THE WORLD BANK

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BASELINE STUDY

PROVINCES OF ZAMBÉZIA AND NIASSA

Social Accountability, Knowledge, Skills, Action and Networking

The views expressed in this report are the author's alone and do not necessarily represent those of the Wolrd Bank and its agencies or of Concern Universal.

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Acronyms

AP	Provincial Assembly Assembleia Provincial
AR	Mozambique's Parliament Assembleia da República
APE	Community Health Agent Agente Polivalente Elementar
ART **TARV**	Anti Retroviral Treatment Tratamento Anti-Retroviral
ARV	Anti-Retroviral Anti-Retroviral
CGE	General State Accounts Conta Geral do Estado
CM	Municipal Council Conselho Municipal
CM	Council of Ministers Conselho de Ministros
CSO **OSC**	Civil Society Organization Organização da Sociedade Civil
CBO **OBC**	Community Based Organization Organização Baseada na Comunidade
CEDSIF	Center for the Development of Finance Information Systems (MoF) Centro de Desenvolvimento de Sistemas de Informação de Finanças (MF)
DPS	Provincial Directorate of Health Direcção Provincial de Saúde
FBO **OBF**	Faith Based Organization Organização Baseada na Fé
FONAGNI	CSO Forum for Niassa Fórum Provincial das Organizações no Niassa
GP	Provincial Government Governo Provincial
GPSA	Global Partnership for Social Accountability Parceria Global para a Responsabilização Social
HU **US**	Health Unit Unidade Sanitária
IGF	General Inspectorate of Finance Inspecção Geral de Finanças
IFAPA	Public Administration Training Institute Instituto de Formação da Administração Pública
IFPFT	Institute of Public Finances and Tax Training Instituto de Finanças Públicas e Formação Tributária
IOF	Household Survey

	Inquerito do Orçamento Familiar
IESE	Institute of Social and Economic Studies Instituto de Estudos Sociais e Económicos
INTOSAI	International *Organization of Supreme Audit* Institutions Organização Internacional das Instituições Supremas de Auditoria / Controle
LEBOFA	Frame-Law for the Organization and Functioning of Public Administration
	Lei Base de Organização e Funcionamento da Administração Pública
MAE	Ministry of State Administration Minstério da Administração Estatal
MoF **MF**	Ministry of Finance Ministério das Finanças
MPD	Ministry of Planning and Development Ministério da Planificação e Desenvolvimento
MIA	Map of Supplies Mapa Mensal de Consumíveis
MOPH	Ministry of Public Works and Housing Ministério das Obras Públicas e Habitação
MPF	Ministry of Public Service Ministério da Função Pública
MUNISAM	Municipal Social Accountability Monitoring Monitoria de Responsabilização Social ao Nível Municipal
NAFEZA	Forum of Women Organizations in Zambézia Núcleo das Associações Femininas da Zambézia
OD	Development Observatory Observatório de Desenvolvimento
OE	State Budget Orçamento do Estado
PESS	Health Sector Strategic Plan
	Plano Estratégico do Sector da Saúde
P 13	Municipal Support Program to 13 Municipalities in the Center and North of Mozambique Programa de Apoio a 13 Municípios no Centro e Norte de Moçambique
PDA	Municipal Development Programe Programa de Desenvolvimento Autárquico
PFM **GFP**	Public Finance Management Gestão de Finanças Públicas
PRM **GRP**	Public Resources Management Gestão de Recursos Públicos
PEFA	Public Expenditure and Financial Accountability Despesas Públicas e Responsabilidade Financeira
STI **IST**	Sexually Transmitted Disease Doença de Transmissão Sexual
SISTAFE	State Financial Administration System Sistema de Administração Financeira do Estado
TTL	Task-Team Leader Líder de Equipa
TA	Administrative Court (Mozambique's SAI) Tribunal Administrativo
ToC **TdM**	Theory of Change Teoria da Mudança
UGEA	Procurement Unit Unidade Gestora e Executora de Aquisições
UFSA	Procurement Supervising Unit Unidade Funcional de Supervisão de Aquisições
SDMAS	District Services for Health, Women and Social Action Serviços Distritais de Saúde, Mulher e Acção Social
SME **PME**	Small and Medium Enterprises Pequenas e Médias Empresas

Executive Summary

1. This report offers a baseline analysis and assessment of the current situation of social accountability in the health sector in the provinces of Zambézia and Niassa. It is part of the activities scheduled for SAKSAN - Social Accountability Knowledge, Skills, Actions and Networking Program, currently being implemented in the Provinces of Zambézia and Niassa, in the Centre and North of Mozambique, respectively. The main objective of this baseline is to enable a reliable picture about participation processes in the Provinces of Zambézia and Niassa in general, taking into account civic participation around public resources management processes (namely, planning, execution, reporting and internal control, oversight and policy review and analysis) and the engagement of health authorities in the province with civil society and other local interest and civic groups, in the provision of justifications and explanations on the above referred processes and on how these are undertaken, as well as, how such engagement influences the provision of health services (CMH and ART) at the level of communities, health units and in target Provinces in general.

2. The results and findings herein presented will serve as a reference for comparing progress and impact achieved with the implementation of the program. These findings will also guide the collection of baseline data as the program is implemented, especially where baseline data was not possible to collect due to the unavailability of information during this exercise. Such data will be collected by the project team and by the CSOs and civic groups involved to enable these to be used for analyzing progress. Any weaknesses and difficulties identified by demand side actors will be taken into consideration by SAKSAN's results framework and will be addressed through capacity building and follow-up of these actors in the achievement of program activities. Furthermore, this analysis will also feed into the program's planning process and, coupled with the *Outcome Journal*, will serve a monitoring function.

3. During this exercise we also reviewed a broad set of documents, from legal documents, national level planning documents and all documents and roles we have had access regarding MCH and ART in Mozambique and in target provinces. This draft version will be shared with all relevant stakeholders to validate its findings and to get it as closer to reality, as possible.

4. The Study portrays deficiencies in the legal framework related to civic participation and access to information. If, in one hand, the legal framework establishes the right to participate and to access information; government policies establish that the involvement of citizens and communities is a cornerstone for development and poverty reduction, in the other hand, neither the law nor policies establish clearly and effectively what mechanisms are there for participation and access to relevant information. In some cases, where the law establishes the right to access and to consult specific relevant documentation, the public authorities responsible for disclosing such data do not do so.

5. In what concerns Public Financial Management processes, there isn't an effective public participation. Limited exception can be referred regarding the annual planning process. However, monitoring and follow-up of the remaining public resources management processes (such as, execution, accounting and reporting, internal and external control and policy analysis) is still lagging behind ideal. Part of the absence of effective participation in these processes results from the lack of civic groups' capacity - whether collectively or individually - to understand, capture, analyze and utilize budget information and relevant technical details.

6. The study also identifies some risks and challenges for the health sector in target provinces and risks related to the project. Challenges for the sector include:
   (i) Issues associated to **drugs** rotate around three fundamental aspects. The first is related to the availability of drugs for undertaking ART. The second has to do with drugs' storage and transport / distribution conditions whether to provincial depots or to health units in districts. Another challenge that this report does not underline, but that has been largely reported by other documentation consulted[1] and people contacted, is related to the distribution of drugs with

[1] GAO, United States Government Accountability Office, Report to Congressional Requesters PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF, Drug Supply Chains Are Stronger, but More Steps Are Needed to Reduce Risks, April 2013, Corruption within the pharmaceutical supply chain, open briefing, , 1 July 2013; A Corrupção no Sector da Saúde em Moçambique, CIP, 2006.

expired validity, greatly affecting the quality of treatment and often worsening patients' conditions;

(ii) The health sector in Mozambique and in the two target-provinces face difficulties related with their **capacity** to adequately provide the services that they are meant to provide. In one hand, there is an issue of insufficient human resources (both in terms of quantity and qualifications). On the other hand, financial resources are limited for the fulfillment of the mandate of DPS and HUs. Limited capacity to purchase and maintain diverse equipment is coupled to this. All of that has a negative impact on the efficiency, efficacy, effectiveness and quality of health services;

(iii) Another challenge that is not clearly raised by this report is **perceived Corruption** in the sector. Accounts from several other studies portray this matter exhaustively and have indicated cases of corruption in the procurement of medicines and briberies being demanded from users. Here, the role that entities such as the AR, the PGR/GCCC, IGF, the TA is crucial to ensure that these issues are mitigated and that any situations are duly channeled for due correction and resolution;

(iv) The current **political-legal-institutional** framework regarding civic participation is too generic. The Constitution, the LOLE and its regulations, the LEBOFA and other norms pertaining to the interaction between public administration bodies and citizen/communities establish that citizen participation is important for good Public Resources Management. However, a significant gap related to civic participation is the lack of legal objectivity around this. That is, if in one hand, the legal framework establishes the principles of participation and transparency in Public Resources Management, on the other, it does not seem to us that such framework has been successful in establishing and determining how such participation is to be effected - with due exception of the right to submit petitions provided for by the LEBOFA (the frame-law for Public Administration Organization and Functioning). The provincial and central level DOs and the local consultative councils are spaces (institutions) created for dialogue between the diverse social actors, however, the existing literature indicates a need to improve clarity within the current framework;

(v) Oversight bodies (such as the AR, the TA, the APs, the AMs, IGF, the Ombudsman, amongst other) are bodies that have the mandate to hold executive accountable for the way they use public resources, in the same way that the Government is accountable to the AR or gets audited by the TA. In one hand, the country has been registering, at province level, an increasing interaction between civil society and Provincial Assemblies, and, on the other, at central level, this relationship also has been strengthened between the AR and civil society, especially with the FMO and parliamentary journalists, in an attempt to establish communication ties between oversight / inspection bodies and civil society. However, there isn't still any effectively established interaction between the Mozambican SAI and civil society. This is important to ensure transparency and access to reliable and quality information. It is, therefore, crucial to reinforce the **communication between oversight bodies and civil society** around Public Resources Management issues.

7. In summary, related risks identified include namely:

Component	Risks Identified	Observations
1. Increase the capacity of CSO/CBO to engage in social accountability	Will and commitment of CBOs / CSOs in carrying out social accountability work	In Mozambique, the intervention of civil begins to show some development. Civic groups however still play a "provider" role in which they replace the role and responsibility of the State in the provision of services. This is often justified by lack of quantitative capacity by the State in providing services. In the area of ART and PMCT, for example, we are will find more organizations, civic or voluntary groups providing home care, counseling or encouraging to testing and adherence to treatment. Though this work is helpful and important, it is also urgent to have CSOs / CBOs engaged in the promotion of transparency and access to information on how public resources are spent in this area or in the performance of health services and professionals. This is an approach that may lead to some degree of conflict and might also be accompanied by political connotation given the demand for data and information. For that reason there is a significant risk that the will of civic participation and engagement may be compromised by this fear. To address this issue, the training process should focus towards raising awareness on social accountability as a human right (aligned with high-level regional and international documents about the rights of the man and with the Constitution of Mozambique) rather than a political right.
	All of the participants available to participate in sessions - including gender balance	The risk that exists here has basically to do with the following issues: • Will the training dates not coincide with other responsibilities of the participants? It will be necessary to assure that the training dates do not coincide, mainly, with specific moments of the agricultural season as most of the members of the beneficiary organizations live off agriculture; • Are access roads favorable for the timely and regular participation of beneficiary organizations? There is a risk that, in one hand, access roads will not be favorable that transport and accommodation costs for these will be high, since it will not be possible to organize training sessions in each of the target-districts. Another issues adds-up: the risk that training sessions coincide with the raining season and, consequently, affect the level of participation. • Will it be easy to involve more women - considering their specific responsibilities and the local culture - in the process of training? Will it be possible to move participants to training venues even when it is far from their normal areas?
2. Increase engagement between demand and supply side actors around	Availability of relevant public documents	Access to information is a cross-cutting factor in any one of the project stages. Any activity that is not properly informed by evidence is, in principle, doomed to fail. Informal and formal mechanisms to access and consult information shall be promoted.

Component	Risks Identified	Observations
the quality of the ART and MCT services	CBOs / CSOs' social accountability engagement capacity	In general, the concept of social accountability is still new in the country. See, for example, that no existing official documents use this concept so far. There are few social accountability initiatives led by civil society. Specifically, such initiatives involve undertaking budget work, procurement monitoring, expenditure tracking, etc., which are, most of the time, not the strongest skills of the people involved in project activities. It expected that this risk is going to be significantly reduced during the training process, which will in a very simple and adequate manner support participants in the use of these tools.
3. Knowledge & Learning	The CBOs / CSOs that work in social accountability in the health sector are willing to share and recognize mistakes and learn with these	This is a risk that is also posed to the project team. In order to ensure that the groups working with the project recognize when they are "*riding a dead horse*", the project will (a) provide support, assistance and necessary guidance during implementation; and (b) follow closely the implementation and discuss with the partners adequate forms of intervention.
	Capacity, skills and time made available to producing documents	The project team should dedicate room to colect and analyze data/information and to capture lessons learned on project implementation. Because learning is a process that requires time, discussions will be held within the team and with implementation partners to review the actual situation of the project.

8. The SAKSAN's approach will have to focus on the creation of a valid recognized ecosystem (spaces, environment and mechanisms) which contributes for a culture of social accountability that effectively influences access to public services and the quality of these services. There are accounts of social accountability initiatives that contributed to improving the interaction between users - service providers and the quality and access to health services, because today, it is generally accepted that a socially accountable governance environment contributes to (i) improve service provision, (ii) the legitimacy of public actions, (iv) the increase of revenue collection, and (v) greater stability and development.

9. SAKSAN aims to achieve change - to demonstrate that initiatives which promote increased participation is useful to improve monitoring and follow-up of the quality of public services and is not a responsibility or effort reserved solely to public entities.

