CSOs and SWAPs

The role of civil society organisations in the health sector in Mozambique

By

Randi Kaarhus and Pamela Rebelo

Noragric Report No.16
September 2003

Noragric
Agricultural University of Norway

Noragric is the Centre for International Environment and Development Studies at the Agricultural University of Norway (NLH). Noragric's activities include research, education and assignments, focusing particularly, but not exclusively, on developing countries and countries with economies in transition. Besides Noragric's role as the international gateway for NLH, Noragric also acts on behalf of the Norwegian College of Veterinary Medicine (NVH) and of Norwegian Agricultural Research International (NARI), which form alliances with NLH.

Noragric Reports present findings from various studies and assignments, including programme appraisals and evaluations.

This Noragric Report is the result of an assignment commissioned by the Norwegian Agency for Development Cooperation (NORAD) to Noragric (see Terms of Reference in Annex I). The contents of this Report will also appear in a NORAD publication.

The findings, interpretations and conclusions expressed in this publication are entirely those of the author(s) and cannot be attributed directly to the Centre for International Environment and Development Studies (Noragric/NLH).

Kaarhus, Randi and Rebelo, Pamela. CSOs and SWAPs -The role of civil society organisations in the health sector in Mozambique.
Portuguese translation by Jorge and Pamela Rebelo
Noragric Report No. 16 (September, 2003)
Noragric, Centre for International Environment and Development Studies
Agricultural University of Norway (NLH)
P.O. Box 5003
N-1432 Ås
Norway
Tel.: +47 64 94 99 50
Fax: +47 64 94 07 60
Internet: http://www.nlh.no/noragric

ISSN: 1502-8127

Photo credits: J.B. Aune, I. Bryceson, P. Wisborg
Cover design: Spekter Reklamebyrå as, Ås
Printed at: Rotator, Ås

CONTENTS

ENGLISH SECTION

ACRONYMS

ADEMO	*Associação dos Deficientes Moçambicanos*/Association of the Disabled
AMETRAMO	*Associação Nacional dos Médicos Tradicionais de Moçambique*/ Association of Traditional Doctors
AMODEFA	Mozambican Association for the Defence of the Family
APE	Community health worker (Basic Polyvalent Agent)
APN/NPA	*Ajuda Popular da Noruega*/Norwegian People's Aid
CCM	Christian Council of Mozambique
CISM	*Centro de Investigação em Saúde*/Health Research Centre (in Maniça)
CBO	Community-based Organisation
CSO	Civil Society Organisation
CVM	*Cruz Vermelha de Moçambique/*Mozambican Red Cross
DANIDA	Danish International Development Assistance
DDS	*Direcção Distrital de Saúde*/District Directorate of Health
DPAS	*Direcção Provincial de Acção Social/*Provincial Directorate of Social Action
DPS	*Direcção Provincial de Saúde/*Provincial Directorate of Health
FDC	Community Development Foundation
GoM	Government of Mozambique
GTP	*Gabinete Técnica de Planificação*/Technical Planning Office
GT-SWAP	*Grupo de Trabalho SWAP: MISAU – Doadores*/MoH–Donors Working Group
HAI	Health Alliance International
HSRP	Health Sector Reconstruction Programme
HIPC	Heavily Indebted Poor Countries
IMF	International Monetary Fund
IPP	Integrated Provincial Planning
LINK	*Fórum de ONG's*/ NGO Forum
MAP	Millennium Partnership for African Recovery Programme
MISAU	*Ministério da Saúde*/Ministry of Health
MoH	Ministry of Health
MONASO	*Rede Moçambicana de Organizações contra SIDA*/ Mozambican Network of Organisations Against AIDS
MPF	Ministry of Planning and Finances
MSF	*Medecins Sans Frontiers*
NGO/ONG	Non-Governmental Organisation
NORAD	Norwegian Agency for Development Cooperation
NPM	New Public Management
PARPA	*Plano de Acção para a Redução da Pobreza Absoluta/*Action Plan for the Reduction of Absolute Poverty
PESS	*Plano Estratégico do Sector Saúde/*Health Sector Strategic Plan
PRSP	Poverty Reduction Strategy Paper
PSI	Population Services International
SCC	Sector Coordination Committee
SCN	Save the Children Norway
SDC	Swiss Development Cooperation
SNS	National Health Service
SWAP	Sector Wide Approach
TBA	Traditional Birth Attendant
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organisation

1. INTRODUCTION

This report is based on a case study of the involvement of civil society in health issues in Mozambique. It presents findings from this case study and raises a number of questions for further discussion. A central objective of the study has been to explore the roles of *civil society organisations* (CSOs) in relation to health sector programmes, and more specifically in relation to the *sector-wide approach* (SWAPs) to policy-making and planning in the health sector. The report does not pretend to present a comprehensive overview and analysis of the total field of interlinkages between Health and Civil Society in Mozambique. An important objective has been to *contribute to a broader discussion* of the potentials for a greater involvement of civil society organisations and target groups more generally in planning, monitoring, advocacy, and implementation at different levels of the health sector. A key assumption is that the involvement of a wider range of stakeholders in health issues will contribute to sector transparency and promote *sector accountability* to the people the health sector is there to serve. Thereby increased civil society involvement could also contribute to *improving the quality of* these *services*.

1.1 Background, purpose and key concepts

The case study presented here is part of a larger comparative study commissioned by NORAD. Its aim has been to explore the roles of civil society organisations in countries where NORAD has supported SWAP processes in the health and education sectors. A background document from the first phase of this larger comparative exercise discusses general principles and common assumptions concerning sector-wide approaches in development cooperation (Kruse 2002). Parallell case studies in Malawi, Uganda, and Zambia are presented in separate case-study reports (Kruse 2003a, Kruse 2003b, Lexow 2003).

