and mechanisms. Nevertheless, nearly all of them also allocate a portion of their budget to projects or provide direct support to NGOs or institutions, for example.

The emergence of many health initiatives, global funding arrangements and powerful vertical donors presents challenges for the health SWAp. Although the majority of development partners are signatories to the Paris Declaration on Aid Effectiveness, there is still a lot of

room for improvement in terms of applying the principles of donor harmonization and alignment at country level. Issues like late disbursements, unpredictability of funding and lack of sustained long-term financing agreements, agency-specific reporting mechanisms, and resistance of the agencies to coordination, remain some of the challenges to be addressed.

In 2007, the Global Fund and PEPFAR alone were providing over half of all funding for the sector. Mozambique was the first country where the GFATM channelled its support through the common fund. This willingness to align with country mechanisms was reversed in 2008 as a result of demanding reporting requirements for different rounds and performance-related triggers for disbursements. The introduction of the National Strategy Application (NSA) promises a simplified and more aligned application process from which Mozambique hopes to benefit.

The donor landscape in Mozambique remains very diverse and fragmented, raising concerns about ineffective and inefficient use of available resources. This multitude of donors and implementing partners requires on the part of the MoH a stronger stewardship role and enforcement of a clearer regulatory framework. In response to this complexity, the Government of Mozambique and its development partners signed a *Country Compact* for the purpose of improving effectiveness of external aid and strengthening efficient management of available resources. It builds on the principles and agreements of the health SWAp. All signatories commit to uniting around one strategic plan for the health sector and HIV and AIDS, one budget and one monitoring and evaluation framework.

Trends in Flow of Health Sector Funding

Table 2: below shows the trends in health expenditure for 2004–2008 and their respective sources.

Table 2: In US$ million

Source[31]	2004	2005	2006	2007	2008*
Government Budget	105	104	108	127	138
Common Fund (Prosaude)	63	106	99	125	131
Vertical Funds	85	130	141	150	243
Total Expenditure	253	340	276	402	512

1US=26 MT
* figures refer to financial commitments, not yet disbursed
** projected, CFMP 2009-2011

The Government's contribution has been increasing in absolute numbers over the past five years. This could be attributed partly to an increase in general budget support, but the exact proportion is not known. More than 70% of health sector financing is currently provided by development partners. They channel their contribution through agreed financial mechanisms, namely: direct budget support, common fund (Prosaude), off-budget funds and support for projects. The common fund contributions have doubled since 2004, but the trend seems to be levelling off, despite the fact that more partners are signing up to the Prosaude MoU. The slower increase of the common fund is in contrast with the rapid increase in the vertical funds, particularly since 2005, with the inception of PEPFAR.

Vertical funds are channelled according to donor-defined priorities, often with an HIV focus, and through a network of implementing NGOs. This modality is preferred by partners who cannot contribute to pooled funds arrangements. However, it entails high transaction

costs and undermines MoH ownership by creating a parallel network through NGOs instead of strengthening the MoH. It is also difficult to monitor and assess the effectiveness of these contributions. The predictability and disbursement of the funds do not always follow the government budget cycle.

Mozambique spent more than US$ 200 million on HIV and AIDS between 2004 and 2006. Annual spending on HIV and AIDS increased from approximately US$ 48 million in 2004 to US$ 96.6 million in 2006. The proportion of public domestic expenditure on HIV and AIDS doubled during the reporting period from US$ 7.3 million to US$ 14.3 million. In line with the PARPA commitments, the proportion of highest spending during the reporting period went to prevention (40%) and care and treatment (29%).

External financing accounted for 82% of all HIV expenditure during 2004–2006, while public funds constituted 16%, and private sources of funding accounted for only 2%. This shows the heavy reliance on external sources of financing for the national response to HIV. A substantial amount of external assistance for HIV and AIDS is disbursed and reported through vertical projects and is, therefore, not captured in government accounts.

3.2 UNITED NATIONS REFORMS – "DELIVERING AS ONE"

Mozambique is one of the eight pilot countries for implementation of the United Nations (UN) reform through the "Delivering as One" approach, aimed at ensuring faster and more effective development operations and accelerating progress to achieve the MDGs. The WCO is actively involved in the UN reform, whose vision consists in delivering, through a more coherent, better coordinated, funded and managed UN at country level, to the poorest and most disadvantaged population groups.

WHO brings the health perspective to the joint programmes and contributes to specific areas where it has a comparative advantage, namely HIV/AIDS, gender empowerment and human rights, maternal and child health, including nutrition, decentralization, disaster risk reduction and emergency preparedness.