10. Some limitations were found due to the absence of reliable, detailed and complete information about the various sector aspects in the province. The study identified that often data in possession of health units and organizations that work in health and that of the DPS are different from each other and are not reconciled. This means that it is difficult to use the existing data as a means to inform strategic decision making. SAKSAN expects to be able to maintain an updated register of information that will serve as support to follow-up progress along project implementation. The reports that SAKSAN will produce will be crucial to analyze the implementation of activities and the achievement of expected goals. Reports will also be produced by the organizations/groups responsible for implementation on the ground to keep the project team updated on most recent developments. Each activity carried out in the scope of the SAKSAN will be recorded and analyzed by the project team in order to ensure the compilation of lessons learned and its use during the project's life-span.

1. Introduction

1.1 Background

1. Mozambique is a rich and diversified country, both geographically and culturally. The country obtained independence in 25 June 1975 after five centuries of Portuguese colonial domination. Then, the country adopted a mono-partisan system and socialist Constitution. Its development as a country was affected by a devastating civil war that weakened the main economic infrastructures and killed thousands of Mozambicans leading Mozambique to be amongst the countries with the worst human development levels in the world.

2. In the late eighties a Program of Economic Restructuration (PRE) was introduced and a new Constitution was approved in 1990. It introduced, amongst other aspects, (i) the reinforcement of fundamental rights and freedoms (including the freedom of association), (ii) established basic democratic representation rules, and (iii) took the first steps towards the implementation of local governments and the participation of citizens in public life and in the relevant decision-making processes. These aspects were reinforced by the Constitution of 2004, which is currently in force and under revision by the AR. More recently, with the exploitation of energy and mineral resources a high level of growth has been recognized; however, critical governance and Public Resources Management aspects affect the provision of health services. Despite the fact that the existing policy and legislative framework opens room for civic participation, it is still limited in key sectors, mainly in the health sector and no effective social accountability mechanisms exist.

In the health sector civil society organizations face serious challenges and lack support to combine rigorous monitoring methodologies and citizen empowerment. These challenges do not just affect the capacity of civic groups to monitor the performance in the health sector, but, in the end, they affect the capacity to ensure the required quality in the services that are provided. This is what constitutes the justifying grounds for SAKSAN. The SAKSAN - Knowledge, Abilities and *Networking* for the social accountability is a program that puts emphasis in the capacity building of local CBOs / CSOs aiming to engage in social accountability interventions.

1.2 Objectives

General

3. SAKSAN's main objective is to contribute for the improvement of the life of the most vulnerable people (women, children, people with disabilities, people with HIV/AIDS, etc.) in the provinces of Niassa and Zambézia and their quality of life through strengthening social accountability and the level of response to social needs by the services provided in the health sector.

Specific

4. More specifically, the objectives of the SAKSAN are:

- Ensure the development of skills and capacities of local CBOs and CSOs that work with or represent vulnerable groups in the provinces of Niassa and Zambézia in aspects related to the engagement around transparency and accountability in the provision of health services;
- Promote engagement around locally identified issues related with the quality of services provided in the areas of MCH and ART in Niassa and Zambézia;
- Promote the use and sharing of good practices and lessons learned to enable the issues identified and the lessons learned locally to feed into dialogue and influence similar initiatives in the country and globally.

5. The SAKSAN expects to intervene at national and sub-national levels (district, province). At the sub-national level the SAKSAN will be implemented in the two above referred Provinces. SAKSAN expects to benefit directly partner-organizations' members in Niassa and Zambezi shown in the table below:

Province	Implementation Partner (s)	No. of beneficiary members
Zambézia	NAFEZA	150
Niassa	FONAGNI	63

Table 1- No. of members of beneficiary organizations who will benefit from capacity building on evidence-based engagement

6. Part of the civic organizations that will be involved already have skills and capacity to implement governance initiatives. Such skills are relevant and the capacity building activities will have built itself on these existing skills. For some organizations, however, this will be the first opportunity to use governance monitoring tools and, in either case it will reinforce their capacities.

7. The project believes that intervention through social accountability monitoring - specifically on how health services are provided, the possibility of influencing services, the quality of services, the level of satisfaction of users, etc. - will exercise pressure on supply side actors leading them to gradually improve the provision of services. The program also aims to follow-up the drug supply chain to address issues related to stockout, conditions of drugs, validity dates, etc. SAKSAN will use tools that should be applied taking into consideration the local context and ownership and the development of capacities in evidence-based engagement.

8. With this social accountability initiative that looks into the health sector, we expect to benefit around 5 (five) million people in the provinces of Niassa and Zambézia through the improvement of the engagement mechanisms and consequent improvement in the implementation of national health related policies. This project aims to intervene in the health sector focus on the area of Child Maternal Health related with the ART and on the access to ART services in selected districts.

9. SAKSAN expects to influence and foster engagement between communities / users and the provincial / district health authorities in Quelimane, Nicoadala and Mocuba (Zambézia) and Maúa, Marrupa and Muembe (Niassa). SAKSAN's approach defines communities, population, CSO/CBOs and the users of health services in general as demand side actors. Health authorities (central, provincial, district and municipal) and all those public entities with responsibilities over service provision or assurance are considered as supply-side actors. On the other hand, oversight and control/inspection entities, namely, the Administrative Court, the General Inspectorate of Finance, Parliament, Provincial Assemblies, Municipal Assembly, etc., are considered supply-side actors, although, in some cases, such as in the case Municipal or Provincial Assemblies, such actors are representatives of demand-side actors. They represent, thus, important entry points for social accountability initiatives and where important champions can be identified. The intervention will be essentially of a focused capacity building, involving training in social accountability tools, the monitoring of the use of such tools and the production of lessons learned to feed into national dialogue processes. Such capacity building processes will be linked to the internal good internal governance of beneficiary associations and civil society organizations, the promotion of transparency and access to information, Budgetary Accountability, procurement, the identification of irregularities and the implementation and adoption of correcting mechanisms.

10. Experience tells us that socially accountable governance requires a balance between the capacities of both supply-side and demand-side actors. If in one hand, supply-side actors possess capacities and skills - even if limited - to exercise their responsibilities, on the other, the capacities of demand-side actors are seriously precarious. It is crucial to strengthen their capacities to create the referred balance. Demand-side actors need to understand how governance processes work to be able to understand the best moments for intervention, the main actors in each of these moments and the relevant documentation that should be utilized for the purposes of monitoring governance and the use of public resources.

1.3 Theory of Change and Approach

11. SAKSAN is founded in the principle that if we reinforce the capacities of demand-side actors, these are going to exercise pressure and reinforce the need for improvement of the capacities of the demand-side actors, leading to improvements in the access to services, in the quality of services, in the implementation of policies and even in a bolder responsiveness of health related public policies.

12. SAKSAN's Theory of Change is based in these basic elements and puts emphasis in changing the capacities, thinking and actions of both demand-side and supply-side actors, and at both grass root level as well as at more centralized governance levels:

    (i) Changes in capacity - new techniques and competences are internalized, new resources are dedicated for the provision of basic health services, introduction of new rules, implementation of new tools and adoption of new practices;
    (ii) Changes in thinking - new ideas are expressed, new options are considered, different points of view are articulated; and
    (iii) Changes in behavior - promotion of changes in the way both actors behave or act and promotion of new (or better) engagement practices.

13. The Project has 3 (three) components, namely:

SAKSAN Components		
Component	**Intermediate results**	**Activities**
Increase of the capacity of CBOs/CSOs for social accountability engagement	(i) CBOs / CSOs in target provinces are provided with skills and techniques for promoting evidence-based engagement (including budget analysis initiatives) and (ii) Improvement of their own internal governance and internal accountability mechanisms	1. Baseline study and Actor Mapping; 2. Training of the members of beneficiary organizations in social accountability, Plan and Budget Cycle and Processes; 3. Training in Budget Analysis Mentoring techniques and tools (including scoring cards, social audit, expenditure tracking and monitoring, procurement monitoring, public hearings); 4. Promotion of internal dialogue within CSOs/ CBOs (including principles of internal governance, communication, transparency, gender balance, legal compliance).
Improvement of citizen influence in the quality of the health services provision and the access to these services	Special emphasis will be given maternal-child health, access to ART, budget decentralization and budget accountability tools will be used, identification of user satisfaction levels and concerning issues in order to produce relevant data to be shared with the relevant sector entities. Intermediate results include: (i) Effective monitoring of the quality of health services; and (ii) Increase of the effective dialogue between the local civic organizations and the government around health issues.	1. Increase of citizen's access to public information on local health issues (MCH and ART). 2. Support to civic groups in the use of social accountability tools for monitoring the health sector; 3. Provision of support in the collection of baseline evidence about the sector; 4. Promotion of an effective dialogue and evidence-based engagement.
Knowledge and Learning	(i) Better practices identified, lessons learned (case studies, life-stories, digital stories, etc.) disseminated; (ii) Common challenges in the use of social accountability tools identified and disseminated; and	1. Support to local media in the education of the public about social accountability and dissemination of project information and findings; 2. Production of lessons learned to share information, challenges, experiences and good practices.

SAKSAN Components		
Component	**Intermediate results**	**Activities**
	(iii) The reality in the ground influences health policies (focus in the MCH and ART and in the humanization services).	3. Organization of Workshops for sharing information, lessons learned and challenges with different stakeholders; 4. Establishment of a partnership with relevant Parliament's working groups.

1.4 Methodology

14. Concern Universal participates actively in regional and national networks and forums (and more recently, in the platform and community of practice of the Global Partnership for Social Accountability - GPSA, through the Knowledge and Learning Forum) and has had the opportunity of participating in a series of events to share experiences and lessons with other stakeholders. In Mozambique, Concern Universal is a founding member Independent Governance Group (GIG), which meets every 6 weeks to discuss issues related to governance in the country, undertake joint research activities and round-tables for joint advocacy. Concern Universal is also a member of a group of international NGOs in health and HIV/AIDS in Mozambique, NAIMA +. We have also recently joined as a member of the National Group of Drugs, a group of CSOs that discusses and interacts with government around medical drug-related issues. In addition to work within these networks Concern Universal expects to gather support from all of actors, namely relevant Government Institutions, Civil Society, Parliament and other oversight bodies, by keeping them informed of all stages of implementation and raising wider interest in promoting social accountability for health.

15. The involvement and collaboration of the Government is crucial as it is the most important recipient of the findings and constraints identified in the ground. We intend, therefore, to channel all the evidence generated by the Project to the provincial (Zambézia and Niassa) and national development observatories. Provincial Assemblies in Mozambique are functioning since 2010 and are important partners to the process. Although both development observatories and Provincial Assemblies are still not fulfilling their oversight roles to their fullest, these are actors may not, by any means, be left outside of the scope of this intervention. In addition, they are crucial to help to fill the huge gap between existing policies and legislation and their implementation in practice.

> Social accountability as a human right is still a novelty in Mozambique and therefore one of the strategies of the SAKSAN is to use social media, mainly community radios and other digital means (digital stories, for example) to create awareness and influence public opinion.

16. As we referred above, our special focus will be in maternal-child health and in the access of this group and other users to ART services. In this component, SAKSAN's cornerstone is the analysis of information related to budgeting (plans, budgets, execution reports or alike) and other aspects of budget decentralization. In general terms, Mozambique has advanced policies in the health sector, such as, for example, the sector's strategic plan (Strategic Plan for the Health Sector 2013-2017), the National Plan for the Improvement of the Quality and Humanization of the MCH, the Strategic HIV Response Plan, amongst other, but there still are factors that withdraw its full implementation, namely:

- The geographical stretching of the country and uneven population distribution, hindering an appropriate coverage of users, mainly in the rural areas;
- The limited quality of access infrastructure;
- The complexity of the decentralization and deconcentration process.

17. Furthermore, the project will coordinate closely with other CSOs that work in the area of monitoring to at national level and with other donor funded projects. Although the project is founded on a solid learning and knowledge basis, its approach is to build the capacity of the beneficiaries in capturing and following-up users' access to target services and in the identification and sharing of

constraints related to the availability of such services to users. To capture such information SAKSAN shall use tools to follow-up the process of planning and budgeting, to monitor procurement (for example of drugs), public hearings, and other potential tools, taking into consideration the core objectives described bellow in Table 2:

Main Objectives	Tools and Mechanisms
Transparency and Access to information	Development of information and communication material to make health related public information available to target audiences.
	Submission of requests to access public information about health.
	Development of materials for online dissemination of public information in accessible and user-friendly formats.
	Independent budget analysis (covering the sector) at national, provincial, district and municipal level.
	Access and use of the reports produced by the Administrative Court and by other reports and data produced by other oversight entities.
Voice and Representation	Capacity building of CSOs, CSO networks and selected civic groups.
	Training of civic committees.
	Use of the formal processes for submitting petitions or informal or collective organization of petitions (for example, with resource to online petition tools).
	Use of the formal citizen participation mechanisms (for example, ODs).
Social Accountability	Monitoring of plans, budgets and execution / performance reports.
	Design and implementation of community score cards or user score cards to assess the provision of services (availability of working elements, quality of services).
	Design and implementation social audit processes.
	Independent monitoring of procurement processes.
	Collaboration with oversight and accountability institutions (Ombudsman, Administrative Court, Provincial Assembly, Parliament and other applicable entities).

Table 2 - Objective and Tools of the SAKSAN's Approach

18. Another not less important actor and, perhaps, the most important one, is the community itself. SAKSAN is going to work with NAFEZA, in Zambézia, and with FONAGNI, in Niassa. Both organizations are networks of civil society organizations whose majority of members work at community level. In the scope of SAKSAN, members of the NAFEZA and of the FONAGNI are going to receive training in the use of social accountability (see Table 2, above) and the project team is going to provide the required follow-up in the use of such tools. At community level it will be also important to work with other existing civic groups; with groups that provide peer support and home-care; with the health units and respective staff; with the Co-Management Committees, where these exist; with the Community Health Councils, where these exist; and other relevant actors.

19. At the province level, the program is going to interact with other organizations and programs that support the development of health and channel the constraints and findings identified for sharing in the Development Observatory, through the thematic area of health and human development. At this level the Provincial Directorate of Health (DPS), the Provincial Assembly (AP), the provincial Delegation for Combating HIV/AIDS (DPCS) is also important.