Civil society

The concept of *civil society* carries with it a number of more-or-less realistic assumptions concerning the roles of different actors in modern states; assumptions that are often challenged by the social and political realities in post-colonial Africa. One of these assumptions is that *state* and *civil society have complementary roles* within society at large. On the international scene, the so-called *New Political Agenda* places this idea in a framework of neo-liberal political reform processes (cf. Kruse 2002). As part of a broader trend in economic and political thinking, this New Political Agenda includes a redefinition of the role of the state: That is, towards a policy-making, strategic planner, and facilitating role for the state, tending towards a state delegating more of policy implementation to other social actors. The role of being an active agent in *economic activities* should, according to the *New Political Agenda,* be transferred to the *private sector,* while the implementation of policies and the delivery of services in the *social sectors* to a greater extent should be transferred to NGOs or civil society organisations. In this context, NGOs, Civil Society and community-based organisations are also commonly seen as vehicles of *democratisation* through their capacity to counterweigh state power and promote pluralism.

Key concepts used in this report

SWAP
What defines a *SWAP* are arrangements making all significant (national and external) funding for a *sector* (such as the health sector) support a single sector policy and expenditure programme, agreed upon by all partners, but under Government leadership, leading to the adoption of common approaches across the sector.

Civil Society
As an operative agency, NORAD uses a definition of *civil society* as "the formal and informal networks and organisations that are active in the public sphere between the state and the family".
(Norwegian Ministry for Foreign Affairs and NORAD 2001)

NGOs and CSOs
The term *NGO – Non-Governmental Organisations* became common in the 1970s, referring to organisations that were separate from Government, usually value-based, non-profit, and established to benefit others. *Civil society* entered the development scene in the 1990s as a concept that covers a wider range of associative forms than 'traditional' NGOs. *CSO – Civil Society Organisations* include interest groups such as trade unions, churches, community-based groups, as well as professional institutions and independent media. In this report we use CSO and NGO as partly, but not totally overlapping terms.

Accountability
Accountability refers both to the *ability* to account for decisions, resource use, and expenditure, and the *willingness* to give such information. Institutions and persons in power positions and/or entrusted with collective resources are expected to provide information and be answerable. *Upward accountability* means to be answerable and provide information to superior levels of an institution or within a sector. *Horizontal accountability* refers to answerability and information-sharing at the same level of an institution – and across sectors. *Downward accountability* refers to providing information and being answerable to beneficiaries, target groups, citizens, electorate – in short, to the people.

Involvement and Participation
WHO operates with a definition of *involvement* that is similar, but perhaps more demanding and ambitious than what is usually understood with the term *participation. Involvement* implies participation, but not only in terms of being consulted at some point in a process, or making a contribution in cash or kind. Involvement as defined by WHO refers to participation both in defining problems and objectives, setting priorities and making decisions, and following up processes of implementation. This means that involvement will also include a sharing of responsibilities for results and outcomes.

Advocacy
Advocacy refers to acts and information-sharing that defend a cause or proposal, but also to making the views or problems of one social group known to other sectors of society. The term *advocacy* is commonly used with reference to a conception of basic *human and citizens' rights*. *Health advocacy* will include consciousness-raising, information, criticism, and cross-sector mobilisation and preventive action on factors that affect the health situation of individuals and communities.

Monitoring
Monitoring refers to keeping track of processes of implementation of policies and strategies, and checking how defined objectives are followed up in practice.

Watchdog role
A 'watchdog' role will usually refer to *civil society actors'* efforts to make governments accountable for decisions and actions, often with reference to human rights or international standards and conventions.

More generally, we also see that *civil society* is used as a normative concept providing a *vision of a desirable social order*. The fact that increasing numbers of people and institutions use this concept to orient their work can in fact strengthen this normative function. So far there is, however, only scattered documentation and relatively limited systematic knowledge available in this field. On this background, NORAD commissioned the larger comparative study that provides the framework for the present report. Our aim here is to make a realistic assessment of present roles and future potentials and challenges. We will try to move beyond describing *civil society* as an abstract whole with virtues that can be promoted through external agencies' interventions, or just pointing out the "weaknesses" of civil society in Mozambique at present.

The present report builds on an earlier and more general study of civil society in Mozambique, commissioned by NORAD in 2002 to provide a basis for decisions on future Norwegian support to Mozambican civil society organisations (Rebelo et al. 2002). Addressing some of the challenges involved in using the concept of civil society in a Mozambican setting, the former NORAD study pointed to the difficulties in identifying and characterising a *Mozambican civil society,* when there is no clear separation between the 'formal' and the 'informal', 'modern' and 'traditional', what is 'inside' and 'outside' the formal structures of the State (Rebelo et al. 2002). The study nevertheless identified two *contrasting types* of *Mozambican civil society organisations*. In between these two types of CSOs, some interesting 'hybrids' are emerging, but the dominant types seem to cluster at opposite ends of a spectrum:

- on the one hand, the essentially urban-based, professional NGO, modelled on foreign counterparts, and dependent on external donor funding
- on the other hand, the rural-based informal CSO, with no external funding and very limited economic resources.

The 2002 study points to some dilemmas in this overall picture: The more professional, urban-based NGOs, modelled on foreign counterparts and favoured by external donors, commonly appear as *trustee* rather than as *representative* forms of civil society organisations. They can hardly survive without outside support, and appear as less rooted in society than the informal, rural-based associative forms – which for formal reasons will hardly ever qualify for external economic support. The locally based rural CSOs, on their part, usually have a local constituency and on that basis need to be responsive to their members' demands. In this sense they can be characterised by a relatively higher degree of *downward accountability* than what characterises donor-financed NGOs. At the same time, it is important to keep in mind that the more professional 'trustee' CSOs in Mozambique appear to be in a better position to act as advocates, lobbyists, and watchdogs with the objective of *making State institutions more accountable* (Rebelo *et al.* 2002).