3.3 CIVIL SOCIETY AND NGOS

Civil society participation is critical for implementing and monitoring activities, as well as for assessing needs, setting priorities, developing, implementing and monitoring national health plans and strategies so as to ensure accountability. Although civil society participation is growing, active engagement and strong representation is still weak, partly due to fragile organizational and coordination structures.

In the health sector, NGOs play a role in the implementation of prevention activities at community level and are responding to demands for clinical services, which the NHS is not able to provide. The number of national and international NGOs is growing. The challenge is to make use of their complementary role in health delivery and ensure that they align with national priorities. This requires strengthening coordination and improving interaction with the NHS. The signing of the NGOs Code of Conduct, the formation of a NGO working group in a SWAp context and the commitment of several Civil Society Organizations to the principles of the International Health Partnership are a positive step towards improved coordination and cooperation.

SECTION 4

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO is undergoing major changes in its operation aimed at increasing its performance in the support to Member States, in order to address key health and development challenges in the perspective of achieving the health-related Millennium Development Goals. This organizational change process has, as its broad frame, the WHO Corporate Strategy.[32]

4.1 GOAL AND MISSION

The mission of WHO is "the attainment by all peoples, of the highest possible level of health." (Article 1 of the WHO Constitution). The Corporate Strategy, the 11th General Programme of Work 2006–2015[33] and the Strategic Orientations for WHO Action in the African Region 2005–2009[34] outline key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

4.2 CORE FUNCTIONS

The work of WHO is guided by its core functions, which are based on its comparative advantage. These are:

- providing leadership in matters critical to health and engaging in partnership where joint action is needed;
- shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
- setting norms and standards, and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalysing change, and building sustainable institutional capacity;
- monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas, namely:

1. investing in health to reduce poverty;
2. building individual and global health security;
3. promoting universal coverage, gender equality, and health-related human rights;
4. tackling the health determinants;
5. strengthening health systems and equitable access;
6. harnessing knowledge, science and technology;
7. strengthening governance, leadership and accountability.

In addition, the Director General of WHO has proposed a six-point agenda as follows: (1) health development, (2) health security; (3) health systems; (4) evidence for strategies; (5) partnerships; and (6) improving the performance of WHO. Additionally, she has indicated that the success of the organization should be measured in terms of results regarding the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

The Global Priority Areas were outlined in the 11th General Programme of Work. They include:

1. providing support to countries in moving to universal coverage with effective public health interventions;
2. strengthening global health security;
3. generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
4. increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
5. strengthening WHO's leadership at the global and regional levels, and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The regional priorities took into account the global documents and the resolutions of the WHO governing bodies, the health-related Millennium Development Goals, and the NEPAD health strategy, resolutions on health adopted by Heads of State of the African Union and the organizational strategic objectives, as outlined in the Medium-Term Strategic Plan (MTSP) 2008–2013.[3535].

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In addition to the priorities mentioned above, the Region is committed to supporting countries in attaining the health-related MDGs, and assisting in tackling its human resource challenges. In collaboration with other agencies, the problem of how to assist countries in sourcing financing for their own specific goals will be done under the leadership of the countries. To meet these added challenges, one of the important priorities of the Region is the decentralization and installation of Intercountry Support Teams to further support countries in their own decentralization process, so that communities may derive maximum benefit from the technical support availed to them. To effectively address the priorities, the region is guided by the following strategic orientations:

1. strengthening the WHO Country Offices;
2. improving and expanding partnerships for health;
3. supporting the planning and management of district health systems;
4. promoting the scaling-up of essential health interventions related to priority health problems;
5. enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the expression of WHO's cooperation strategy at country level will vary from country to country, depending on the country-specific context and health challenges. Building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization, as outlined in the "Core Functions" section above, may be adjusted to suit each individual country's needs.

SECTION 5

CURRENT WHO COOPERATION

The current WHO cooperation strategy in Mozambique was defined in 2004 for the period 2004–2008. It was anchored to the Action Plan for Reduction of Absolute Poverty (PARPA I, 2001–2005) and sector-specific policy and strategic plans.

The period under review has seen positive changes with impact on national health and development challenges. A notable development is the Heavily Indebted Countries (HIPC) Initiative, of which Mozambique was a beneficiary, and which enabled the country to free debt service obligations to support social service delivery. Mozambique has also benefited from the Millennium Challenge Account, which invests in infrastructure development, including water and sanitation in disadvantaged regions.