20. In addition to this baseline report SAKSAN will also produce regular progress reports (six-monthly and annual), monthly reports by implementation partners (NAFEZA and FONAGNI), and other project-related information. Concern Universal is going to keep a regular and updated registry of the activities carried out (training, meetings, participation in dialogue/discussion sessions) with respect to the ToC, the description of any changes verified in the way actors think and act, reference to the data used, evidence and an analysis about the activities planned but not carried out, and other relevant factors and the main lessons that will be captured in the process. All this information will be included

in an appropriate Outcome Journal which represents the most important tool for monitoring, evaluation and learning within SAKSAN.

Objective of this Diagnosis

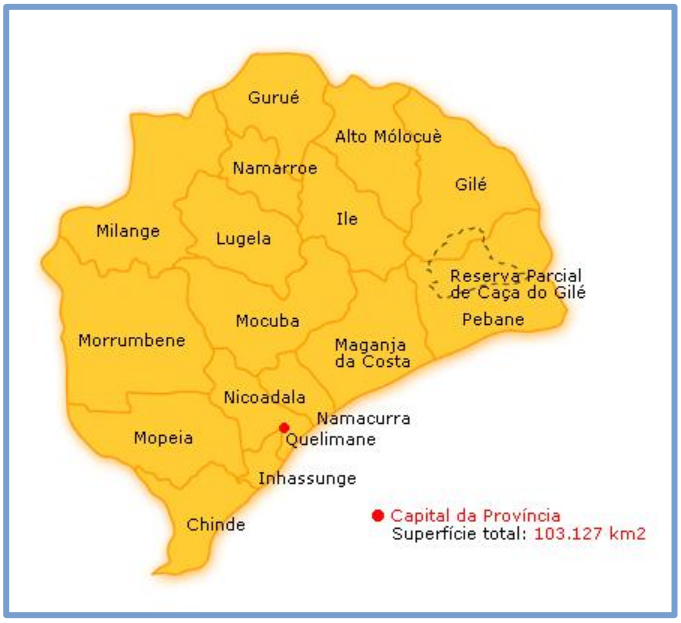
21. This baseline study is an integral part of the activities programmed in the scope of the SAKSAN - Social Accountability Knowledge, Skills, Actions and Networking Program, currently being implemented in the Provinces of Zambézia (center) and Niassa (North). The main objective of this baseline is to obtain a reliable portrait the participation processes in the Provinces of Zambézia and Niassa in general, taking into consideration civic participation in the public resources management processes (namely, planning, execution, reporting and internal control, oversight and policy review) and the interaction of health authorities in the province with civil society and other local interest and civic groups, around the provision of justifications and explanations on how the management processes above indicated are being carried out and how such engagement influences the provision of health services (MCH and ART) at community and health units levels and in the province in general.

22. The results and findings herein presented will serve as a reference for comparing progress and impact achieved with the implementation of the program. These findings will also serve as a reference for collecting baseline data as the program is implemented, where baseline data was not possible to collect due to the unavailability of information during the exercise. Such data will be collected by the project team and by the CSOs and civic groups involved to enable these to be used for analyzing progress. Any weaknesses and difficulties identified by the demand side actors will be taken into consideration by SAKSAN's results framework and will be addressed through capacity building and follow-up of these actors in the achievement of program activities. Further to that, this analysis will also feed into the program's planning process and, coupled to the *Outcome Journal* will serve a monitoring purpose.

23. During this exercise we also reviewed a broad set of documents ranging from legal documents, national level planning documents and all documents and roles we have had access regarding MCH and ART in Mozambique and in target provinces. This document was shared with all the relevant stakeholders in order to obtain their validation of its findings and to get it as close as possible to the reality found in target provinces. Its structure is the following: (i) an **Introduction** (to which this subsection belongs) that describes the context of the project, its Theory of Change, the methodology and approach of the study, the objectives of the project and portrays the Provinces of Zambézia and Niassa; (ii) the document contextualizes the SAKSAN in terms of legislation, policies and strategies and maps the main institutions and relevant actors for the intervention; (iii) we further describe the **Public Financial Management processes** in Mozambique (with details on provincial, central, district and sector levels); (iv) following a more detailed addressing of the situation of health in Zambézia and Niassa; (v) The document is concluded with a section of **Conclusions** which seeks to offer ideas and recommendations of intervention taking into consideration the previous sections, the challenges for the sector and the risks for SAKSAN.

1.5 The Province of Zambézia

24. Zambézia, once a Portuguese Overseas Province, is a province in the central part of Mozambique, and its capital is the city of Quelimane. The province has an area of 103 478 km² and is divided into 16 (sixteen) districts. Zambézia has 6 (six) Municipalities namely Alto Molocué, Gurué, Milange, Mocuba, Quelimane, and Maganja da Costa[2].



25. This is the second largest province in the country and, according to the most recent population census (2007); it also is the second most populous. Said census indicated a total of 3.849.455 inhabitants, after Nampula, to the north. The province has established limits with the provinces of Nampula and Niassa, to the north, the Indian Ocean, to the east, the province of Sofala, to the South, and to the West, the province of Tete and Malawi.

26. In 2012/2013 the Province of the Zambézia already accounted over 4.4 million people, and despite its potential in agriculture, mineral resources, fisheries and, more recently, in the implantation of industries, it is considered one of the poorest provinces of Mozambique[3]. According to the Household Survey 2008/2009 the province of the Zambézia was where poverty levels increased most, with 26,2%, followed by the provinces of Sofala and Manica. Another important challenge indicated by the IOF 2008/2009 includes access to health care. According to the survey the majority of the respondents (around 44%) have to travel more than 30 minutes to arrive at a health unit.

Caracteristicas seleccionadas	Tempo em minutos para a fonte de agua					Tempo em minutos para a unidade sanitaria				
	Menos de 30	30 - 44	45 - 59	Mais de 60	Total	Menos de 30	30 - 44	45 - 59	Mais de 60	Total
Provincia										
Niassa	95.4	2.6	1.7	0.3	100.0	58.4	23.7	3.3	14.5	100.0
Cabo Delgado	73.1	16.2	3.4	7.3	100.0	58.6	25.0	4.6	11.8	100.0
Nampula	86.4	6.1	1.3	6.2	100.0	49.6	15.2	5.9	29.3	100.0
Zambezia	88.2	7.8	1.9	2.0	100.0	28.9	18.9	8.0	44.2	100.0
Tete	88.1	6.5	1.6	3.9	100.0	38.2	19.8	6.2	35.8	100.0
Manica	85.6	7.4	0.5	6.5	100.0	32.5	20.4	13.2	33.8	100.0
Sofala	95.3	2.5	0.5	1.7	100.0	46.7	27.2	5.1	21.0	100.0
Inhambane	90.1	4.4	2.1	3.4	100.0	33.5	14.7	9.0	42.8	100.0
Gaza	85.1	7.9	1.9	5.1	100.0	35.1	19.9	9.1	35.9	100.0
Maputo provincia	89.6	7.4	1.8	1.1	100.0	50.9	28.3	4.5	16.4	100.0
Maputo cidade	98.6	1.1	0.1	0.1	100.0	58.5	27.3	8.6	5.5	100.0

Table 3- Time required to Access, on foot, a health unit (Source: INE)

27. Health indicators related to the situation of children in Zambézia also raise concerns when compared to the provinces. In a recent interview, the current UNICEF representative to Mozambique refers that the Government should dedicate more attention to the region and that the difficulties have to do with limited child health budget availability, accompanied by a limited budget management capacity.

[2] This latter municipality was created on the context of the creation on new municipalities in 2013.
[3] See Household Survey 2008/2009. The last IOF was undertaken in 2002/2003 by INE.

28. In what concerns HIV/AIDS women, mainly younger ones, is the most affected part of the population in this province. Data of the CNCS indicate the prevalence rate is high, about 15.5% (almost double the rate, especially amongst male individuals) with higher incidence in the urban and corridor areas. One of the challenges for the provincial health authorities in this area is the definition of effective strategies for communication and dissemination of prevention messages for reducing maternal-child mortality as a result of HIV/AIDS and the prevention of new infections, especially in urban centers.

1.6 The Province of Niassa

29. **Niassa**, a name originating from Nyanja means "Lake" and it is a province in the northwest of Mozambique. Its capital is the city of Lichinga. Despite being the largest province in the country it is the less populated one, with a population of around 1.170.783 inhabitants and a rate of 9.5 inhabitants per km², in a territory of around 129 thousand km2. It has 16 (sixteen) Districts, namely Cuamba, Lichinga-distrito, Lago, Chimbonila (where Lichinga is located), Majune, Mandimba, Marrupa, Maúa, Mavago, Mecanhelas, Mecula, Metarica, Muembe, N'gauma, Nipepe and Sanga. The province has 4 (four) Municipalities: Cuamba, Lichinga, Metangula and Marrupa[4].

30. Itsestablished borders are, to the north, Tanzania, to the West, with the Republic of the Malawi, to the East, with the Province of Cabo Delgado and to the South, with the provinces of Nampula and Zambézia. The Province's Strategic Plan underlines some relevant points which constitute constraints to the economic and social development of the province, namely:
    a) The large distances that separate the province from the main economic, business and political centers of the country (Maputo, Beira, Nampula, the Port of Nacala and Pemba);
    b) Large territorial extension of the province, associated to its low demographic density and to the lack of transport infrastructures;
    c) The fact that, comparing to the national reality, the province of the Niassa is the most deprived one in terms of infrastructure. Its location is severely far from the main production and consumption centers in the country, in particular due to the poor interconnection of access roads and transport systems;
    d) Its road network is comprised mostly of dirt road and - in spite of the progresses achieved in recent years, in particular in the south area of the province - many of the reasonable and/or bad shape roads, however, are intransitable in the rainy season, in particular due to the precarious state of respective bridges and *pontecas*;
    e) The railway network in Niassa links the province to Nampula (Malawi - Entre-Lagos-Cuamba-Nacala) and Cuamba to Lichinga, the latter is not operational. The Northern Corridor Development Company (CDN) is currently undertaking the rehabilitation of the railway line from Cuamba-Lichinga, and it is also expected that improvements will be made in the line Moatize-Malawi-Entre-Lagos-Cuamba-Nacala which may bring new dynamics do the province's development.

31. The following characteristics can be cited when it comes to the health sector (also please see, the Province's Strategic Plan): (i) The situation includes an increase in transmissible illnesses such as malaria, diarrhea, tuberculosis and HIV/AIDS and, in parallel, there is an increase in non-transmissible illnesses (for example, cardiovascular illnesses and/or effects of trauma); (ii) Maternal and child

[4] The latter municipality was created on the context of the creation on new municipalities in 2013.

mortality is still high and it is mainly due to avoidable causes; (iii) Serious limitation of human resources, deficient furbishment in equipment of the health units, as well as, a poor infrastructure quality.

32. According to its PEP 2017, Niassa has around 154 health units comprised by a provincial hospital (01), rural and district hospitals, health centers and health posts. In addition, there are community hospitals run by a Commission of the Catholic Church. All the health units offer curative services. The Provincial Hospital of Lichinga and the Rural Hospital of Cuamba offer specialty surgery services, medical care, gynecology and obstetrics, pediatrics and orthopedics. All the health units located in the district headquarters have conditions for admitting in-patients and a maternity ward, but the health network is insufficient for meeting existing needs and is distributed unevenly, with a provincial average of 9009 inhabitants by health unit. The provincial average number of beds per 1000 inhabitants is of 0,606 beds per 1000 inhabitants. Only about 65% of the 154 existing health units offer antiretroviral treatment (ART). In 2012, of a total of 137 HUs only 27 provided ART services. In spite of the limited coverage an increase of ART (around 28%) was registered.

District	Health Units	Beds per 1000 hab.
City of Lichinga	17748	1472
Chimbonila		
Cuamba	16980	1345
Mandimba	15424	
Marrupa	12800	
Mecanhelas	10970	
Ngaúma	10326	0,678
Maúa	10304	
Lago		0,706
Majune		
Mavago		
Mecula		
Metarica		
Muembe		
Nipepe		
Sanga		

Table 4 - Distribution of inhabitants per HU and Beds per 1000 inhabitants

33. The current Provincial Strategic Plan (PEP 2017) indicates that the HIV/AIDS prevalence rate is of 11,1%, only higher than Cabo Delgado (8,6%) and Nampula (9,2%), but the INSIDA Report 2009 positions the province as being the one with the lowest prevalence amongst adult individuals (3.7%), followed by Nampula, with 4.6%. According to health authorities the tendency of evolution of sexually transmitted infections (STI) is concerning in high risk areas associated to the districts located around large roads of the province and in the border areas with Malawi and in the urban centers such as Cuamba, Mandimba, City of Lichinga (including the district of Chimbonila), Marrupa and Maúa, where there is a higher number of STI cases. Women and girls are the most affected and the sero-prevalence rate amongst women is above 60%.

34. Considering this scenario, it is important that the project intervention attempts to ensure that better prevention mechanisms are put in practice in an environment where the dialogue about sex-related issues and sexually transmitted diseases may still be a taboo. The CNCS, on that respect, underlines that it is **necessary to defined concrete strategies** to prevent new infections, as well as, provide treatment and solidarity to the people infected and affected by the disease.

35. The same pattern can be pointed out regarding other basic public service areas. Education, for example, still has one poor school coverage and limitations in the technical-professional area and qualified human resources. This it has resulted in excessively high illiteracy rates, where women are the most affected (around 62.3%). This, coupled with the problem of deficient access roads, irregular geographical distribution of water availability and the scattered distribution of the population makes it difficult to access drinking and treated water.

36. Although the rate of orphans due to HIV/AIDS is of 9%, almost twice less than the national average, the rate of early marriage is very high, for example, while in the south of Mozambique this rate is lower than 10%, in Niassa it reaches 24%. These numbers are of concern because higher early marriage rates contribute for an increase in HIV/AIDS prevalence rates amongst this vulnerable group, especially in a social and cultural setup where the use of preventative measures such as condoms is practically weak and a taboo.