What appear as dilemmas in the 2002 study can, however, also provide a basis for a broader discussion of *different but complementary roles* of CSOs/NGOs within a plural civil society. For instance, during the interviews carried out in the present case study (see Annex 3) the following question was raised: *Are foreign-based NGOs working in Mozambique part of Mozambican civil society?*

There are different opinions on this point. Some interviewees said they are definitely not, others said it depends on how the foreign NGOs relate to the larger society. For example

foreign NGOs that are willing to be open and share their priority-setting and decision-making processes with Mozambican counterparts and other civil society organisations, could be considered part of Mozambican civil society.

The 2002 civil society study (Rebelo et al.) presented a set of surveys where people were asked to identify issues of major concern in their daily lives. In these surveys *health* actually came up as a predominant issue of concern. At the same time, the study points out that health is *not* among the main advocacy or engagement issues taken up by national CSOs in Mozambique. The national NGO Forum LINK has recently defined six main challenges for civil society action. Health in general is not one of these, although HIV/AIDS is.[1] One objective of the present report is, however, to bring up the issue of health for a broader discussion, and invite CSOs to take part in this discussion.

SWAPs

Since the 1990s there has been a general trend in international development cooperation to move away from direct *project support*, and develop mechanisms of programme and budget support. *Programme support* in social sectors, such as health and education, has commonly been linked to the development of *sector-wide approaches* (SWAPs) to policy-making, programming, and planning. A *SWAP* will generally involve:

(i) development of a *common vision* among key stakeholders in a reform process aiming at a broad-based development of the sector
(ii) agreement on sector *policies and strategies* by national stakeholders and international/donor agencies
(iii) development of transparent mechanisms of *priority-setting* and *resource-allocation* in the sector, including projections of resource availability and multi-year expenditure plans
(iv) establishment of *common management arrangements*, using national systems, to improve coordination of external assistance to the sector

A SWAP can incorporate different *financing instruments*, including pooling agreements, sector investment programmes, and sector budget support (cf. Cassels 1997, TAG 1998).

As *agreements* between partners seeking *to promote a broad sectoral development*, SWAPs can be justified on several grounds:

- a SWAP provides both a common framework and a set of agreements between central partners, primarily the Sector Ministry and external donors supporting the sector, and thereby promote *coordination* and *better use of resources* – for a common goal
- a SWAP provides a framework for the Sector Ministry and donors to *discuss policy and strategic planning*
- by establishing common procedures of financial management, a SWAP can contribute to *increased sector transparency and accountability*

The expanding role of SWAPs in key social sectors does not only concern technical money management. A Health SWAP also involves key sector policy issues, which in turn has made several donors bring up questions regarding:

[1] The six challenges defined were: Poverty reduction, HIV/AIDS, improvement of the judiciary, reduction of vulnerability to natural disasters, sustainable community-based natural resource management, and finally peace, national unity and democracy.

- *transparency:* which groups do actually have access to information about sector policies and priorities, except for the Government and the donors themselves?
- *accountability*: who is accountable? – to whom? – for what? – within the sector, to key target groups and to the public
- possibilities for increased *democratic participation* in important decision-making processes
- the *representation of views and interests* of different stakeholders and primary target groups (urban and rural) in Health-SWAP processes

These questions are also relevant if we see SWAP processes in Mozambique in the context of a broader international wave of public reform initiatives over the last 15–20 years. On the global scene, this wave of public sector reforms has been accompanied by an increasing influence of market models and neo-liberal democratic theory – the so-called *New Political Agenda*. Many governments now increasingly involve private sector and NGOs in social-service delivery, and new user fees have been introduced in different parts of the world. Drawing upon common ideas, *reforms within the public sector* have been promoted under the general term of *New Public Management* (cf. Hood 1991, Tranøy & Østerud 2001). Both PRSP and SWAP processes put some elements of New Public Management into practice. Of particular interest in this context are:

- The emphasis on budget frames and public expenditure control
- Explicit definition of goals, targets, and indicators of success – preferably expressed in quantitative terms
- Separation of roles and responsibilities between central and decentralized sector levels, between policy making and policy implementation
- A clearer definition of management roles and assignment of responsibilities
- Increasing use of term contracts and public tenders

It is generally agreed that a SWAP, through coordination of efforts and information-sharing among central partners, can contribute to increased transparency and accountability, both from the perspective of the Ministry and from external donors' perspective.

A SWAP arrangement can in this way strengthen *upward accountability* within the sector, and *horizontal accountability* among central partners. A question to be addressed here is, however, if a SWAP can also provide a framework for strengthening accountability towards civil society, primary target groups, and people in general – that is, contribute to a strengthening of *downward accountability.* When such topics are addressed, *organised civil society* is often identified as a potentially important stakeholder. Our discussion here will bring up the following question for further discussion: Will an expansion of the range of key stakeholders in health provide a framework for better, more democratic and more participatory decision-making processes on health issues? How should such a broader range of stakeholders be organised?

NORAD, as one of the long-term international partners in the health sector in Mozambique, has over the last years played an active role in initiatives towards pooling donor support to the sector, as well as in the step-wise process of introducing a more comprehensive SWAP arrangement. To follow up these long-term commitments, NORAD commissioned the present case study (see also Terms of Reference, Annex 1) in order to:

a) Review the roles of civil society organisations (CSOS) in health sector programmes:
    - as contributors to policy discussion and strategic planning processes
    - in advocacy, mobilisation, and lobbying
    - as service deliverers – in operative roles
    - in monitoring and 'watchdog' roles
    - as innovators – introducing new approaches and linkages
b) Present an assessment of current inter-action between government and civil society with regard to health challenges
c) Discuss the potentials and constraints for a more active involvement of CSOs in health sector programmes and activities at central, provincial and local levels, aiming at:
    - strengthening the involvement of primary target groups
    - promoting sector transparency and downward accountability
d) Initiate a discussion on these issues among national and international partners and among CSOs/NGOs with a potential for representing both key stakeholders and primary target groups.