A favourable health sector environment was predominant during the implementation of the generation Country Cooperation Strategy (CCS). The new aid environment, generated after the Paris Declaration on Aid Effectiveness (OECD, 2005), reoriented approaches towards "harmonization and alignment" and "predictable long-term financing". This has resulted in an increase in international support to health.

The UN in Mozambique embarked on a reform aimed at ensuring more effective and cohesive response by the different UN agencies. The WCO supported this move and contributed to the development of a strategic framework for "Delivering as One".

The identification of health priorities and the dialogue and coordination with the Government and other partners have enhanced the implementation of activities under the cooperation agreement, and are in line with the mission statement of the WHO in Mozambique. The statement reads: "To support the development of an efficient and equitable health system in order to achieve the health-related MDGs, in strong partnership with all UN agencies, international and national health partners".

During the past five years, WHO in Mozambique aimed at providing quality technical advice, strong advocacy for health development and active participation in dialogue and coordination of partners.

Technical support in the formulation of sector policies and strategies provided to the MoH and often with support of other partners, contributed, among others, to the development of the national health sector strategy; the human resources development plan; the roadmap for health management information systems; the national strategy for HIV; a five-year action plan for TB; a roadmap for reduction of maternal and neonatal mortality, a comprehensive multi-year plan for EPI as well as a policy and strategic plan for newborn and child health.

At a more functional/operational level, technical assistance was provided for completion of the service availability mapping (SAM), a review of the pharmaceutical sector, as well as an evaluation of the laboratory network and a review of innovative financing methods to increase access to HIV/AIDS care, treatment and prevention.

Advocacy for health development is an essential element in the fight against poverty. The WCO has brought this message to different forums and various stakeholders. Through this active engagement in the health policy dialogue, the WCO was able to articulate public health policy options. It has taken up the co-chair position in the Health Partners Group for a third consecutive year and has been participating in nearly all of the health SWAp technical working groups.

5.1 STAFFING

The staff capacity of the Country Office has nearly doubled to a total of 42 since 2002, mainly due to an increase in national technical staff, support staff, and UN volunteers and junior programme officers. In order to optimise the use of available expertise, the Office revised its organizational management structure, following an in-depth re-profiling exercise. This led to the adoption of the cluster approach, which aims at maximizing the synergy between international and national professionals and strengthening a more integrated, coherent programmatic approach. There are five clusters: AIDS, Tuberculosis and Malaria; Disease Prevention and Control; Mother and Child Health; Health Systems; and Enabling Environment.

Table 3: WCO Human Resources, 2004–2009

	2004-2005	2006-2007	2008-2009
National Technical Staff	10	13	14
International Staff	8	6	6
Support staff	21	19	22
Junior Programme Officer	0	1	2
UN Volunteers	2	2	2
Total	**41**	**41**	**42**

5.2 SUPPORT FROM WHO REGIONAL OFFICE, INTER-COUNTRY TEAMS AND HEADQUARTERS

The WHO Country Office has benefited from the wide range of technical expertise available across the Organization. The contribution from the Regional Office, headquarters and through the Inter-Country Teams has been notable in many areas, from direct assistance in emergency response, technical contributions to the development of strategic documents to support in training and advocacy activities.

5.3 BUDGET

Financial allocations have shown a positive trend, particularly due to an increase in voluntary contributions in the current biennium. The assessed contributions remained at the same level, and cover most of the WCO operational costs in addition to supporting priority programmes activities.

Table 4: WCO Financial Allocations, 2004–2009 (US$)

Source of Funds	2004-2005	2006-2007	2008-2009
Assessed Contributions	3 089 000	3 374 000	3 477 000
Voluntary Contributions	4 307 055	4 524 167	7 935 473
Total	**7 396 055**	**7 898 167**	**11 412 473**

5.4 KEY CHALLENGES TO BE INCLUDED IN THE NEXT CCS

Based on an analysis of the strengths and weaknesses, as well as opportunities and challenges of the current cooperation strategy, the WCO identified several key challenges to be addressed in the next CCS.

The expansion of personnel and adoption of a cluster approach have enabled the office to function better and more coherently. The WCO should now continue to enhance its effectiveness and efficiency by building a stronger team approach at country level and with colleagues across the Organization.

It is increasingly difficult to plan for and resource activities, given the modest allocations that are often earmarked to priority programmes. The office will initiate resource mobilization at country level. It will appeal to partners for direct support to WHO in Mozambique for fulfilling its role as a leading authority on health, and allowing it to expand to new areas of work in response to the changing environment and growing demand for quality health care.