1.7 General Considerations on Civic Participation

37. An important moment for dialogue that takes place at provincial level is the Provincial Development Observatory. This is an important space for dialogue which counts on the participation of the Provincial Government, civil society and representatives of NGOs and of development partners in the province. In this event, the Government presents the activities carried out and other undertakings against the provincial Economic and Social Plan and Report of the previous year (the *Balanço do Plano Económico e Social*). Civil society participation in this forum is effected through participation in thematic areas. While in Niassa there have been significant improvements registered in terms of the Observatory, in Zambézia, our interviewees, both from DPS and from civil society, indicated that there isn't much interaction regarding the issues of health at the provincial DOES

38. In addition to the Development Observatory there is space for dialogue at district level, the local consultative councils[5]. These are local bodies which discuss local issues and are formed by members elected within the community, influential people and opinion leaders and, by representatives of the district services. The purpose of these spaces is to discuss aspects related to the development of the district (including planning aspects and sharing of information) and, more recently, the process of analysis and approval of beneficiary of projects funded by the District Seven Million Fund. Any of these spaces have limitations related with the effective participation of the civil society representatives around health issues at this level.

39. Accounts of previous works and studies on the effectiveness of the DOs indicate that some challenges remain in this area, namely, the late communication of the date of the event, the late sharing of discussion documents and the fact of the DO is still less open to discussion given its limited time which makes a one-stand-only short event. Indeed, with relation to the degree of civil society participation in governance matters, including in the area of HIV/AIDS, the following challenges remain:

    a. The interventions in the area of governance are still affected by an inherent automatic political connotation attributed to monitoring interventions. Especially in situations where such interventions forward criticisms or recommendations to authorities or address their performance;
    b. Limited knowledge of public management processes, namely strategic planning and budgeting; budget execution; accounting, reporting and internal control; external audit; and reviewing of policies and strategies (at both province and district levels);
    c. The limitation above is strongly accompanied by a limited familiarity with instruments and tools that enable an appropriate follow-up of public management.
    d. The existing spaces for dialogue, although consolidated (for example, the Observatory of Development), are a mere routine of the process and are not contributing for an effective decision-making process on health issues in both provinces. On the other hand civil society has a perception that their involvement in planning processes does not produce results. Civil society feels that their contributions are systematically and recurrently neglected, creating a feeling of frustration with relation the process and discouraging participation.
    e. Persistent absence of civic / interest groups organizational capacities to function adequately and in representing their communities or constituencies;

[5] The local consultative councils were created by means of the Law on Local State Bodies, Law 8/2003, of 19 May (LOLE), which is regulated by Decree no. 11/2005, of 10 June. Its implementation was uneven throughout the country. In Niassa, the CCLs were less effective in the past and between January 2010 and December 2012 the FORCA program was implemented by Concern Universal, with EU funding to revitalize these councils. Despite the good results, there are still challenges related to their effectiveness.

f. Absence of an interaction and effective synergies between the several institutional actors (government, civil society and private sector).

2. Legal, Policy & Institutional Mapping

2.1 Legal and Policy Framework

Legal Instrument	Description / Observations
Constitution	Mozambique enjoys a clear legal framework that governs the PFM system and participation, approved by the Constitution of 2004. The Constitution of the Republic of Mozambique (CRM) defines with accuracy the structures and the division of competences and attributes amongst the main State bodies in general aspects related to the budget, its preparation, execution and verification, and, establishes which bodies shall control the budget processes. The CRM is the main legal instrument in the Republic of Mozambique[6], and stipulates that the Economic and Social Plan (PES) guides economic and social development and that it is expressed, in financial terms, by the State Budget (OE), which shall be approved by the Assembly of the Republic (Mozambique's Parliament or AR) accompanied by reports on main sector and global options, including their respective justification[7]. i) The Law on State Budget (LOE) is prepared by the Government and is submitted to the AR, containing information that justifies revenue forecasts, expenditure ceilings, deficit financing and all the elements that form the basis of the budget policy. ii) The LOE is the instrument that defines budget execution rules and the criteria around budget amendments, execution period, as well as the process to follow whenever it is not possible to comply with the terms for submitting and voting the budget document.[8] The OE execution is controlled by the Administrative Court (TA) who then issues a report and opinion. That report and opinion forms the basis for parliament to review and decide whether or not to approve the General State Accounts (CGE). The AR is also responsible for reviewing the options contain in the PES and OE and their respective execution reports, and approve the OE[9]; The Council of Ministers (CM) is responsible for preparing (on behalf of the Government) the Economic and Social Plan and the Budget and executes these after approval by the Assembly of the Republic[10]; and the Prime-Minister (PM) is the entity responsible for submitting their respective drafts to the approval of the AR[11].
Ministry Diploma no 94/97, of 22 October	**Approves the Statutes of MISAU.** The previous organic statutes of MISAU were defined by Ministerial Diploma no 35/85, of 14 August, but the transformations that occurred in the country since then added new responsibilities to the sector leading to the approval of new organic statutes by means of the Ministerial Diploma no 94/97, of 22 October. This new statute met the need to respond to the process of decentralization of the services to lower levels of government. This ministerial diploma establishes for the MISAU around seven areas of action, namely[12]: • Promotion and preservation of Health; • Prevention and treatment of illnesses; • Pharmacy; • Research; • Organization and administration; • Training; and • Inspection.

[6] CRM, Arts. 2 and 4.
[7] Idem, Art. 128.
[8] Idem, Art. 130.
[9] CRM, Art. 179.
[10] Idem, Art. 204.
[11] Idem, Art. 206.
[12] Idem, Art° 4°.

Legal Instrument	Description / Observations
	This diploma establishes that MISAU is comprised of its central bodies, the Provincial Directorates of Health, district services of health and the city directorates. The structure and functions of each of these bodies is regulated by their respective statutes[13]. The organic statutes of MISAU establish even it operates with the following collegiate [14]bodies: • The **Consultative Council** – composed by the Minister of Health, Deputy-Minister, Permanent Secretary, National Directors and by any "other officials or institutions that the Minister of Health invites". The Consultative Councils meets weekly. • The **Coordinating Council** – constituted by the Minister of Health, Deputy-Minister, Secretary-general, General Inspectors, National Directors, Heads of Central Departments, Directors of Institutions Subordinated to Central Bodies, Provincial Directors of Health, provincial Medical Head Doctors, Directors of Central Hospitals, and other officials that the Minister of Health invites. The Coordinating Council meets once a year, in any point of the country. • The **Hospital Council** – is a collegiate body comprised by the Minister of Health, Deputy-Minister of Health, Secretary-general, National Directors, Head of the Medical Assistance Department, Provincial Directors of Health, provincial Medical head Doctors, Directors of provincial and Central Hospitals and other officials that Minister of Health invites. This collegiate body meets once a year in any point of the country.
Law 7/2012 "LEBOFA"	Base Law for the Functioning and Organization of Public Administration.
SISTAFE Law	The State's financial management function is governed the Law 09/2002 of 12 February (Law of the State's Financial Administration System – SISTAFE). The SISTAFE Law establishes the basic principles and general norms of a financial administration integrated system for the State bodies and institutions in a consistent, comprehensive, and global manner[15]. This said one can assert that the SISTAFE establishes and harmonizes rules and procedures for programming, management, execution and control of funds, in order to enable their effective and efficient use. It also establishes rules on how information is produced – in an integrated and timely manner - regarding the financial administration of state bodies and institutions. The objectives of the SISTAFE are: • Establish and harmonize the rules and procedures for programming, management, execution, control and evaluation of public resources; • Develop subsystems that provide timely an reliable information about the patrimonial and budgetary behavior of State bodies and institutions; • Establish, implement and maintain an accounting system for the adequate control of asset and budget execution ensuring compliance with the requirements for registration, information organization and of performance assessments of the actions developed in the field of the financial activity of State bodies and institutions; • Establish, implement and ensure the efficiency of the internal control system and alignment with internal audit internationally accepted procedures; • Establish, implement and maintain a system of procedures adequate for a correct, efficient and effective economic undertaking of activities planned in programs, projects and other operations in the scope of programmatic planning and objectives established; The SISTAFE Law establishes that the bodies and institutions of the Subsystem of the OE have the responsibility to: • Prepare and propose the necessary elements for the preparation of the OE; • Prepare the draft Budget Law and respective justification; • Evaluate draft budgets of State bodies and institutions; • Propose the necessary measures for OE to begin to be executed in the beginning of its respective financial year;

[13] Ministerial diploma no 94/97, of 22 October, Artº 1º.
[14] Idem, Artº 2º.
[15] Idem, Artº 3º er seq.

Legal Instrument	Description / Observations
	• Prepare, in coordination with the Subsystem of Public Treasure, the programming related to the financial and budget execution, in line with provisions of the SISTAFE Law and regulations; • Assess the amendments to the OE; • Assess the processes of financial[16] and budget execution. Under the SISTAFE Law the OE shall foresee the revenues (minimum limits) to collect and set the expenditure to effect during a specific financial year in order to fulfill with the State's financial policy[17]. The Government **submits the Draft OE to the AR until 30 of September each year**[18]. For the purposes of presentation of the OE proposal to the AR the Government must also put together all of the necessary elements to justify the budget policy, namely: • The Government's Economic and Social Plan; • A draft report of the State's Budget execution of the year in course; • The justification of tax revenues forecast and the establishment of expenditure ceilings; • A statement of the global financing of the State Budget with discrimination of the main source of resources; • A listing of all State bodies and institutions, as well as of all autonomous institutions, public companies and municipalities; • The budget proposal for of all agencies with financial and administrative autonomy, municipalities and the State enterprises[19]. Upon receipt of the OE proposal, the AR has approximately 75 days (two months and half) to **analyze the proposal of the State Budget Law, from 30 September to 15 December**[20]. Government also has to submit to the AR and to the TA the General State Accounts until 31 May of the following year. The report and opinion of the TA on the General State Accounts should be submitted to the AR until 30 November, for review and approval of the accounts. [21] Internal control (inspections and audits) entails the Subsystem of internal control - SCI which is comprised by the bodies and entities that undertake inspection and audit of the processes of revenue collection and use of public resources and includes their respective rules and procedures[22]. The bodies above referred should verify the application of the procedures established and compliance with the law, regularity, economicity, efficiency and effectiveness bearing in mind good management in the use of resources made available to State bodies and institutions[23].
SISTAFE Regulations	The regulations of the SISTAFE Law also adds provides for e-SISTAFE (the SISTAFE electronic platform) by establishing its definition; structuring; security and control; transactions; database; development, maintenance and output; communication network; and implementation[24].
Decree no 15/2010 of 24 May, Procurement Regulations	The Procurement Regulations established a series of *procurement procedures* including principles of public interest, transparency, publicity, equality, competition, impartiality and good financial management. The UFSA is the supervision and support entity for the entire national level procurement process. At the level of each institution with its own budget to perform Ministerial Diplomas 141 and 142/2006 of 05 of September, establish that specific

[16] Idem, Articles 11° – 17°.
[17] Idem, Articles 18° *et* 19°.
[18] LSISTAFE, Preamble.
[19] Idem, Art. 11.
[20] LSISTAFE, Art. 13.
[21] Idem, Art 21.1.
[22] Idem, Art 21.2.
[23] Idem, Art 22.1.
[24] Idem, Art. 22.2.

Legal Instrument	Description / Observations
	procurement units are established. These units are designated Procurement Executing and Management Units (UGEA).
Provincial Directorate of Health	It inserts a tool and defines the relationships between the entities of the province, district and with MISAU.
Law 5/2007 of February 9	Decree which establishes the legal framework for the implantation of Provincial Assemblies and defines its composition, organization, functioning and competences.
Decree 6/2006 of April 12	Approves the Organic Statutes of District Governments.
Law 8/2003 of May 19	Law on the Local State Bodies - Establishes the Principles and Norms for the Organization, competences and functioning of Local State Bodies. In terms of MISAU bodies at sub-national level, namely provincial, district, administrative post and of locality this instrument defines their principles and organizational norms, competences and functioning in the province, district, administrative post and locality.
Decree 11/2005 of 10 June	Regulations of the Law Local State Bodies.
Decree 15/2000 of 20 June	This decree establishes the means of articulation of Local State Bodies with the Community Authorities.

Table 5 - Legal Framework

40. The legal framework described in this subsection is not exhaustive of the entire sphere related with the sector in any one of the levels but enables the reader to have an idea of the contours in terms of the institutions and relationships that are established between the various public entities in the process, an important understanding for an intervention that aims to be comprehensive and intends to establish linkages with the different governance levels. It does not seem to us, however, that other aspects related to civic participation are duly treated by legislation. The LEBOFA, above indicated, already inserts principles and mechanisms for civic participation, for example, through the submission of petitions by the citizen(s), however there is still a gap regarding concrete forms of citizen intervention in key governance moments in the process. The Constitution of the Republic and LOLE also establish principles related with civic participation. Some aspects of community participation, in the perception of the MISAU, are referred in the sub-section below relatively to sector policies and strategies on HIV/AIDS.

2.2 Policies & Strategies

Strategic Plan for the Sector Health 2014-2019 (PESS 2014-2019)

41. The PESS is a comprehensive document that establishes priorities for all health sector areas and seeks to adopt solutions to health issues which affect Mozambique's population including curative and preventive services, in one hand, but also, on the other, advocacy for health, collective and individual strengthening as key sector interventions, with focus on:

- The required and continuous commitment to prioritize less privileged groups of the population and poverty alleviation actions;
- The provision of primary care and the development of quality hospital care;
- Strengthening of individuals and communities to enable them to take on the responsibility and control over their own health;
- Consolidation of large investments of postwar reconstruction side-t-side with the continuous expansion of the health network;
- Advocacy for health, including environmental sanitation, drainage of dangerous waters, supplying of drinking water, general education of the population, particularly of woman to improve women social and economic status.