1.2 Methods of work

The case study was designed within the framework of a broader comparative assessment of the roles CSOs could play in SWAPs in the social sectors of health and education. Information was collected through a review of relevant literature and key policy documents related to the health sector in Mozambique, combined with a series of interviews carried out in February and May 2003 by a team consisting of Pamela Rebelo and Randi Kaarhus, supported by Lise Stensrud, Counsellor of the Norwegian Embassy in Maputo. A first presentation of findings was given at the Ministry of Health in Maputo on May 14, 2003, in a meeting attended by Ministry of Health personnel, as well as by bilateral and international donors, and NGO representatives.

The team has concentrated its data collection during this case study to:

- Maputo – interviewing informants representing the central level:
    - in the Ministry of Health
    - bilateral donors involved in the Health Sector SWAP process
    - other bilateral donors in the Mozambican health sector (e.g. USAID)
    - international agencies (UNFPA, UNICEF)
    - foreign NGOs
    - national CSOs
    - independent researchers carrying out poverty and health-related work in communities
    - national umbrella organisations/networks (LINK, MONASO)

- The Province of Tete – interviewing informants representing:
    - the Provincial Health Directorate (DPS)
    - the Provincial Directorate of Social Action and Women (DPAS)
    - foreign NGOs based in the province
    - national CSOs and religious organisations
    - provincial-level HIV/AIDS organisations/centres

- The District of Maniça, Maputo Province – interviewing informants representing:
  - District Administration
  - District Directorate of Health (DDS)
  - Municipality of Vila de Maniça
  - Régulo in Maniça
  - a locally based Spanish-Mozambican health research centre (CISM)

- The locality of Hindane, District of Matutuine, Maputo Province, interviewing:
  - Red Cross (CVM) personnel involved in Community Health project
  - local health activists participating in a refresher course under the project
  - Health Center nurse

DANIDA advisors and staff, both at the Danish Embassy in Maputo and at the *Direcção Provincial de Saúde* (DPS) in Tete, generously provided support in planning the team's visit in Tete. APN in Tete and CVM in Maputo provided unfailing practical assistance during field visits. At the Norwegian Embassy in Maputo, Tahia Carim played a crucial role in organising the whole case study programme. The team members would like to express our sincere gratitude to all who assisted us in our work, and shared their knowledge, views and experiences with us.

1.3 Content of the report

Chapter 2 starts with a brief overview of health and poverty indicators and a description of different health service providers in Mozambique. It also presents observations on Mozambican civil society in general and, more specifically, civil society organisations' roles in health.

Chapter 3 gives brief overviews of initiatives that at present re-structure development approaches and relationships between international agencies, State, and donors involved in poverty reduction and health sector development in Mozambique, focussing on:
(i) the formulation of a national *Poverty Reduction Strategy Paper* (PARPA), and (ii) the processes leading up to the presentation of a *Strategic Plan for the Health Sector* (PESS).

Chapter 4 gives an assessment of CSO/NGO roles in the health sector in Mozambique, based on a *list of questions* which is also used in the case studies carried out in Malawi, Uganda, Zambia. The questions are draw from the more comprehensive NORAD-study background document *Civil Society and SWAPs* (Kruse 2002).

Chapter 5 presents a list of immediate and future challenges related to the further involvement of civil society organisations in health issues and health sector reform processes in Mozambique – as stakeholders and representatives of primary target groups.

2. COUNTRY CONTEXT

The national census and household survey completed in 1997 registered a Mozambican population of approximately 16.1 million.[2] With a national territory of roughly 800,000 km², the population density proved to be relatively low, close to 20/km². Projections for 2001 indicate a population of 17,6 million.[3] Estimates for 2005, taking into account the impact of AIDS, indicate a population of about 18,1 million people.[4] The data shows that some 70% of the population lives in rural areas and 81% of the economically active population is engaged in agriculture. A large part of contemporary Mozambicans, 45%, are under 15 years of age.[5]

2.1 Health and poverty indicators

At the time of the 1997 census, life expectancy at birth was 42,3 years but subsequent projections suggest that by 2005 this may fall to 35,2 years due to the impact of AIDS.[6] Official figures show that nearly 70% of the Mozambican population live in *absolute poverty*.[7] There is, however, considerable provincial variation: At the one extreme there is the Province of Sofala with an absolute poverty rate of 88%, and Tete and Inhambane with 82-83% of the population living in absolute poverty. At the other end of the scale is Maputo City, with absolute poverty affecting approximately 48% of the population. The same provincial pattern is reflected in the prevalence of extreme poverty or *destitution,* affecting 65% of the population of Sofala, and 53-54% of the population in Tete and Inhambane, but not more than 17% of the population in Maputo City.

For the adult population over age 15, illiteracy rates in 1997 was 33,3% in urban areas and 72,2 in rural areas, while female illiteracy in rural areas was as high as 85%. Over the last years, however, increasing numbers of children are able to attend schools, with a gross primary-school enrolment rate reaching 91% in 2000 (Republic of Mozambique 2001). Over the last years considerable economic growth has also been recorded, above all benefiting the southern provinces close to the capital. Annual GDP growth reached 12,1% in 1998, sinking to 2.1% in 2000 (due to the devastating floods in the south of the country that year), then returning to an estimated level of 12,2% in 2002 (Country Profile 2002).