Although the health-related MDGs seem to be on track, the challenges remain overwhelming. The office will step up its efforts to help deliver the health-related MDGs against the set targets. It will do so by increasing the focus on health system issues. Through advocacy and promotion of universal access to safe and effective health care, based on principles of Primary Health Care, the WCO aims to broaden the scope of the health development agenda from a disease-specific to a more horizontal approach. The office will also initiate selected interventions to draw the attention to the rise in noncommunicable diseases, the hidden burden of violence and injuries and the importance of neglected diseases.

The WCO invested a lot in technical support for the development of policies and strategies. It will continue to communicate sound policy options and demonstrate that these are based on evidence. It will also support the dissemination and mobilization of resources for implementation of approved health sector plans. It will stimulate and equip local authorities to monitor and measure the impact of the various programmes. Monitoring the health situation and assessing the health needs remain the cornerstone of WHO's work.

Broader and more balanced support and active engagements with all stakeholders and across sectors, guided by the principles of impartiality and neutrality, are not in contradiction with WHO's mandate. It reflects an adaptation to a changing context and a stronger orientation towards the broker role of WHO. This implies, among other things, more effective work with nongovernmental organisations and the civil society as a whole. Another challenge is to strengthen the link and flow of communication between the strategists and planners of the Ministry of Health and the frontline service delivery providers.

The challenges presented above require a significant investment in the financial and human resources of the WCO. It is an opportunity for development partners to invest in a stronger WHO at country level and a challenge to the WCO to demonstrate its worth.

SECTION 6

PRIORITIES AGREED FOR WHO COUNTRY COOPERATION FOR 2009-2013

The WHO Cooperation Strategy for Mozambique is based on 13 selected strategic objectives and aligned with the Medium-Term Strategic Plan (MTSP) 2008–2013, which addresses the challenges facing the country in its health development agenda. It will be implemented in the context of the 11th General Programme of Work for 2006–2011 and the Medium-Term Strategic Plan, 2008–2013 adopted by the World Health Assembly, as well as within an advanced process towards "Delivering as One" under the UN reform, of which Mozambique is one of the pilot countries.

Priorities for 2009-2013

Within the 11th General Programme of Work, the WCO will focus on the following priorities:

1. Strengthening Health Systems.
2. Reducing Disease Burden.
3. Improving Mother, New Born and Child Health.
4. Addressing Health Determinants.
5. Leadership, Governance and Partnership.

PRIORITY 1- STRENGTHENING HEALTH SYSTEMS

The health system strengthening priorities are in line with WHO's Framework for Action for Health System Strengthening and focus on (1) health workforce, (2) service delivery, (3) medical products, vaccines and technologies, (4) health information and (5) financing.

Health workforce

The critical shortage of health workers calls for an accelerated response and development of human resources in health. This needs to be supported by further developing and updating HRH-related policies and strategies within the framework of national plans. Strengthening HRH management and planning capacity and increasing access to evidence-based information are important areas of focus for the WCO. The following strategic approaches will direct the support provided in human resource development:

- pursue the support for development of strategies and plans addressing workforce education; recruitment, retention and motivation, performance and quality of service provision;
- support the review of training programmes and development of innovative approaches for pre-service as well as continuous training programmes;

- facilitate the generation and dissemination of information on availability, distribution and performance of the health workforce (observatory, HRH, HIS);
- support national capacity building in HRH planning and management at all levels;
- provide financial support for post-graduate training through the fellowship programme.

Service delivery

Increasing equitable access to health services and building management capacity in the public health sector as well as expanding the coverage of the health facility network are essential steps to improving service provision at all levels and increasing users' demand. The WCO will provide technical support in:

- the design of integrated packages of health service delivery at the primary level and other levels of care in response to users' demand, including promotion of community involvement;
- the strengthening of primary health care management and hospital-based services as a means of expanding coverage and ensuring cost effective use of resources, as well as strengthening institutional development processes;
- increasing focus on patient safety and quality of care, as well as creating a safe working environment for providers;
- increasing access to appropriate technologies;
- contributing to processes aimed at developing sustainable infrastructure development and logistics;
- the identification and implementation of community health activities related to MDG programmes in Millennium Villages.

Medical products, vaccines and technologies

WHO will support improved access to, and improved quality and use of, medical products and technologies by:

- building the capacity of responsible authorities to improve inspection, licensing and enforcement within the National Regulatory Authority;
- strengthening the regulatory framework by supporting further implementation of existing and appropriate policies and regulations;
- improving quality assurance through the development and introduction of internationally-accepted norms and standards and capacity-building within control laboratory staff;
- building capacity and systems for the development and promotion of evidence-based clinical practices and appropriate use of medicines and technologies;
- strengthening the monitoring and evaluation system to avoid unnecessary stock-outs of essential medicines;
- improving the rational use of medicines and medical products and technologies.