42. The PESS finds its "*main axis of action of the sector on community agents with emphasis in community participation and mobilization*". Historically community participation in health begins in late 70s with the introduction of the Program of Elementary Versatile Agents (Programa de Agentes Polivalentes de Saúde), which were community members with functions to develop health promotion and prevention of illnesses activities and to assist in the treatment of common illnesses. This was, however, losing field under the control of MISAU. But health care by community members has never ceased. An example is the care work provided by home care givers within communities.

43. The GoM recognizes that community participation in the improvement of health and the PARP, the PQG, as well as the PESS make reference to this. The PESS previous established as priorities in this area the (i) establishment and operation of Health Committees and of Co-Management Committees; (ii) the revitalization of the APEs Program (community health agents); and (iii) Education and Communication for Health adds-up to these priorities. MISAU indicates that the adoption of the measures above indicated has brought improvements to the rate of institutional births, Maternal-Child services, adherence to ART treatment, and a higher coverage of patients. It seems to us that, so far, however, in terms of the sector, community participation is seen more as a complementarity to the provision of health services, and in some cases (the Co-Management Councils, for example) in the management of health units, and Not, necessarily, an effective civic participation with the possibility of intervention in the processes of strategic planning, policy review, annual planning and budgeting, of follow-up of the execution and oversight.

National HIV/AIDS Prevention Strategy

44. The National HIV/AIDS Prevention Strategy (ENPS), in what refers to the pillar of Community Involvement, recognizes the need of creation of Health Committees and Health Co-Management Committees, however during the past 10 years the communities were being organized to collaborate with the health sector through other forums with different designations, such as, for instance Community Leader Councils (CLC), Health Councils, Mother Groups, Peer Groups, reproductive health activists, amongst other, as means of community participation as referred in the previous subsection. Most of these groups work with the support of organizations based in the province, for example FHI, Action Aid, amongst other, in coordination with the district health authorities and with the health units, but this intervention varies from district to district and from health unit to health unit.

2.3 Main Actors & Participation Mechanisms

45. Figure 1, below seeks to illustrate the ecology of the several institutions / entities / relevant actors for civic participation in what concerns the SAKSAN. The institutional situation is similar in most provinces; however, some nuances can be specific from one location to another. This graphic and this subsection are built in the assumption that all the characteristics are, as a rule, common. Figure 1 also seeks to visualize the key actors for the SAKSAN and to understand and discuss their relative positions in the system, the role they have and the influence that each one may exercise. For the development of its activities SAKSAN was designed with this system, processes and actors in mind.

46. The initial level of interaction is at the level of community and/or health unit, which represents the level of services (provision of ART and MCT). The mapping of actors is then taken to the level of management of the health unit and of the health authorities that supervise this level. The same happens with the provincial and central level. The mapping exercise also embodies the oversight / inspection institutions at the district, provincial and central levels, taking into consideration the specific functions of each actor. It also analyzes the role of the institutions of internal control and of external audit as warrantors of the compliance with processes, norms and to ensure value-for-money

47. SAKSAN will have of take in consideration all of these actors while its planned activities are being developed.

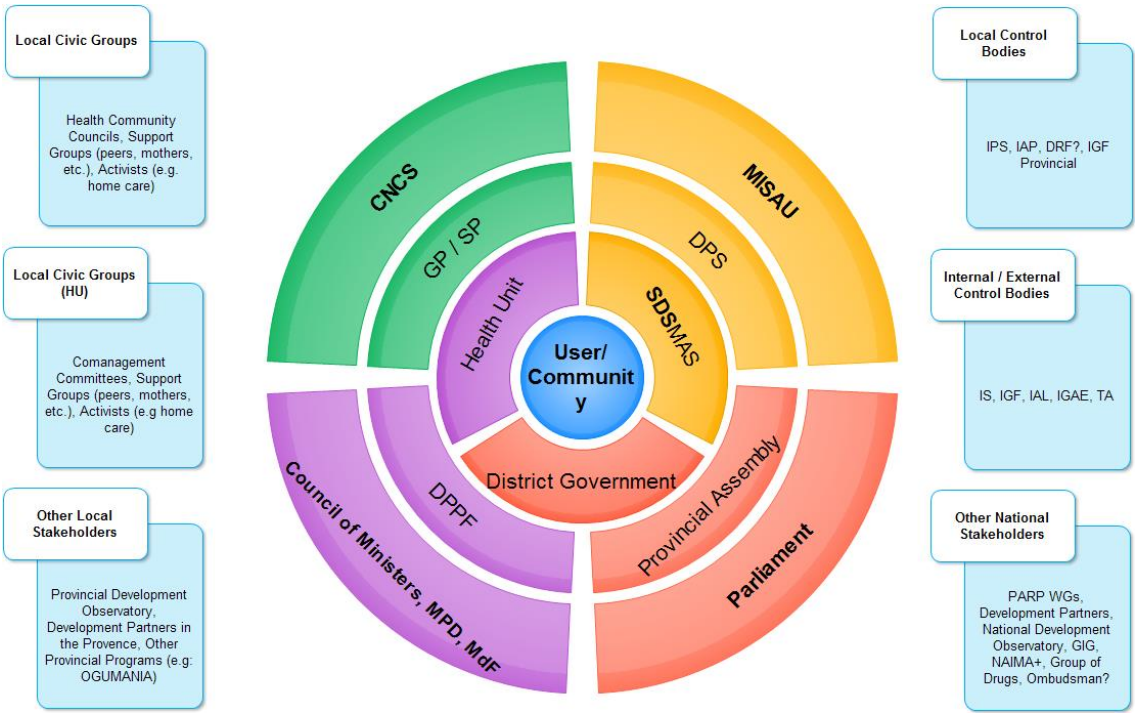


Figure 1 - Mapping of the Actors for SAKSAN

48. Table 6, below seeks to describe the role of each one of the entities / levels of actors identified in the mapping and their relevance to the project.

Level	Actor (s)	Role / Mandate	Relevant Documents	Interacts with...	Observations / Opportunities
District	Health Community Councils, Support Groups, Activists, APEs, Co-Management Committees, Community Leaders, Opinion Leaders, etc.	Interaction with the community and with the health authorities and serve as a linkage between demand-side and supply-side actors.	Reports, satisfactometers	Community, health authorities, health personnel	They can be crucial beneficiaries of the training process and they may be useful in filling, collecting and analyzing the information produced by the score cards
	CBOs, CSOs and other civic groups	• The same as above; • Undertaking of specific programs and/or activities - of voluntary nature or not - on behalf of the improvement of the health care in the community and/or in terms of the HU	Reports, satisfactometers	• Community, health authorities, health personnel; • Other organizations with similar initiatives, partners in province / country, provincial authorities.	They may be potential / crucial beneficiaries of the training process and may asset in filling, collecting and analyzing the information produced by the score cards
	Health Unit	Provision of services and health care	• Statement of Service • Instructions for Patients • Medicine Prices (where applicable) • Execution / performance reports	• Community (patients, family members); • Health authorities, health personnel; • CSOs, CBOs, partners of the health sector in the district and province, DPS/MISAU; • Internal/external control and internal/external audit entities.	Execution / performance reports are not currently considered public and are not made available for public consultation.
	SDMAS / District Administration	Ensure the full operation of health services in the district, including in terms of policies and service provision. Coordination of health services in the district.	• PESOD • Execution / performance reports (Balanço of the PESOD)	All of the actors above.	The reports of the Balanço of the PESOD are normally made available for consultation (case-by-case basis). These do not have, however, disaggregated information about the process of execution of each HU

					making it difficult to follow-up individual HUs and effectively track down their activities. The internal and external control reports could offer this helpful information but are Not considered public.
Province	GP / SP	Coordinate the operation of all the public institutions in the province, including the interaction with the private sector, cooperation partners and citizens in general.	• PESOP • CFMP (MTEF) provincial • Execution / performance reports (Balanço of the PESOP)	• Institutions in the Province • Citizen, groups, CSOs, CBOs, FBOs, etc.; • Private sector and cooperation partners; • Cooperation partners in the province; • DPS MISAU; • Internal/external control and internal/external audit entities.	• It is the maximum authority of the State in the province. An important point of entrance for the activities of the project; • Under the responsibility of the GP is the provincial Administrative Inspection which is an internal control body of cross-cutting nature with powers to inspect and control the actions of any entity in the province, including the public authorities of level D. • The provincial Inspection of Health and the DRF are part of, respectively, the DPS and the DPPF, being accountable to their provincial directors. However the GP is the entity with powers to demand action to be taken based on their findings.
	DPPF / DRF	DPPF is the institution with responsibility of financial management in the province.	Provincial REO (quarterly Budget Execution Reports), Plan (PESP) the Province and of each sector in the province. information about the performance of the districts	• GP / SP; • DPS/MISAU; • IGF; • Provincial TA; • Central TA; • IAP, ISP, IAL, IGAE and IGF • Development Partners in the province.	Potential of interaction with civil society, even if at the level of the provincial DO only.
	DPS				
	Provincial IGF				
	IPS, IAP, DRF				

	Provincial Assembly				
	Development Observatory				
	FONAGNI and NAFEZA				
Central	MISAU				
	MPD / MoF				
	IGF				
	Assembly of the Republic	National oversight body. Inspects the activities developed by the provincial Government. Analyses and approves the PES and OE and the CGE. Main recipient of the reports and opinions of the TA. It has powers to demand specific audits to be taken by the TA.	PES OE, CGE	Government, control and audit institutions, citizens in general, cooperation partners.	The issues related with health are treated by the Commission of Social Matters. The AR also has a specific Office for HIV/AIDS Prevention and Combating.
	Ombudsman	It ensures the observance and respect for human rights.	Annual Report	AP, CM, PGR, amongst other.	
	Development Partners	Support to OE and Government programs. Technical assistance and support to advocacy	Reports pertaining aid in country. Technical assessments.		
	IS, IAL,				
	IGAE				
	Administrative Court				
	Discussion Forums (NAIMA +, GIG, Group of Medicines				

Table 6 - Relevant actors for SAKSAN

3. The Health System in the Province

3.1 Zambézia

49. This section aims to offer a portrait about the situation of health in the province, with focus in the area of HIV/AIDS, especially in what respects to the processes and challenges related with accessing ARV treatment. According to the contacts made in the Provincial Directorate of Health of Zambézia (DPSZ) there have been in the previous year's various improvements in an attempt to improve services provided to patients in the area of HIV/AIDS. One of these improvements introduced by the sector is the fact that in Zambézia the health care professional category (this includes health technicians, nurse, medicine agents) starts receiving training in the provision of ART during their basic pre-work training. In the past, this was not part of the training curriculum for these health care professionals. They would have to receive on-the-job training to provide HIV/AIDS related care. There remains a challenge related to the control of how care is provided in practice, because this is still NOT done in a regular and systematic manner.

50. In terms of Community Health some of the activities are developed by activists (community health agents) and by mobile health brigades. Mobile health brigades are comprised of health personnel that regularly visit communities to provide health services (for example, SCI, ART) and often for undertaking clinical consultations (such as, for example, TB related).

51. Activists do not necessarily provide clinical care. Their activities in the community and at the level of the health unit include community counseling and mobilization (family planning, peer counseling, nutrition, etc.). Activists do not provide ART. Specifically in the area of HIV/AIDS activists provide household care to patients in bed, visits and perform a crucial role in identifying patients in remote areas or individuals who have dropped-out or weren't yet involved in ART.

52. The health sector has defined around 15 (fifteen) national priority districts for ART using a software (Spectrum) that estimates the numbers of patients that need ART out of the total of people with HIV and the percentage of patients that need but do NOT have access to treatment. 9 (nine) of these districts are located in the province of the Zambézia. For establishing that a district is a *district at risk* there must be 4000 patients without treatment but that should, however, be receiving it. One of the causes of that has to do with the restrictive criteria that the Health used to require for initiating treatment. Today, with the introduction of the ART Acceleration Plan 2013-2015 these criteria are more comprehensive, for example, a pregnant mother already initiates ART once tested HIV-positive during pregnancy. Thus CD4 count isn't the sole requirement for initiating treatment.

53. Another factor that is contributing for a higher coverage of ART services in the province was the decision to decentralize to the District the opening of ART services (a decision previously centralized within MISAU). The SDMAS currently have the prerogative and freedom to open ART services, provided they do so in coordination with the DPS, which only establishes the minimum requirements in terms of security, equipment and process, and since 2013 it was possible to extend ART services for around 30000 patients, having duplicated the number of patients in ART.

Priority District	Distance from Quelimane (Province capital) (km)
Quelimane	N/A
Inhassunge	10.33
Nicoadala	52.6
Namacurra	71.5
Morrumbala	195
Mocuba	156
Pebane	359
Maganja da Costa	186
Milange	302
Chinde	75

Table 7 - Distance from Quelimane to other TARV Priority

Districts

54. Access is a determinant element to support the decision about the target-districts of this project. While, for example, Mocuba is a little over 150 km from Quelimane, it is much easier and takes less time than traveling to Inhassunge which is less than 15 km away from the capital. It takes much less effort and time to travel to Mocuba than to Chinde that is located less than 80 km away from Quelimane. On its turn, while is less lengthy to travel to Morrumbala that is located 195 km from Quelimane (03 hours), it takes much more time to travel to Maganja-da-Costa which is located 186 km of the capital of the province. All these elements are important to take into consideration given the limited available resources for the implementation of the project. At the same time, the problem of the access roads affects access to health services. In Milange, for example, several people of the interior of the district cross the border to receive medical treatment in Malawi, or worse, cross into Malawi and cross back to Mozambique to arrive at the municipal town of Milange to receive treatment, traveling long distances as a means to avoid the difficult access roads.