The Ministry of Health (MoH) in its Strategic Plan 2001–2005 presents an overall picture of the population's state of health as very much conditioned by the present level of socio-

[2] INE (1999) II Recenseamento Geral: Indicadores Socio-Demográficos.
[3] INE (1999) Projecções Anuais da População por Província e Área de Residência 1997-2010.
[4] INE (2000) Impacto Demogáfico do HIV/SIDA em Moçambique.
[5] INE (1999) II Recenseamento Geral: Indicadores Socio-Demográficos.
[6] INE (2000) Impacto Demogáfico do HIV/SIDA em Moçambique.
[7] The 1997 National Household Survey on Living Conditions (reported in "*Understanding Poverty and Well-Being in Mozambique, the First National Assessment", 1998*) established 13 region-specific per capita poverty lines based on the sum of a food poverty line (based on nutritional standards of approximately 2150 calories per person per day) and a non-food poverty line. The poverty lines reflect a level of per capita consumption expenditure considered to be consistent with *meeting basic consumption needs*. Households whose basis consumption was below the poverty line were considered to be *absolutely poor*, while those with a consumption below 60% of the poverty line were considered to be "ultrapoor" or *destitute*. In monetary terms the national poverty line was 5.433 Mt per person per day (cited in the PRSP document *Action Plan for the Reduction of Absolute Poverty 2001-2005),* and the survey found that *average consumption* in the country was less, 5.285,92 Mt per day, making for a monthly per capita consumption of 160.780 Mt equivalent to US$ 170 at the exchange rate prevailing at the time of the survey.

economic development in Mozambique – as reflected in the poverty indicators given above (PESS 2001). The health sector is faced with an epidemiological situation dominated by *communicable infectious diseases*, such as malaria, diarrhoea, respiratory infections, tuberculosis, in addition to HIV/AIDS. 1997 data show that malaria accounts for 15% of registered illnesses, and tuberculosis is a major cause of hospitalisation in rural areas. The indicators for maternal and child health in Mozambique are among the worst in the world, with a maternal mortality rate of 1,5% in 1999. One of 6 children have low birthweight, due to the mother's poor nutritional status. Infant mortality rate ranges from 183/1000 in the Province of Zambezia to 60/1000 in Maputo city. Child (<5) mortality in the country as a whole is calculated to 219 per 1000 live births, and 43% of children under 5 suffer from chronic malnutrition (PESS 2001).

These indicators reflect a health situation that presents serious challenges to the health sector as a whole. They indicate the need for a continued emphasis on preventive measures against communicable diseases, as well as the need to focus on reproductive health related activities, and show the importance of efforts to prevent illness through health advocacy. They also emphasise the need to strengthen basic health care services and community health programmes – especially in rural areas and in the most disadvantaged provinces. In a regional context, the Mozambican health indicators are still relatively poor. But in contrast to some of the neighbouring countries, in Mozambique many indicators, except for HIV/AIDS, have actually improved over the last decade (see 2.3).

2.2 The challenge of HIV/AIDS

Like other countries in the region, Mozambique has over the last years been forced to respond to the challenges of the HIV/AIDS epidemic. The spread of HIV/AIDS in Mozambique did, however, come later than in neighbouring countries as a result of the isolation and depopulation of many areas due to the war affecting the country during the years 1977 – 1992. More than 1,5 million Mozambicans fled to neighbouring countries in this period. With peace refugee populations returned from highly infected neighbouring countries, demobilised soldiers returned home, and key road transport corridors re-opened. All contributed to an accelerating spread of the epidemic, especially in the central Beira and Tete corridors linking Malawi and Zambia to Zimbabwe, and the inland regions to Beira port. Since 2001, the Ministry of Health has operated with an infection rate of 12.2%, but this national average conceals large regional disparities, with provincial figures ranging from 5.2% in Nampula, to 21.1 in the central Province of Manica.

Two major complementary arrangements have been established to address the challenge: The National AIDS programme in the MOH and the National AIDS Council (CNC) established to coordinate multi-sector initiatives, including civil society efforts. In 1999 a three-year National Strategic Plan to Combat HIV/AIDS (2000-2002) was presented, and a large number of activities are at present being initiated both at central and provincial levels in order to prevent the further spread of the epidemic. The magnitude of this challenge, and the need to approach the epidemic through multi-sector efforts involving all levels of society, have opened the way for new contacts and patterns of collaboration, including new contacts between the formal health-service providers and practitioners of traditional medicine. The efforts to combat the epidemic have also paved the way for new CSOs, as a response both to the challenge itself and to the new funding opportunities through funds specifically targeting the combat of HIV/AIDS. MONASO, a national network of civil society organisations, was created to coordinate initiatives and channel funds to smaller and less professional CSOs with plans to work in HIV/AIDS prevention.

The *National Strategic Plan to Combat HIV/AIDS (2000-2002)* was the result of a comprehensive process involving ministries, donors, NGOs and community-based organisations (CBOs). The National AIDS Council comprises both sectoral Ministers and a number of civil society representatives, and Provincial Nuclei have been established to ensure the maximum non-governmental involvement in the efforts to combat AIDS. The Tete Provincial Nucleus has a number of working groups for different kinds of stakeholders; health sector, other public sector focal points, international and national NGOs, CBOs, private sector, and social organisations. For funding purposes, organisations have been divided into two categories: the first category comprising CSOs with a strong internal organisation and accounting capacity (predominantly foreign NGOs); the other category comprising (national) organisations without own resources or accounting systems. Funds are in principle channelled to the first category, which can then subcontract organisations in the second category.

2.3 Formal health service providers in Mozambique

It is estimated that the National Health Service (SNS – *Serviço Nacional de Saúde*) covers 50% of the population in Mozambique. Especially in rural areas, large part of the population continue to use the services of traditional medicine practitioners, either exclusively – where SNS services are unavailable or hard to reach – or as an alternative to or in combination with SNS. Private sector and non-profit NGOs do not really play very prominent roles as health service providers at a national scale, but some play important roles at the local level where they are operative and working.