Health information

There is a need to improve the quality and reliability of data in the HIS and strengthen the use of information for evidence-based planning. The WCO will:

- provide technical advice in the development of the main components of HIS strengthening;

- provide technical assistance to define and implement a long term strategic plan for the strengthening of the HIS nationwide and secure funds and resources for its implementation;
- revise the tools for data collection and flow in the HIS, the supportive supervision system and the feedback mechanism;
- strengthen national capacity in interpretation and use of data at all levels, through the use of a unique M&E framework for harmonizing the indicators of different vertical programmes;
- implement international standards for disease classification (ICD-10, ICF) in the hospital discharge and mortality registers;
- update yearly the Service Availability Mapping (SAM).

Financing

The WCO will continue to promote evidence-based decision-making at all levels of the health system through enhanced capacity to generate and use financial information. It will advocate for addressing financial barriers impeding access to health in order to reduce catastrophic expenditures on health. The main strategic approaches include:

- strengthening the capacity of MoH/Provinces to pursue resource-tracking exercises and monitor resource allocation to the sector;
- support for building national capacities;
- support for developing health financing policies, including alternative financing mechanisms;
- support for promoting health financing policies that target the poor in order to remove financial barriers impeding access to health by the most vulnerable groups.

PRIORITY 2 - REDUCING DISEASE BURDEN

The high mortality and morbidity caused by the double burden of communicable and noncommunicable diseases remains the focus of WCO's attention. Through technical and financial support for strengthening coordination with all partners in the health sector, the WCO will step up its effort to support the Government in achieving the health development goals.

Communicable diseases

The objectives are to: strengthen national capacity to reduce malaria, tuberculosis and HIV/AIDS-related morbidity and mortality; achieve high-level immunization coverage for vaccine-preventable diseases; eradicate polio and eliminate/control measles and neonatal tetanus; reduce morbidity due to helminthiasis, lymphatic filariasis and schistosomiasis; and eliminate leprosy.

The control of emerging and re-emerging diseases requires a strengthening of surveillance systems and adequate response to epidemic-prone diseases. The strategic approaches supported by WCO are:

AIDS – Tuberculosis - Malaria

- supporting provincial/district planning and implementation for AIDS, TB and malaria (ATM);

- providing and coordinating technical assistance for the elaboration and implementation of funding proposals for the Global Fund;
- providing technical assistance for the elaboration, implementation and M&E of the ATM national strategic plans;
- strengthening collaborative activities between the TB and HIV national programmes;
- providing support to expand the laboratory capacity for ATM, including quality control and assurance;
- promoting a coordinated participation of ATM partners and civil society in planning and delivering ATM community-based interventions.

Neglected Tropical Diseases and Leprosy

- supporting nationwide mass drug treatment for helminthiasis with preventive chemotherapy;
- intensifying multidrug therapy for leprosy, through community health workers;
- strengthening active detection of leprosy cases to maintain elimination levels in all districts.

Vaccine-Preventable Diseases and Surveillance

- revitalizing the national polio certification committee (NCC) and its subcommittees, namely the national polio expert committee (NPEC) and the national task force for laboratory virus containment (NTF);
- providing technical and financial support for the surveillance system and laboratory services related to vaccine-preventable diseases;
- strengthening the EPI information system, through capacity building.

Emergency Preparedness and, Response and Surveillance

- developing a policy and legal framework for integrated disease surveillance, including compliance with the International Health Regulations;
- supporting the implementation of pluri-annual plans for prevention and control of public health emergencies such as avian flu and cholera;
- strengthening early detection and diagnosis capacity, through the development of an effective network of clinical and public health laboratories;
- supporting health sector capacity building to mitigate the health effects of natural disasters;
- supporting the health sector capacity building to mitigate the health effects of natural and possible man-made disasters by integrating health emergency preparedness and response as a cross-cutting issue in its working cooperation.

Noncommunicable diseases (NCD)

The objective is to reduce and control the burden of NCD, which includes the promotion of healthy lifestyles. The WCO will contribute in the following areas:

- supporting the implementation of the national NCD strategy, through community-based approaches;
- promoting a multisectoral and integrated approach for NCD and violence, injury and disability prevention and control;

- supporting development of a National Multisectoral Strategy for Road Safety in the framework of the recommendations of the Global Status Report on Road Safety;
- supporting capacity building for integration of mental health and essential NCD interventions into primary health care;
- intensifying NCD surveillance and its integration into the Integrated Disease Surveillance Response.