55. Health authorities in Mozambique are unanimous in affirming that with relation to HIV/AIDS the country is NOT yet aware of the actual dimension of the problem, in one hand, due to the levels of testing (although this number is increasing when compared 2010 - 2013 data). On the other hand, the elimination of hospitals-day is today generally accepted as a measure that was appropriate as this kind of hospitals were exclusively located in provincial capitals affecting the level of adhesion to treatment and consequently the coverage of patients in remote areas. With the elimination of the HDs ART services were installed in districts in order to will be closer to the patients. This increased the level of testing and adhesion, but these are still very low, in general, throughout the country, and a significant number of patients are still not included in statistics. In Zambézia there are approximately 200,000 patients infected and approximately 40% need ART and, according to the DPSZ, until December 2013 roughly 60% of these had access to ART.

56. In terms of community participation MISAU - in line with the PESS 2014-2019 and with the PENIII - is seeking to develop community involvement as a cross-cutting component to all health programs. In one hand, it involves consultation of the communities. And each health unit is supposed to have a co-management committee that is going to address aspects related with the operation of the facility and improve the perception the community regarding its operational matters. For example, hypothetically, if the HU received a Lot of paracetamol with 100 (hundred) units the co-management committee is called upon to witness to inform community members about existing limitations in terms of the availability of the drug. There are, at community level, Community Health Committees which meet regularly with the facility's staff to discuss issues mainly related to curative medicine.

57. The health sector aims to work permanently form with communities and these organized groups as to improve their involvement in identifying patients and in creating awareness regarding adhesion to treatment. In addition to the co-management and community health committees there also are Mother-to-Mother Groups (HIV positive with infants that meet regularly to share knowledge about, for example, the preparation of porridges, nutritional counseling, etc.), the Community Counseling Group / GAC (formed by HIV patients with specific conditions which form groups of two to three individuals that alternate on visits to the health unit to collect drugs but also send to the HU information on any opportunistic infections affecting the three, CD4 counts, etc.). There also are associations of people living with HIV/AIDS and all of these actors meet regularly (usually monthly) at the health units with the personnel with health partners to discuss issues related with the service, use of medicines, the recovery process, amongst other aspects. Such meetings are called "positive tea day" or "family day" depending on the areas and of the partner that supports the initiative.

58. The concept of Community Participation only means interacting with the health units and health personnel around service quality and drug availability, but has not been crossing these limits to include elements related to performance / execution monitoring, the available budget and how monies are been used by health authorities.

59. One of the challenges found during the baseline exercise is the difficulty related with the management and distribution of the stocks (medicines). Such fact is a result of the poor reporting level on the part of the responsible staff in health units. Monthly each HU is responsible to prepare a specific report, the "MIA" (Monthly Map of ARVs), which is checked by the SDMAS before being submitted to DPS. To DPS sends drugs to health units based on the MIA. However, the process does not always run

smoothly as not all HUs submit their maps on a timely manner. As the procurement of medicines is done centrally by MISAU this affects the provincial drugs management and, consequently, the quantity of medicines that is dispatched to districts is less than required. There are no stockouts because SDMAS have to reorganize available drugs and distribute the existing quantity per existing HUs, but that affects the medicines management system of these HUs which are duly "organized" are penalized in the process. Challenges that exist in this area include:

- Distribution - it is possible to ensure an appropriate distribution to districts where drugs are distributed with the support of the partners in the province. The challenge lies in ensuring that drugs arrive quick but the existing distribution is not sufficient and in other cases access roads are not appropriate;
- Activities and progress reporting - the level of reporting of the justifications on the use of HIV testing kits is around 40% of the Kits distributed although all Kits distributed will have been used by the HU. DPS believes that this situation has to do with poor recording by HUs;
- Not all districts submit the MIA on time and if one HU does not submit, the district (SDMAS) is forced to manage the existing *stock* on the detriment of the *stock* availability capacity of "compliant" HUs causing internal *stock issues at* district level;
- The distribution process also has issues related with the lack of capacity that the medicines are transported in the most appropriate conditions of temperature;
- Storage of medicines in the province also is challenging and there is a risk of affecting the conditions and efficiency of drugs.

60. Despite of existing community involvement meetings above referred civil society and/or the communities are not part of f planning processes, and DPS does not seem to know of any signs of effective civil society participation in Development Observatories.

61. In terms of expansion of ART its respective plan should be read in conjunction with the Plan of Prevention Mother to Child Transmission (PMCT). PTARV in Zambézia foresees a gradual expansion (with quarterly goals), in 2014, and indicates that around 105 HU already provide ART of the total of 229 existing HR in the province. The PTARV for 2014 alone is going to shorten that difference in around almost 50%. However, this is a significant improvement when we notice that in 2010 only 31 HU provided ART services (See, please, the tables below).

District	HF with ART	Type of ART	Start-up Year and Month
Quelimane	17 September	Fixed	Oct 2008
	Coalane	Fixed	Jul 2009
	24 July	Fixed	Jul 2010
	4 December	Fixed	Jan 2013
	Namuinho	Fixed	Jun 2009
	Chabeco	Fixed	Jan 2004
	Micajune	Fixed	Jan 2013
	Central Prison (*Cadeia Civil*)	Fixed	Jul 2009
	Icidua	Fixed	Jan 2004
	DREAM	Fixed	Nov 2013
Alto Molocué	RH Alto Molocué	Fixed	2006
	Nauela	Fixed	2011
	Mutala	Fixed	Jun 13
	Cs de Caiaia	Fixed	January
	CS Chapala	Fixed	January
	CS Mohiua	Fixed	January

District	HF with ART	Type of ART	Start-up Year and Month
Chinde	Chinde	Fixed	2006
	Micaune	Fixed	2011
	Marcacao	Fixed	Aug 13
	Luabo	Fixed	Oct 13
	Jorge	Fixed	Nov 13
Gile	Gile	Fixed	2006
	Alto Ligonha	Fixed	2011
	Uape	Fixed	Aug 13
	Mamala	Fixed	2013
	Moneia	Fixed	2013
	Muiane	Fixed	Nov 13
Gurué	GURUE CS URBANO B	Fixed	2006
	Lioma	Fixed	Jan 13
	Muacuaro	Fixed	12-06-13
	Ruace	Fixed	31-07-13
	Tetete	Fixed	30-06-13
	Invinha	Fixed	30-06-13
	Mepuagiua	Fixed	24-06-13
Ile	Ile	Fixed	Aug 06
	Mugulama	Fixed	Mar 08
	Mulevala	Fixed	Nov 12
	Socone	Fixed	23-07-13
Inhassunge	Inhassunge	Fixed	Jun 06
	Chirimane	Fixed	Nov 11
	Gonhane	Fixed	Jul 09
Lugela	Lugela	Fixed	Jul 07
	Tacuane	Fixed	Aug 13
	Namagoa	Fixed	Mar 08
	Mulide	Fixed	May 13
	Puthine	Fixed	February
Maganja da Costa	Maganja da Costa	Fixed	2006
	Nante	Fixed	13-07-12
	Mucubela	Fixed	Jan 13
	Tapata	Fixed	08-07-13
Milange	MILANGE CS URBANO B	Fixed	2006
	Mulumbo	Fixed	21-11-12
	Malua	Fixed	16-07-13
	mongue	Fixed	23-09-13
	Dulanha	Fixed	May 13
	dachudua	Fixed	30.08.13

District	HF with ART	Type of ART	Start-up Year and Month
Mocuba	HR Mocuba	Fixed	2006
	CS Sede	Fixed	Aug 2013
	Samora Machel	Fixed	Sept 13
	16 de Junho	Fixed	Nov 2013
	Alto benfica	Fixed	Aug 2013
	Munhiba	Fixed	Jul 2013
	Namanjavira	Fixed	Jul 2013
	Mugeba	Fixed	2010
	Muakiwa	Mobile Clinic	Dec 2013
	Caiave	Mobile Clinic	Dec 2013
Mopeia	Mopeia	Fixed	2006
	Chimuara	Fixed	May 13
	Posto Campo	Fixed	Jul 13
	Lua Lua	Fixed	March
Morrumbala	HR Morrumbala	Fixed	2006
	Chire	Fixed	Oct 2010
	Muandiua	Fixed	Jul 2013
	Derre	Fixed	2011
	CS de Mepinha	Fixed	Jul 2013
	CS de Megaza	Fixed	Jul 2013
	Guerissa	Mobile Clinic	Oct 2013
	Pinda	Mobile Clinic	Sep 2013
Namacurra	Namacurra CS Sede	Fixed	2007
	Muebele	Fixed	Aug 13
	Macuse	Fixed	2008
	Malei	Fixed	Apr 12
	Mixixine	Fixed	Apr 12
	Furquia	Mobile Clinic	Feb 2013
	Umbaua	Mobile Clinic	Aug 2013
Namarroi	Namarroi	Fixed	Oct 2006
	Mutatala	Fixed	Sep 2013
	Mutepua	Fixed	May 2010
	Regone	Fixed	Jul 2013
	Mareia	Fixed	Aug 2013
	Mudine	Fixed	Aug 2013
Nicoadala	Nicoadala	Fixed	Jul 2006
	Licoar	Fixed	Dec 2012
	Maquival Sede	Fixed	Dec 2012
	Namacata	Fixed	Mar 2013
	Madal	Fixed	10-07-13

District	HF with ART	Type of ART	Start-up Year and Month
	Varela	Fixed	01-10-13
	Ilalane	Fixed	Jul 2013
	Alto Malanha	Mobile Clinic	Oct 2013
	Amoro	Mobile Clinic	Nov 2013
	CS Quinta Girassol	Fixed	March
	CS Maquival Rio	Fixed	March
Pebane	Pebane	Fixed	Jun 2006
	Nabur	Fixed	2010
	7 de Abril	Fixed	Jun 2006
	Alto Maganha	Fixed	Jul 2013
	Magiga	Fixed	Jul 2013
	Mulela	Fixed	Jul 2013
	Pele-Pele	Mobile Clinic	Aug 2013
	Tomeia	Mobile Clinic	Sep 2013

Table 8 - health units with ART in Zambézia (total 110)

62. This year DPS-Zambézia expects to expand ART to 50 (fifty) additional USs, as described in Table 8, below.

District	Open till 1 semester	Open till 2 semester	Open till 3 semester	Open till 4 semester
Quelimane	CS de Sangariveira			
A.Molocué	CS de Caiaia	CS de Ecole		
	CS de Chapala	CS de Novanana		
	CS Moiua	CS Nacuaca		
Chinde		CS de Madal		
		CS de Matilde		
Gilé			CS de Kayane	
			CS de Pury	
Gurué	CS de Muagiua	CS de Serra		
Ile		CS Chiraco	CS de Mulequela	
		CS Niboia		
Inhassunge		CS de Bingagira		
		CS Palane-Mucula		
Lugela	CS de Mungulune	CS de Puthine	CS de Muabanama	
Maganja da Costa		CS de Gurai	CS de Naico	
		CS de Alto Mutola		CS de Missal
Milange	CS de Majaua***	CS de Corromana	CS de Sabelua	
	CS Licirio***			
Mocuba	CS de Nhaluanda	CS Muanaco		
	CS de Magogodo			
Mopeia	CS de Lua-Lua	CS de Gulamo	CS Noere	
			CS de Catale	
Morrumbala	CS de Sabe	CS de Boroma		
	CS Chilomo	CS Fabrica		
		CS Muera		
		CS Machindo		
Namacurra		CS de Mugubia		
Namarroi			CS de Lipale	
Nicoadala		CS de longe	CS Quinta Girassol	

District	Open till 1 semester	Open till 2 semester	Open till 3 semester	Open till 4 semester
		CS de Maquival-Rio		
Pebane	CS de Malema***	CS de Impaca	CS de Muligode***	
Total	**14**	**24**	**11**	**1**

Table 9 - ART Expansion Plan - Zambézia (2014)
Source: DPS Z. * Mobile Clinics**

3.2 Niassa

63. This subsection is intended to offer a portrait about the situation of health in the province of Niassa and, like in the previous subsection, with focus in the area of HIV/AIDS, especially in what concerns the processes and challenges related with access to ARV treatment. This component of the report was prepared with resource to available documentation, to previous contacts made with DPS and some telephone contacts with stakeholders that operate in the health sector in the province.

64. The Economic and Social Plan of the Provincial Directorate of the Health in Niassa - in its introductory part - establishes some important considerations about the challenges that the province currently faces in this area, namely:

i) The index of infectious illnesses (including HIV-AIDS) is high and is aggravated by malnutrition levels (about this we will speak further ahead) given poverty rates in which the majority of the population live and the limited response capacity of the health system.
ii) Community involvement is still deficient, claiming for concrete actions in the health sector but also for a greater clarity in coordination actions between the several sectors in the province.
iii) The information produced by the information System is not always used for decision-making due to its poor reliability and to its delayed availability to managers.
iv) There are deficiencies in financial management and logistics aggravated by the incipient computerization of Sector activities and, deficiencies in Maintenance of the physical infrastructure, furniture, medical equipment and vehicles, and DPS staff do not have a proper culture of maintenance of its transport equipment.
v) The issue of Humanization and elevation of service quality is also a concern that should go side-by-side with the expansion of health care access. Currently, the quality of the user's attendance does not match their expectations in spite of the efforts of Humanization of the service.
vi) Other relevant constraints include: (a) the deficiency in Human Resources, (b) the decrease in the geographic coverage of infra- structures, in particular the Rural Health Centers of Type II, (c) the efficiency of the Medicines Warehouse, and (d) the absence of residences for workers.

65. These data were taken from PESP 2013 a time, as PES 2014 was not yet available for consultation at the time this report was written. Such delay is most probably related to the need that the sector has to adjust its budget and priority activities after the budget has been approved at central level and the undertaking of consultation meeting with sector partners in the province in order to cover the more pressing activities that went without budget funding. However, according to contacts made by the research team, the situation did not see significant changes since this PES entered into force.

66. As we have referred previously Niassa has, according to its PEP 2017, around 154 health units and only about 65% of these offer anti-retroviral treatment (ART). In 2012, of a total of 137 HUs only 27 provided ART services. In spite of the limited coverage ART has increased in about 28% (from 27 to 47). In 2014, ART was expected to be expanded to 128 additional HUs, but it was still not possible to advance with this goal due to difficulties of financial order because some partners had abandoned funding to the province. Currently, 47 HUs provide ART, out of 154. This represents geographically a presence of ART services in 9 of the 18 districts of the province (50% of the districts offer ART through its referral units).