Public health services

From independence in 1975, the Mozambican Government and the public health services placed a strong emphasis on primary health care. But a devastating civil war resulted in large-scale destruction of public health infrastructure, and especially in many rural areas public health services ceased to function. After the peace accord in 1992, major efforts were directed at rebuilding health infrastructure and building new health units. These efforts have resulted in a substantial reduction in inequity between the most and the least favoured areas in the country, but the quality of the services offered, to poor people in particular, is often questioned (cf. Serra 2001).

SNS facilities operate at four levels: Levels I and II, health posts and health centres, are responsible for *primary health care* and have important *preventive functions*; while levels III and IV, clinics and hospitals, in principle have more *specialised curative functions* within the formal structure of health services. In 2002 the number of primary level (1) units had reached a total of 1070, making for an average of 16.069 inhabitants per basic health unit. But the coverage varies between provinces, with figures ranging from 7.800 inhabitants per primary health unit in Niassa to over 20.000 in Zambezia. The average physical area covered by a health unit ranges from 13km² in Sofala to 19 km² in Niassa. [8] Even though national health indicators continue to raise concern, health sector performance as a whole has improved significantly since 1993. Institutional deliveries (births) increased from 26 – 41% in the period 1993 – 2001, and there has been a decrease both in maternal deaths and in neo-natal deaths. Vaccination programmes have improved their coverage, with children under 1 receiving DPT-3 increasing from 57% to 82% in the period 1995 – 2001.[9]

[8] That is, excluding Maputo city which is a special case given its dense urban population.
[9] Cf. Hodne Steen *et al.* (2001), PESS (2001), República de Mozambique (2002).

Private sector and civil society organisations in the health sector

Private medical practice was banned by Government shortly after independence, but was reintroduced in 1992. Since then the establishment of private medical facilities has in practice been heavily concentrated in the national and provincial capitals. Meanwhile, the introduction of 'private services' in the main public hospitals has, on the one hand, provided added income for health workers and institutions, but also created new organisational tensions within the institutions themselves. Beneficiary assessments indicate that users who have had 'private consultations' in public health institutions often are examined more thoroughly and given more adequate explanations about their health problems than users having 'public service consultations' (Scuccato & Soares 2001). More generally, it has been observed that public sector personnel tend to pay insufficient attention to informing patients about key issues such as the causes of illnesses, how immunisation works, or the effects of prescribed drugs (Austral/DPS Tete/ DANIDA 2001).

When medical practice was liberalised in 1992 it was hoped that a considerable input to the total supply of health services would be provided by non-profit CSOs running health facilities. This has so far not happened. Scuccato and Soares' (2001) survey found a total of 31 non-profit providers, all run by religious/faith-based organisations (with a few more about to open), mostly in urban areas. 60% were actually based in Nampula city and Nampula province. Many were dependent on the SNS for nursing staff, drugs and other recurrent expenditure. The survey found no barriers to access by the poor in these institutions. They performed better than SNS facilities in some aspects (e.g. hygiene, drug availability, information), but overall did not appear more efficient, organisationally or technically, than their public counterparts.

During the war, the total number of external NGOs in Mozambique grew from 7 in 1980 to 130 in 1989 (Brochmann & Ofstad 1990). In the immediate post-war period, new NGOs arrived in the country to participate in the reconstruction. Their efforts in the health sector were above all directed at rebuilding infrastructure, but some organisations also started to support various kinds of primary care programmes. While providing important contributions to the recovery effort, their fairly uncoordinated activities also created considerable problems of coordination for the Ministry of Health (MoH) and the public SNS (National Health Service). Infrastructure might be built in the "wrong" place or provisions for running costs or staff might be lacking, or foreign NGOs paid salaries for their staff unheard of for public-sector Mozambican health personnel, who in turn felt devalued and marginalised. The NGOs were themselves usually dependent upon external funding from donors that tended to emphasize short-term results of their "own money" at the expense of the broader sector-wide results of coordinated action (cf. Pfeiffer 2003).

However, this sort of problems over time created an increased awareness, not only in the public sector, but also among NGOs about the needs to unite efforts and let the MoH and Provincial Directorates perform their coordinating and strategic-planning roles within the health sector. With the end of the immediate post-war reconstruction period, many NGOs also left the country while others, such as Save the Children Norway (SCN), decided to concentrate their work on other key issues – in SCN's case on children's rights. While the health-sector activities of some NGOs were phased out, a number of NGOs continued to work in health or health-related areas. More recently, new organisations dedicated specifically to HIV/AIDS work have appeared, such as the network organisation MONASO. The range of organisations now working in health (see also Annex 2) basically fall into two broad categories:

- *General development NGOs* embracing a variety of developmental activities, usually combining health with education, water or agriculture projects; there are some infrastructure projects (usually coordinated with the local health authorities), and various kinds of capacity building and local-activist programmes.
- *Specialised health organisations*, but these are few and, given the size of the country, have a limited presence on the ground; each usually works in a few localities in one or two provinces, often as executive agencies for bilateral donor programmes.