PRIORITY 3 IMPROVING MOTHER, NEW BORN AND CHILD HEALTH

Improving mother and child health remains one of the priorities of the WCO. Much progress has been made in the development of key policy and strategic plans such as the integrated plan for MDGs 4 and 5 and the Expanded Programme on Immunization, Comprehensive Multi-Year Plan (EPI cMYP). The overall objective is to improve access to and performance of the integrated MNC health services in order to achieve MDGs 4 and 5. The office will contribute to the following:

- developing and/or updating and implementing policies, strategies and normative documents related to SRH (Sexual and Reproductive Health), MNCH (Mother, New Born and Child Health), nutrition and adolescent health, particularly supporting the implementation of the integrated MNCH strategic plan at district level and addressing adolescent health problems in a more comprehensive manner by integrating adolescent health services into the health care delivery system;
- building managerial and technical capacity to implement quality SRH, MNCH, nutrition and adolescent health interventions by strengthening provincial and district capacity for planning and managing health services and strengthening the capacity of health professionals to deliver quality services;
- strengthening community capacity and involvement in health promotion activities and supporting community-based interventions to provide appropriate home care during the course of life;
- mobilizing resources for SRH, MNCH, nutrition and adolescent health programmes and advocating with partners for sustainable funding for their implementation according to programme priorities;
- strengthening coordination mechanisms and harmonizing support among UN agencies, according to agreed division of labour and facilitating coordination among all key stakeholders for the planning, implementation, M and E of health interventions and their related results frameworks;
- expanding existing partnership through implementation of the grant plan for the Partnership for Mother, New Born and Child Health (PMNCH) and the UN joint programme and thereby contribute to impact on under-five mortality in Mozambique, based on the multi-evaluation platform;
- achieving and sustaining high-level routine immunization coverage by strengthening EPI service delivery and integrated services under the Reach Each District approach (RED) and supporting the introduction of pentavalent and other new vaccines.

PRIORITY 4 - ADDRESSING HEALTH DETERMINANTS

As Mozambique faces a double burden of disease and calls for new ways of thinking to address health challenges, the need to reflect on the key social determinants of health is crucial. The contribution of WHO in each priority area will be:

Health and environment

The main objectives are to (1) reduce water-related diseases and optimise the health benefits of sustainable water and sanitation conditions and (2) improve recognition by decision-makers of the holistic nature of health issues and the importance of cross-sectoral synergies as well as involvement of local communities. The following strategic approaches will be pursued:

- ensuring consideration of health issues in the multisectoral strategies and decision making;
- improving water safety, using WHO guidelines and norms on water quality and household level water treatment and safe storage practices;
- promoting better hygiene via providing knowledge on norms and best practices;
- ensuring availability of low-cost technologies and sustainable community management approaches;
- assisting non-health sectors in understanding and acting on the health impacts of their policies and actions;
- mobilizing resources from a wide range of sectors to address health problems in an integrated manner;
- building and maintaining national collaboration and partnerships;
- advocating for the mainstreaming of environmental health issues into development policies;
- promoting participatory approaches in all environmental health interventions.

Human rights and, health and gender equality

The WCO is committed to strengthening gender equality and the human rights approach in the health sector. It will promote multisectoral collaboration on the prevention and control of gender-based violence. The contribution will focus on:

- supporting the integration of gender equality and human rights into national health policies and strategies;
- supporting the creation of human rights networks in the development of specific projects;
- supporting the dissemination of human rights documents focusing on the rights of women and children;
- supporting progressive training on gender mainstreaming in the health sector;
- supporting capacity building for multisectoral and integrated services for gender based violence in order to reduce double victimization;
- strengthening access to health, medico-legal and police services for victims of violence, based on the human rights approach.

Social and economic determinants of health

- strengthening the capacity to collect socioeconomic data relevant to health to support evidence-based policies on equity and health;
- supporting the improvement of tools and methodologies for equity in health-based surveys;
- promoting equity-based approaches in health nationwide;
- supporting the setting up of a core number of equity-related indicators.