67. Despite this being the province with the lowest prevalence rates at national level there are some elements of concern. The first one of them is that there is a high demographic growth in the province. In one hand, the original population of the province is growing, and, on the other, there are high numbers of *comers* that by various reasons (including the business potential) set residence in the

province. According to our interviewees these members of the population originating from other parts of Mozambique or outside bring together a different type behaviors and culture. Indeed, the population of the province grew in approximately 50% more since the last population census in 2007. Contacts made indicate that coupled to the demographic growth Niassa is a remote province, far from the rest of the country and with a high poverty rate, in spite of figures and statistics revealing a different situation. All this adds-up to the risks in the battle and prevention of HIV/AIDS. The organization RENASCER à Vida (reborn to life), a local CSO, is currently carrying out community testing in the City of Lichinga. From January to June 2014, they tested around 7169 individuals, and 711 of them tested positive. Considering that the City of Lichinga has currently approximately 320,000 inhabitants one does not need to a sophisticated mathematical expert to be tempted to conclude that one in 10 people in the City of Lichinga, is infected by the HIV virus. This is a figure below the national average, but claims for an urgent intervention for to mitigate the situation.

68. Some districts offer additional concern due to their economic-social and geographical situation. These are the districts of Mecanhelas (corridor are), of Cuamba (as result of the recent investments in the economy and infrastructure and because it is most important commercial centre in the province), Mandimba (it is located in a border area and has high business levels) and the Lake (also a border area). However, the priority districts of the province are Cuamba, Marrupa, Lichinga, Mandimba and Lake (please, see the explanation about the Spectrum software referred in the previous subsection).

69. On the contrary to what happens in the sector in Zambézia (DPSZ) and in spite of the effort of the DPS-Niassa to expand ART, the training of the technicians, nurses and agents and health in ART still is carried out in an *ad-hoc* manner. ART training still is organized in a sporadic manner. At the level of institute of health sciences in Niassa the only related training that the health personnel receive in the provision of psychosocial support to patients. However, this training is still less comprehensive as it only provides general instructions on the procedures to follow when an HIV patient is received. Additionally, the province has a high staff turnaround rate - this, by the way, is an issue in all sectors in the province and in the country - further impacting the quality of ART services provided. What happens is that once the health professional becomes familiar and experienced in the provision of the treatment is transferred to another HU or district and the new technician often does not have the required qualifications and experiences for providing treatment, thus, affecting service quality.

70. As we have referred, Niassa is a province that faces serious malnutrition problems as a result of poverty. This situation is aggravated by the fact that many patients have fallen in treatment economic failure due to their lack of working capacity due to HIV/AIDS symptoms and, consequently, face nutrition related difficulties This originates serious concerns with the current Tenotovire treatment, because this drug, due to the nutritional deficiency of patients, has been causing collateral damages such as blindness, paralysis, etc., leading people to drop out of treatment. Another negative effect of malnutrition in this context is that the civil society organizations and community agents that work in promoting adherence to treatment are confronted, in one hand, with the responsibility to motivate patients to stick to treatment, and, on the other, they are perfectly aware that side effects resulting from adherence, given malnutrition, is only going to worsen the patient's situation.

71. Like in Zambézia, the issue of accessing drugs is also a challenge. In a recent past there have several cases of drugs *stockout*, and patients had to travel 15 - 20 km to access ART in the referral unit. Upon arrival to the referral unit often drugs were not available leading some patients to give up on treatment. Because the *procurement* of ARV drugs is done centrally from Maputo and DPS had difficulties in ensuring efficient transport from Maputo to Niassa (staying for almost three months without receiving medicines), recently FHI 360 (with support of USAID) made available trucks to transport the medicines. However, the sustainability of this solution is questionable as - and in line with the challenges stated in the PES above referred - DPS has not being able to manage and maintain its fleet. There have been many accidents with transporter vehicles and ambulances. Once these vehicles get involved in accidents DPS does not have the conditions to recover damaged vehicles. Another matter of concern that adds-up to the distribution system, both in Zambézia, as well as, in Niassa is the current of political-military tension situation which is being felt largely in the center of the country. However, the province of the Niassa is where more risk areas has as it is here where RENAMO has the majority of its former military bases. Indeed, at province level, there is a discussion and concern starting to arise because of this matter.

72. Community involvement is one of the priorities of the DPS and it essentially will activate and mobilize the health community councils in the localities and administrative posts. DPS data indicate that, in 2012, 74 health Committees were established, and 115 health units had co-management Committees. In the context of said revitalization DPS data indicate that Niassa has 97 APEs in operation and expected to increase this number to 197, in 2013. One of the people interviewed indicated that the co-management Committee has shown good results, especially in Mandimba, whose case of success will be replicated in Muembe and Lago.

73. Recording issues are also a reality at various levels in Niassa. Data on services provided and kits offered are still not reliable. As an example, is possible go to the pharmacy of a certain health unit and find a number of patients registered in ART, go to the register of patients attended and find a different number (...) different figures may also be found at the level of the SDSMAS and of the DPS. There is a need of standardize the process of collecting and analyzing data and the scoring card foreseen within SAKSAN may help in this sense, since this is not a problem that can be resolved by the mere adoption of data processing technology.

74. The relationship between civil society and the Government / DPS has been registering significant improvements. For example, in the case of SAKSAN, the project was first presented to the provincial Government and this facilitated the interaction with the DPS. After some requests for clarification at DPS level, it showed openness to the initiative and has even suggested that it is initially implemented in Marrupa, Maúa and Muembe, with a possibility to expand it to other localities of reference.

75. Civil society in the Niassa also holds two annual meetings with the Provincial Assembly where the concerns around development pillars (including health) are expressed and discussed. The AP, on its turn, communicates to the provincial government the concerns expressed by civil society. However, this body has limited capacity to issue binding recommendations to the Government, and this is the situation found in the rest of the country.

76. At Development Observatory level several civil society and cooperation partners in the province have advanced positive comments regarding the increasing openness of the government to discuss matters related with the performance of the provincial executive in the pursuance of PARP and PESOP. In health such improvements include more regular meetings with the focal points, with traditional doctors, with community leaders and with the ART management Committees.

3. The Public Resources Management Process at Province Level

77. This section - and subsections that follow - aims to establish the public resources management processes in Mozambique, specifically at provincial (and district) level. In Mozambique the public resources management cycle also is also designated by Planning and Budgeting Cycle and comprises the following phases:

i) Strategic Planning;
ii) Budget Preparation;
iii) Budget Execution
iv) Accounting & Reporting;
v) External audit;
vi) Policy Analysis and Review.

Table 10 - Planning and Budgeting Cycle

78. This cycle is not designated as such by the law but this is the definition used and it is in line with international budget analysis concepts.

79. Concern Universal also uses, for the purpose of social accountability, the terminology created by the PSAM (Public Sector Accountability Monitor[25]) part of the Faculty of journalism of the Rhodes University, South Africa (please, see figure 3, below).

Figure 2- Social Accountability Cycle - PSAM Model

80. The first phase of the referred cycle (PSAM Model) includes all of the aspects of strategic and annual planning and budget preparation, but the following phases are practically the same in terms of content, with a slight difference in designation. To talk about the planning and budgeting cycle and/or speak about the social accountability cycle is speaking about the same matter in two different perspectives. The first it is more a perspective of process and public language, the second, expresses a more human rights approach perspective and of satisfaction of social needs. Any one of these is perfectly applicable to the kind of initiative that SAKSAN represents, however, the team opted to use a more general

[25] Idem, Art. 26.

cycle which will, certainly, especially during the training process and advocacy use a mix of both approaches as it is deemed best.

81. SAKSAN's Theory of Change (ToC) assumes that civic participation in each one of the phases of the public planning and budgeting cycle, starting from understanding how the process works, is one of the foundations for demand side actors to contribute for improving supply-side actors' performance.

3.1 Strategic Planning

82. This stage of the process - led mainly by the Ministry of Planning and Development (MPD) - produces the medium and long term political agenda of the Government and seeks to establish the connection between such agenda and the medium term expenditure framework. This is done by balancing the political goals (shopping *lists*) and the forecast of expenditure and required revenues to affect such expenditure. In Mozambique, this process results in the preparation of the strategic poverty reduction document, the PARP, the PQG (the Government's Five-Year Plan) and the Sector, provincial and District Strategic Plans (where applicable). The political long term Vision (Vision 2025) is also one of the products of this process.

3.2 Budget Preparation

83. The budget preparation process is led by the Ministry of Finance (MoF) and here the budget for the following year is prepared with reference to a macroeconomic medium term expenditure framework the CFMP, in a process that initiates with the MoF determining the expenditure ceiling and providing guidelines on the preparation of the budget for the coming year with specific expenditure ceiling guidelines for each relevant sector/institution. Each institution/level/sector prepares its budget proposal and submits to MoF for the purpose of approval, following a moment for discussion of the budget proposals (also known as budget defense or negotiation). Since 2012 that this process began being carried out at province level opening room for more interaction amongst the several provincial public entities around planning and budgeting[26].

84. After the end of the process of defending or negotiation of the budget proposals are finalized (including the proposals of provincial PES and Budget) and submitted to the approval by the Council of Ministers, which will do this until mid-August. The Council of Ministers approves the final draft Budget (including all state institutions at central, provincial and district level) and submits it to the Assembly of the Republic for approval purposes until 15 of December each year.

85. Another important aspect is CFMP. If in one hand, this instrument is important for forecasting expenditure and revenue for the three following years, on the other, there are still limitations on its effective use at all levels. Many entities claim that it is still very hard to use this instrument and that it is not actually used as a reference for annual planning. Accordingly for the CFMP to become an instrument that serves its purpose, the country should embark in a serious program budgeting process and then it will become easier to identify priority areas in the OE.

3.3 Execution

86. Once the Budget is approved by the Assembly of the Republic, expenditure can begin to be implemented in line with a process defined by the Law of the State's Financial Administration System (SISTAFE). This process is rolled out in five phases, namely the authorization (expenditure shall be made in line with their specific budget line and period determined in the OE and as approved by the AR), commitment (where agreements are made between public entities and third parties to undertaking program expenditure), verification (in order to ensure that the goods/services received have the required quality and conditions), authorization of the payment and Payment (where the funds are transferred directly from the institution's to the supplier's bank account.

87. The intention of this subsection is not address in depth all of the elements of the process the execution process or of the planning and budgeting cycle, but we must refer that:

[26] LSISTAFE, Art. 27.

i) Units with their own budget to manage (UGB) only begin executing the budget upon receipt of written communication issued by DPPF about the actual budget allocated;
ii) The Budget made available is often lower than the proposal submitted, both at DPS level, as well as at the level of District Administrations;
iii) part of SDSMAS's budget is covered by the PESOD's budget which means that district services have little autonomy to ensure that all priority actions have budget coverage;
iv) DPS (as happens with all of the sectors in the province) operates on the basis of the e-sistafe, but the district services do not have e-sistafe and their budget is executed using e-sistafe point that exists at District Administration offices.

3.4 Accounting and Reporting

88. This phase is, in one hand, designed to monitor the commitments of committed and actually paid expenditure. Accounting is the instrument used to undertake monitoring as it involves the recording all transactions made by the State. The e-sistafe is the computer platform which processes all accounting operations of State institutions. in a Quarterly basis, actually 45 days after the end of each quarter budget execution reports are issued by the MoF (REO)[27] and 5 months (May) after the end of the previous exercise the government (again MoF / DNCP) issues the General State Accounts (CGE) that has to be submitted to the Assembly of the Republic (AR) for describing the results and budget execution performance for the purposes of verification of the compliance or not with the originally approved Budget.

89. Accounting and reporting in Mozambique are made in line with the classifiers indicated below, depending on the purposed and requirement that information is intended for[28]:

i) Economic Classifier, classifies expenditure in economic categories as, for example, expenditure with personnel's or with goods and services;
ii) Administrative or Organic classifier, classifies expenditure according to the administrative responsibility of who has to manage and execute expenditure;
iii) Functional classifier, classifies expenditure according its objective, for example, amongst other, health, education, social security and housing; and
iv) Programmatic classifier classifies expenditure according to Government programs, for example, HIV/AIDS, Child, Gender, etc. This classifier surpasses the limits of an institution or specific sector. In case of the HIV/AIDS, for example, the reduction of the prevalence rates is not limited to the Ministry or institutions of the Health sector, however, because it is a cross-cutting aspect, embodies a series of activities that must be developed by institutions of several sectors.

3.6 External Audit

90. Audit is a crucial phase of the PFM Cycle to ensure an effective accountability by entities with public resources management and service provision responsibilities. Public external audit is also an essential part of an entire oversight system, which also includes the Administrative Court (in the quality of external audit body and Supreme Audit Institution in Mozambique), the Assembly of the Republic (in the quality of supervising body and with powers of request specific actions on the part of the Government and other bodies and mechanisms of control established), and at more decentralized level the Provincial and Municipal Assemblies). The Ombudsman, in the quality of warrantor of the observance of human rights, also should be considered an oversight body for social accountability purposes.

91. The Administrative Court, in addition to working as the SAI and an actual administrative Court exercises prior control public contracts and undertakes an important audit function through the pre-verification:
i) Of the existence of deviations regarding the practices and acceptable public management standards; and

[27] Idem, Art. 28.
[28] *In* www.portaldogoverno.gov.mz.

ii) Of the existence of eventual irregularities to the principles of legality, efficiency, efficacy and economy of financial management, and it has powers to force the adoption of applicable corrective actions.