2.4 Informal/traditional health service providers

There is a wide variety of traditional health-service providers in Mozambique. They are called healers or *curandeiros,* herbalists, prophets; in addition there are the traditional birth attendants (TBAs) in rural communities. Their common feature is that they are easily accessible – as one of the few, or possibly the only health service provider in a community. According to the 1997 household survey, 92% of the villages surveyed had a healer, but only 20% had a health post or health centre. The average distance to a traditional healer was 1,5 km, compared to an average distance of 20 km to a nurse.[10] The number of *curandeiros* is estimated to be 80.000 – as compared to the 1070 primary-level SNS health units (Vala 2000). Most people consult a traditional healer at one time or another – not just for health problems but also on other issues involving psychological traumas or social conflicts. However, it appears that for most normal physical ailments, a first choice will be the formal health-service providers if they are readily available. Other factors influencing people's choice between formal-sector and informal/ traditional health-service providers include the attitude of the health workers, the way they treat their patients, the availability of medicines, and the fees demanded.[11]

Several studies indicate considerable provincial and intra-provincial variations in traditional healers' work and skills. In some instances the traditions they represent are changing over time, with the renewal of traditions following the country's turbulent history. As a rule, however, the vocation of a healer or *curandeiro* starts with a "calling from the spirits" in the form of a serious illness that can only by cured through a ritual of initiation into the healing profession (as reported e.g. from the District of Maniça). A long period of apprenticeship with an experienced healer is often required to learn about medical plants, and in order to be accepted by the local community of healers. In parts of Tete Province, many of the healers who are operating at present are persons who became possessed by christianised spirits while they were refugees in Zambia and Malawi during the war. What is worth noting as to the methods of work of *curandeiros* more generally is that: 1) The role of the spirits primarily is to assist in the diagnosis, and indicate the cause of the illness; the illnesses themselves are usually treated with medicinal plants, e.g. the roots of trees. 2) The traditions of 'traditional' healers are also changing with time, not only due to the traumas and displacements of war, but also due to socio-economic and political changes, and new education opportunities.

The national association of traditional healers, AMETRAMO, was officially established in 1992 with Government support. Given the great variety of old and new knowledge traditions within the country, its size and communications problems, the association is faced with a considerable challenge in representing all traditional healers, and it seems doubtful that even

[10] Understanding Poverty and Well Being in Mozambique, the First National Assessment 1996-97.
[11] Cf. Austral/DPS Tete/DANIDA (2001) and CASE (2000) Beneficiary Assessment in Four Mozambican provinces.

at the provincial level it is representative of all practitioners' views and interests. The structure of the association reflects formal organisation models, which often differ from the traditional forms of association of Mozambican healers. From the beginning only literate persons, usually the younger traditional healers, assumed leadership positions in the association, while the elders retained their professional authority within the 'informal community of healers' (cf. Honwana 2002). However, AMETRAMO also aims to function as a professional standards body, requiring proof of a candidate's healing powers before he/she can be admitted as a member.

In Tete Province, AMETRAMO reports to have 1.500 members, of which 1000 are women. At the provincial level, however, the association's work is hampered both by lack of resources and by lack of experience in formal management procedures. In general, AMETRAMO members seem to consider the organisation as mainly a forum for contact with the Government and the formal health sector, and as an organ to obtain some degree of formal recognition in Mozambican society (cf. Austral/DPS Tete/DANIDA 2001). At the same time, a major complaint on the part of AMETRAMO representatives is the lack of recognition on the part of the Government and the formal health sector.

Although various MOH documents stress the importance of strengthening relations between traditional practitioners and the formal health sector, there has been limited progress on the ground. Formal-sector health personnel are often openly critical, or at least ambiguous, in their attitudes to traditional healers. A major complaint is that *curandeiros* often wait to long before they send patients they cannot treat (e.g. patients with malaria) to the local health centre where they, in principle, can receive effective treatment. The competence of *curandeiros* is however, usually recognised in treating infertility, asthma, and some pshychological traumas (Austral/DPS Tete/DANIDA 2001). AMETRAMO members are furthermore called upon to give evidence in judgements on witchcraft accusations in *tribunais comunitários* (community courts). At the moment, however, most contacts between the formal sector SNS and *curandeiros* seem to be related to the problem of HIV/AIDS prevention. Both SNS and NGO personnel are particularly concerned with education and awareness raising that can promote more hygienic practices in traditional techniques, especially those involving cuts in the skin of patients. AMETRAMO representatives are for their part interested in SNS collaboration to test/validate the effects of the medical plants they use in AIDS treatment.

There is no doubt a potential for expanding contacts and strengthening the communication between *curandeiros* and the formal health system, both in the field of AIDS and more generally. But the success of such contacts depend both on the personality, inclination and actual knowledge about traditional medicine on the part of the formal health sector staff. In Manhiça, for example, where the District Director has a very open approach, there are regular contacts and information sharing. More systematic knowledge in the formal health sector on the logic and practices of *curandeiros* would no doubt facilitate communication between formal and informal health service providers. But the objective of communication should not necessarily be to integrate *curandeiros* more into the formal health system. The role they play in present-day Mozambique is the role of alternative service providers in relation to the formal health system, especially in rural areas. This is in principle an important role. However, a general challenge in health in Mozambique is *to make health service providers more accountable to people* – especially for the quality of the services provided. Traditional health service providers should not be exempted from this requirement of strengthened accountability. In order to promote accountability more generally, it is important to contribute

to increased transparency, more open information sharing and communication between formal and informal actors in health, and between the health sector and civil society more generally.

Traditional Birth Attendants (TBAs) have always existed in communities, usually taking care of births in specific families or lineages. As part of the formal health sector's efforts in health advocacy, some of these TBAs (normally one in each community) were selected for special training to improve their methods and hygiene, and to link their work closer to the local health post/centre. The trained "official" TBAs are required to send reports on deliveries to the local health post/centre. In turn, they are in principle entitled to receive basic kits from the SNS. In practice, the TBAs often end up in-between the *formal* and the *informal* sector. They are not really recognised by health personnel and often lack the sanitary material they need in their work (and are entitled to receive). On the other hand, local people see the TBAs as part of the formal sector and expect them to provide free basic services. As a consequence, the families of the women giving birth no longer provide what is needed for the delivery as they traditionally used to do (DPS Tete/DANIDA 2001). The situation is further complicated by the fact that the SNS tends to support only one TBA in each community, while in practice there are usually several. One NGO (Progresso) working in this field felt that this was a mistake, and promoted the view that the MoH should "lower its sights" and adopt a strategy that: a) encompassed all TBAs with basic hygiene training, and b) educated the population on the importance of their contribution/role in a delivery situation, e.g. through providing the blade, lighting, clean sheet, as they used to do before the formalisation of a "community TBA" encouraged them to expect that the health system would take care of everything.