Chronic malnutrition

WCO will foster partnerships for enhancing intersectoral actions to improve health and nutrition, and support implementation of food and nutrition programmes through the following strategic approaches:

- advocacy to ensure consideration of health issues in the multisectoral strategies and decision-making, integrating nutrition, food safety and water and sanitation issues into training curricula of various managerial staff to facilitate intersectoral action to improve nutrition and health;
- strengthening linkages between policy-makers in different sectors (e.g. agriculture, water and sanitation, education, etc) at all levels, including the community level to ensure that the integration of nutrition, food safety and food security interventions are planned and implemented in an integrated manner with the involvement of all stakeholders;
- Building capacities for scaling-up essential nutrition actions for mother, infant and child health, including adolescent and outreach, food-safety and food-security interventions, through technical and policy guidance/support for development and implementation of plans, norms, standards and guidelines;
- monitoring, surveillance and assessment of health and nutritional status, and improvement of generated evidence for best policy and strategy options, including in emergency situations. This implies that the social and cultural factors and poor knowledge base influencing care practices and childhood feeding behaviours are addressed.

Health promotion

In the area of health promotion (HP), the WCO will provide technical support for the development of national policy and strategies on health promotion, strengthen institutional capacity for health promotion and promote the dissemination of the global health initiatives, such as Health Promoting School Initiative (HPSI), Healthy Cities, Healthy Markets and Tobacco Free Initiative (TFI). The WCO will contribute to:

- the development of a national health promotion policy and strategic plan and a health communication strategy;
- support capacity building in HP, in particular for journalists and teachers;
- promote the inclusion of HP in the curricula of training institutions;
- support the updating of the health school strategy and package;
- strengthen and expand the anti-tobacco and anti-alcohol nuclei.

PRIORITY 5 - LEADERSHIP, GOVERNANCE AND PARTNERSHIP

The Government is faced with the challenge of safeguarding country ownership and stewardship and defining its role in health in relation to other actors. WHO will assist in (1) ensuring that the Ministry of Health plays its stewardship role, (2) strengthening country knowledge management and informed decision-making, (3) stimulating the collaboration and partnership among all actors in health and (4) supporting public sector reform processes. The WCO will contribute to:

- strengthen national capacity in health policy analysis and decision-making;
- support institutional development at all levels of the MoH;
- assist in the formulation of policies and standards, and build capacities for governing and managing health libraries and information centres;
- introduce new information management technologies and support setting up information networks in the context of EC/WHO Palop project and ePortuguese platform;
- support the implementation of the Global Ministerial Forum on Research for Health;
- maintain the catalytic and coordinating role of WCO in policy dialogue and technical processes between partners and the Government;
- support consolidation of the IHP+ principles and implementation of partners' commitment to ensure greater harmonization and alignment with national health policies and procedures;
- encourage more active and broad involvement of the civil society in health;
- build synergies between the public and private sectors for maximizing the impact on health outcomes;
- lead the health agenda within the UN "Delivering as One" framework;
- encourage multisectoral dialogue, guide the implementation and monitor the impact of decentralization on service provision and staff availability.

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

7.1 COUNTRY OFFICE

The implementation of the strategic agenda will require greater engagement by the Country Office with health partners in policy dialogue, partnership, advocacy for health and strengthening of health systems. This will be guided by the WHO core functions and will be in a context of greater harmonization and alignment, with the focus on consolidation of the Cluster approach at country level to enhance effectiveness of the technical support to national authorities.

Mozambique and the Ministry of Health have developed national policies and strategies to guide interventions in priority areas within the framework of the Health Sector Strategic Plan. During the period covered by the Country Cooperation Strategy, major actions would focus on operationalization and implementation of most of the plans, supported by monitoring and information to assess its performance and trends so that bottlenecks may be addressed in the process. Moreover, the operationalization of human resources deserves continuous and rigorous follow-up, as it is vital for scaling-up activities towards the achievement of the health-related MDGs.

The main focus will be on strengthening the health systems in the context of decentralization to ensure efficient implementation of the strategies and interventions of the priority programmes aimed at improving health outcomes. A key complement is the fostering of intersectoral collaboration of evidence-based interventions to address social and economic determinants to health, in the context of the recommendations by the Commission on Social Determinants of Health and resolutions of the WHA.

The CCS builds on ongoing re-profiling for an efficient country team focussing on the following dimensions:

1. focusing on a much broader sectoral results-based approach, supported by evidence;
2. better skills matching of programme officers to deliver the national health agenda;
3. given the new aid environment and UN reform, stronger brokerage, advocacy and resource mobilization skills will need to be developed/strengthened within the Country Office;
4. the WCO should strengthen the role of its secretariat to ensure institutional memory and create a stronger platform for providing leadership on matters critical to health in Mozambique.