92. The TA, has the mandate to audit the General State Accounts, and submits its analysis and opinion about the CGE - which represents a true audit report of the CGE - to the Assembly of the Republic (AR) once a year. The problem is that the current parliament calendar does not allow the AR to analyze this report and opinion until two years after the financial year. This means that so far, the AR does not function, with effect, as a true oversight mechanism of the performance of State bodies in the execution of the OE. The report and opinion of the TA on the CGE is analyzed by the Plan and Budget Committee, which afterwards submits its report to the plenary for discussion and decision regarding approval of the CGE. In addition this, so far the AR also does not have any formal relationship established with the entities that perform control and audit functions in Mozambique. However, the legal framework opens room for this interaction by establishing that the Administrative *Court and the administrative courts may undertake, whenever deemed appropriate, by own initiative or by request of the Assembly of the Republic or of the Government, audits of any kind or nature to determined actions, procedures or aspects of the financial management of the entities submitted to its financial control powers* (See, please, the Law of the 3ª Section of the TA, Article 50).

3.6 Policy Analysis and Review

93. This last stage of the budget cycle is focused in the assessment of government policies and way it is applied in order to produce lessons and findings that can guide any needs of change or adjustment of policies, taking into consideration relevance, efficacy and efficiency elements of such policies. The responsibility for this function is not clear in the Law although it seems to us that it is relevant to underline that part of this function is covered by monitoring visits by the AR committees and by the Annual Joint Review visits. In truth, the process for policy review is an important point of entry to influence national policies by using the evidences produced by SAKSAN, thus, it is important that this program interacts with the events above referred.

4. Conclusions & Challenges

94. The Provincial Development Observatory is an important space for dialogue. In addition to the Development Observatory there are mechanisms for dialogue at district level: the local[29]consultative councils, which are local bodies established to discuss local issues. Local consultative councils are comprised of community elected members, influential people and opinion leaders and, by representatives of the district services. The purpose of these spaces is to discuss aspects related to the development of the district (including planning aspects and sharing of information) and, more recently, the process of analysis and approval of beneficiary of projects funded by the District Seven Million Fund. Any of these spaces have limitations related with the effective participation of the civil society representatives around health issues at this level.

95. The previous sections had the objective to contextualize the scenario in which the SAKSAN is in and to produce a portrait about the processes, mechanisms, actors and spaces of participation in health at national level and at the level of the two target provinces. These sections drew considerations about the situation of health in Zambézia and Niassa, about the legal-framework about health and participation in the country.

96. The previous sections also undertook a discussion about various nuances related with the provision of ART in Mozambique and in the two target provinces. Some challenges are raised and the first subsection seeks to objectively (re) address these. To second subsection of this section calls into discussion the risks initially presented during program design, and addresses these risks and attempts to frame them into the discussion carried out along this baseline. Regarding these risks some recommendations are made.

Sector Challenges

97. As one can conclude from this report the health sector in general, and the area of ART / PMCT in special, faces several challenges related, namely, with:

(i) The issues associated to the **drugs** are related to three fundamental aspects. The first is related to the availability of drugs for undertaking ART. The second has to do with the conditions for storing and transporting medicines from Maputo to the provincial warehouses and from these the health units in the districts. Another challenge that this report does not underline, but that has been reported by other documentation, is related to the distribution of drugs whose validity has expired, greatly affecting the quality of treatment and often worsening the patient's health;

(ii) The health sector in Mozambique and in the two target-provinces face difficulties related with their **capacity** to adequately provide the services that they are meant to provide. In one hand there is the issue of insufficient human resources (both in terms of quantity and qualifications). On the other hand, there is a limitation of available financial resources for the fulfillment of the mandate of DPS and HUs. Limited capacity to purchase and maintain diverse equipment is coupled to this issue. All these elements have negative impact on the efficiency, efficacy and quality of health services;

(iii) Another challenge that is not clearly raised by this report is perceived **Corruption** in the health sector. Accounts of several studies portray this matter in an exhaustive manner and have appointed for corruption cases in the area of procurement of medicines and the requesting of illegal fees to patients and users. The role that entities such as the AR, PGR/GCCC, IGF, TA and, amongst others, the Inspectorate of Health is crucial to mitigate the problem and that any irregular situations are channeled for appropriate correction and resolution;

(iv) The current **political-legal-institutional** framework regarding civic participation is generic - and it makes sense to be like that. The Constitution of the Republic, LOLE and its regulation, LEBOFA and other norms pertaining to the interaction between public administration bodies and citizen/communities establish that citizen participation is important for good Public Resources Management. However, a significant gap related to civic participation is the lack of objectivity by the relevant legislation. That is, if in one hand the legal framework establishes the principles of

[29] LSISTAFE, Art. 50.

participation and transparency in Public Resources Management, on the other, it does not seem to us that the current framework has been successful in establishing and determining how such participation can be effected - with due exception of the right to submit petitions foreseen by the LEBOFA. The provincial and central level DOs and the local consultative councils are spaces (institutions) created for dialogue between the various social actors, however, the existing literature indicates some faults of the current framework;

(v) Oversight bodies (such as the AR, the TA, the APs, the AMs, IGF, the Ombudsman, amongst other) are bodies that have the mandate to hold executive accountable for the way they use public resources, in the same way that the Government is accountable to the AR or gets audited by the TA. In one hand, the country has been registering at province level an increasing interaction between civil society and Provincial Assemblies, and, on the other, at central level, this relationship also has been strengthened between the AR and the FMO, for example, and parliamentary journalists, in an attempt of establishing communication ties between oversight / inspection bodies and civil society. However, there isn't still any interaction between the SAI (in our case the TA) and civil society, and this is important in terms ensuring transparency and access to reliable and quality information. It is, therefore, crucial to reinforce the **interaction between oversight bodies and civil society** around Public Resources Management issues.

Risks for SAKSAN

98. To analyze the risks to social accountability initiatives one has to do so bearing in mind the factors that favor social accountability. Such factors include access to information, willingness / capacity of demand side actors to promote accountability and interaction with supply-side actors and vice versa. The proposal submitted by Concern Universal for the purpose of this project refers, thus, to risks which may prevent achieving SAKSAN's goals and objectives. The Table bellow addresses these risks by component:

Component	Risks Identified	Observations
1. Increase the capacity of CSO/CBO to engage in social accountability	Will and commitment of CBOs / CSOs in carrying out social accountability work	In Mozambique, the intervention of civil society is starting to show some development. Civic groups however still play a "provider" role in which they replace the role and responsibility of the State in the provision of services. This is often justified by lack of quantitative capacity by the State in providing services. In the area of ART and PMCT, for example, we are will find more organizations, civic or voluntary groups providing home care, counseling or encouraging to testing and adherence to treatment. This work is useful and important but it is urgent that a commitment is also made towards the promotion of a more transparency and access to information on how public resources are used in health or about the performance of health services. This is an approach that may lead to some degree of conflict, and may also imply possible political connotation of those demanding data and information. For that reason there is a significant risk that the will of civic participation and engagement may be compromised by this fear. To address this issue, the training process should focus towards raising awareness on social accountability as a human right (aligned with high-level regional and international documents about the rights of the man and with the Constitution of Mozambique) rather than a political right.
	CSOs / CBOs committed with internal governance	Many of the organizations that operate in the country, mainly local organizations have been associated to have less democratic internal practices (less transparency, poor communication between members, etc.) and have been

Component	Risks Identified	Observations
	democratic principles	nicknamed as one-man-show organizations. The risk is moderate, but we believe that civil society should lead by example and it would not make any sense to demand for better governance if one does not respect - internally - the same principles being advocated. To overcome this risk SAKSAN, proposes the undertaking of an analysis of the profile and training needs of beneficiary organizations and adapt a training package in internal governance for all beneficiary organizations (this training process will be accompanied by analyzes in profile/needs before/after training).
	All stakeholders available to participate actively in the baseline	The agendas of the organizations and State representatives do not always reconcile with that of the baseline. By coincidence, a significant part of the exercise was carried out on the ground during the Presidents open presidency visit. This has serious implications in the availability of State officials and staff to speak with the baseline team. However, a large part of the information also results from reviewing relevant existing documentation. Furthermore, part of the baseline data will have to be collected after the beginning of the implementation due to the unavailability of relevant information at the moment this exercise was carried out.
	All of the participants available to participate in sessions - including gender balance	The risk that exists here has basically to do with the following issues: • Will the training dates not coincide with other responsibilities of the participants? It will be necessary to assure that the training dates do not coincide, mainly, with specific moments of the agricultural season as most of the members of the beneficiary organizations live off agriculture; • Are access roads favorable for the punctual and assiduous participation of selected trainees? There is the risk of, in one hand access roads not being favorable and high transport and accommodation price issues arise, since it will not be possible to organize training sessions in each of the individual target districts selected. Another issue adds-up: the risk of training dates coinciding with the raining season and, consequently, affecting the level of participation. • Will it be easy to involve more women - considering their specific responsibilities and the local culture - in the process of training? Will it be possible to move participants to training venues even when it is far from their normal areas?
2. Increase engagement between demand and supply side actors around the quality of the ART and MCT services	The Decentralization Agenda remains a priority for the Government	If in one hand social accountability initiatives aim to promote better governance, these can be an important tool to ensure the fulfillment of the Government' decentralization goals. However, it is necessary to ensure that civic participation is an effective component of decentralization policies and priorities.
	Political will of some Government officials to collaborate with civil society	This may pose, indeed, a serious risk. Lack of collaboration with civic groups may require some creativity to advance with important necessary activities. However one must assert that the team received an expression of support from MISAU (central level), and of both Provincial Directorates of health in the target provinces which open room for action. It will be necessary to ensure that all stakeholders are kept up-to-date with the steps taken in the context of SAKSAN.

Component	Risks Identified	Observations
	Availability of relevant public documents	Access to information is a cross-cutting factor in any one of the project stages. Any activity that is not properly informed by evidence is, in principle, doomed to fail. Informal and formal mechanisms to access and consult information shall be promoted.
	CBOs / CSOs' social accountability engagement capacity	In general, the concept of social accountability is still new in the country. See, for example, that no existing official documents use this concept so far. There are few social accountability initiatives led by civil society. Specifically, such initiatives involve undertaking work with plans and budgets, procurement monitoring, amongst other techniques which are, most of the time, not the strongest skills of the people involved in project activities. It expected that this risk is going to be significantly reduced during the training process, which will in a very simple and adequate manner support participants in the use of these tools.
	CBOs/CSOs show interest in producing evidence	Producing evidence and using it can be laborious. The support of the project team in collecting and analyzing evidence will be relevant to mitigate this risk.
	The Decentralization Agenda and participation mechanisms remain a priority for the Government	This aspect already was addressed in component 1, above.
3. Knowledge & Learning	The CBOs/CSOs that work in social accountability in the health sector are willing to share and recognize mistakes and learn with these	This is a risk that may affect also the project team. In order to ensure that the groups working with the project recognize when they are "*riding a dead horse*", the project will (a) provide support, assistance and necessary guidance during implementation; and (b) follow closely the implementation and discuss with the partners adequate forms of intervention.
	Politically favorable environment in Mozambique	Currently, despite of the circumstances referred to along this report, it is possible to assume that conditions are created for a favorable implementation of project activities. However, this, and other social elements constitute a factor that fall outside the control of the SAKSAN team.
	Favorable environment of freedom of the press and freedom of speech	The same as above.
	Capacity, skills and time made available to producing documents	The project team should dedicate room to capture and analyze data/information and to capture lessons learned on project implementation. Because learning is a process that requires time, discussions will be held within the team and with implementation partners to review the actual situation of the project.
	The Assembly of the Republic willing to remain open to work with civil society	This risk is considered limited since this has been the tendency in the way the AR's work has been evolving. The same can be noted a bit throughout the country at the level of APs and Municipal Assemblies. However, this is an element that is out of control of the SAKSAN team.

Table 11 - Risks Identified by Component of the SAKSAN

99. SAKSAN's approach will have to focus in the establishment of a valid and recognized ecosystem (spaces, environment and mechanisms) that promote a culture of social accountability that effectively influences access to public services and to quality services. There are accounts of social accountability initiatives that contributed to improving the interaction between users - service providers and the quality and access to health services, because today, it is generally accepted that a socially accountable governance environment contributes to improve service provision, the legitimacy of public actions, the increase of revenue collection, and to greater stability and development.

100. SAKSAN aims to achieve change - to demonstrate that initiatives which promote increased participation is useful to improve monitoring and follow-up of the quality of public services and is not a responsibility or effort reserved solely to public entities.

101. The reports that SAKSAN will produce will be crucial to analyze the implementation of activities and the achievement of expected goals. Reports will also be produced by the organizations/groups responsible for implementation on the ground. Each activity carried out in the scope of the SAKSAN will be registered and analyzed by the project team in order to ensure the compilation of lessons learned and its use during the project life-span.

ANNEXES

Annex I List of Interviewees (by order of contact)

No.	Name	Entity / Institution	Position
1	Luísa Cumba	DPS	Provincial Director
2	Dercio Filimao	DPS	Provincial Director's Advisor
3	Dr. Oscar	DPS	Head of Medical Assistance
4	Bárbara Matos	DPS	
5	Rodolfo Henriquez	Visao Mundial	Deputy-Head of Ogumaniha
6	Lizete Pagere	ICAP - Zambézia	Advisor to the MCH Program SMI
7	Dr. Vicente	Rural Hospital of Nicoadala	Head Medical Doctor
8	Sr. Zezela	Development Observatory of Zambézia	Vice-Chairman SAMCOM-Quelimane
10	Anabela Lucas	RENASCER	Coordinator
11	Jorge Cardoso	NANA-Mocuba	Coordinator
	Members of the Co-Management Council of Nicodala		
12	Francisco António Torneiro	Igreja Assembleia de Deus	Representative
13	Manuel Daselo	Mulohove	Regulo (tradicional leader)
14	Carla Conceição	MOLA	Member
15	Inacio Marques Messias	Bairro Botão	Community Leader
16	Estevao Celestino	Bairro Supinho	Community Leader
17	Melo Madal	AMETRAMO	Member
18	Maria Araujo	Community Member	
19	Amancio Trigo Colha Mudesa	ANANI	Member

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