As the agency responsible for providing leadership on health, the WCO is committed to fostering greater coherence and consistency within the UN and moving towards full integration of WHO's cooperation strategy into UNDAF within the framework of "Delivering as One".

WHO will continue to encourage development partners to better coordinate their aid and support national plans in order to build a sustainable and equitable health system.

7.2 REGIONAL OFFICE

In spite of the delegation of authority from the Regional Office to the Country Office, technical support from the Regional Office, particularly in areas where national and Country Office expertise is not available, will be needed. The Regional Office should also provide systematic technical supervision from the ISTs when required, guide the normative work and complement efforts with the Country Team on activities where regional approaches can add value to WHO interventions.

Issues on Human Resource Management will need to be addressed at the Regional Office in order to secure the smooth and effective implementation of the present strategic agenda.

In addition, development activities for Country Office staff on new programme tools, programming, monitoring and evaluation will be needed so that they are empowered to engage.

7.3 WHO HEADQUARTERS

In line with the principle of "One WHO", headquarters will work with the Regional Office to provide technical support and mobilize resources for implementation of the CCS in Mozambique and document lessons learned from the CCS process and its impact on WHO's work. WHO headquarters will continue to facilitate networking with internationally, technically sound initiatives and promote exchanges with reference centres of excellence. Headquarters will also complement the guidance related to normative functions, particularly with the introduction of new technologies and tools.

The implementation of the 11th General Programme of Work, under the Global Management Systems (GSM) throughout the Organization, will contribute to more efficient delivery of the Organization's mandate towards the Member States.

SECTION 8

MONITORING AND EVALUATION

The CCS will be operationalized through biennial work plans that include those for 2010-11 and 2012-13.

The monitoring and evaluation of the Country Cooperation Strategy 2009–2013 will be conducted in the framework of performance assessment implementation of the Programme Budget and will include annual reviews, mid-term reviews and bi-annual evaluation at the end of each Programme Budget cycle.

In addition to the CCS annual reviews, reports from the semi-annual monitoring, mid-term review and end of biennium reports will be used as input in monitoring and evaluating the CCS. Given the fact that the CCS will be implemented in the context of greater harmonization and alignment of partners as well as "Delivering as One UN" in Mozambique, monitoring and evaluation reports from UNDAF, government reports (including PRSP evaluation reports), MDG progress reports, MDG monitoring and evaluation reports, joint reviews, (ACA) reports and similar reports from development partners will feed into the process for the monitoring and evaluation of the CCS.

Progress indicators for the strategic objectives will be derived from the work plans and will be assessed against aggregate improvements. Whenever possible, in-depth study, will be conducted in priority thematic areas, in collaboration with other levels of the Organization, the Ministry of Health and health partners working in Mozambique. The evidence from the studies will provide detailed information on achievements of the CCS as well as identifying areas that still need to be strengthened and draw lessons for future CCS processes.

Best practices from the implementation of CCS will be documented and shared with other countries as a contribution to the strategic planning development at country level.

Critical success factors for implementation of the Country Cooperation Strategy include the mobilization and efficient use of resources, increased and harmonized planning and budgeting processes in the context of SWAp and IHP, and availability of competent professionals with adequate backup from other levels of the Organization.

ANNEX I

Mozambique health sector development partners

Multilateral and international financial institutions:

ADB	-	African Development Bank
EC	-	European Commission
GFATM	-	Global Fund to fight AIDS, Tuberculosis and Malaria
UNAIDS	-	Joint United Nations Programme for HIV/AIDS
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Fund for Population Activities
UNICEF	-	United Nations Children's Fund
WB	-	World Bank
WFP	-	World Food Programme
WHO	-	World Health Organization

Bilateral institutions:

AECID	-	Agencia Española de Cooperación Internacional para el Desarrollo
AFD	-	Agence Française de Développement
CIDA	-	Canadian International Development Agency
DANIDA	-	Danish International Development Agency
DFID	-	UK Department for International Development
FINIDA	-	Finnish International Development Agency
FICA	-	Cooperation of Flanders
GTZ, BMZ	-	German Ministry for Economic Cooperation.
IRISH AID	-	Ireland
Italian Cooperation		
JICA	-	Japanese International Cooperation Agency
NORAD	-	Norwegian Agency for Development Cooperation
SDC	-	Swiss Development Cooperation
The Netherlands		
USAID	-	US Agency for International Development

Foundations and NGO networks:

MONASO-Network of national NGOs working on HIV/AIDS

NAIMA+- network of International NGOs working in the areas of HIV/AIDS, TB & Malaria

The Clinton Foundation

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