In the health sector as a whole, Traditional Birth Attendants together with ***Community Health Workers*** (APEs) have in principle been given important roles as primary health-care agents. In the health system established after independence, central authorities placed these two categories of health workers at the front line of primary health care in communities, expecting them to link the informal and formal sectors. APEs were originally trained and introduced in the communities through the public health service (SNS) to work with health promotion, prevention, and basic first aid, being supplied with kits from the SNS. The APEs have been carrying out this function to a varying degree, and at present few are considered to be operative according to the original ideal plans. Nor does the central level at present have any comprehensive overview of its role and function in the communities. Similar or complementary community health workers have, however, in recent years been trained and supported by NGOs. Most notable at a national scale are the local activists – or *socorristas* – of the Mozambican Red Cross (CVM).

2.5 Characteristics of – an incipient – civil society

Post-independence organisation in the Mozambican state was oriented by central socialist-planning principles, with a strong emphasis on the social sectors. One result was a considerable expansion of free primary health care and primary education. At the same time agricultural cooperatives and state farms were established, in addition to party-controlled mass organisations – for youth (OJM), women (OMM), and trade unions (OTM). The one-party State counted on people's voluntary participation in community activities, such as school building and road repair. While traditional authorities were sidelined together with traditional healers and religious/church organisations, in the first years after independence the Government promoted grass-root participatory democracy institutions, such as locality assemblies.

The ensuing war both destroyed social infrastructure and the provision of rural services, and displaced millions of people within the country and outside. It also produced rapid urbanisation, while many traditional bonds of solidarity and mutual assistance were weakened. The 1997 Household Survey indicates that in many traditional activities involving mutual assistance, payment in kind or through work-parties has been replaced by cash payment. But mutual assistance and reciprocity in social relations, especially within families or lineages, are still basic principles of community social organisation. A variety of initiatives and associations working without outside promotion or interference can be found at the local level – such as small micro-credit networks, local sport clubs etc. The *community level* is, however, a term that covers a great variety of local arrangements and regional variations, which are not necessarily well understood either by well-meaning foreign NGOs or by central-level decision makers. In fact, external initiatives aiming at community mobilisation, externally designed forms of community organisation and local institution-building can also marginalize or undermine existing institutional arrangements at the community level. To prevent local conflicts and other unintended consequences of external interventions in local community structures – in a situation moving towards increasing community and household vulnerability resulting from the AIDS epidemic – good local baseline studies become even more crucial than before.

It can be observed that using a definition of *civil society* that refers to "formal and informal networks and organisations that operate *in between the family and the state*" means that a number of important family-based associative forms and activities at the community level will not "belong to" *civil society* as such. By contrast, territory-based or locality-based organisations or interest groups will, according to this definition, be part of civil society. How fruitful such conceptual distinctions are at the local level is rather a practical question. But when we talk of *civil society organisations* – CSOs – at national and provincial levels, the definition is no doubt useful also in a Mozambican context.

With the economic liberalisation and beginning democratic pluralism of the 1990s, an increasing number of national NGOs were created in Mozambique. At present there are about 600 registered NGOs, but not all of these are operative at the moment. In 2001, there were 145 foreign and 465 national NGOs, which means that ¼ of the registered NGOs are foreign (Eys 2002). At present, it seems to be very difficult for CSOs with a formal structure and some professional staff to survive on the basis of membership fees or *quotas* in Mozambique. The fact that such a large part of the population lives in situations of absolute poverty or destitution, in practice also means that the potential for unpaid, voluntary work is not very great.

The 2002 NORAD study on civil society (Rebelo *et al.* 2001) identified two contrasting types of Mozambican CSOs. At the one end of a spectrum, we have the *formal* and professional urban-based NGO, basically dependent upon external funding; and at the other end of the spectrum, the *rural-based informal* CSO, usually without regular external or internal funding. With this spectrum as a backdrop, we will here make the following observations on general features and cross-cutting challenges for CSOs in Mozambique at present:

- *Strong professional CSOs* cannot survive without external donor support. This promotes a certain opportunism, making it necessary to seize funding opportunities, and turn to activities where the money is – such as HIV/AIDS at the moment.

- *Religious or faith-based organisations* have become increasingly important as CSOs. They are to some extent able to mobilise local members resources, in addition to external support, and are involved in various kinds of development projects, public education, advocacy, and in some cases in health-service delivery activities.

- *Provincial-level NGOs* with a formal structure, but little or no permanent funding, will often try to live off small favours from international NGOs (use of phone, some transport), and spend much time seeking ways of raising funds. This situation sometimes creates tensions in relation to foreign NGOs, who feel that they are not primarily seen as partners working for common goals, but rather as a source of economic resources.

- *The media* have an important role to play in civil society, providing *public arenas* for information sharing, outspoken criticism and debate on issues of central concern for CSOs and other civil society actors. A certain paralysis of the national media could be observed after the murder of Carlos Cardoso in 2000, whereas a new standard of *transparency* no doubt was set in the national media during the Cardoso trial in 2002. In the provinces, however, especially the written media (newspapers) have an insufficient presence, whereas Radio Mozambique is an important channel of communication. But in general the national media seldom address health issues, and tend to lack any in-depth command of health-sector problems and issues. However, where community radios have been established, health issues have got a much more prominent place than in the national media. Furthermore, the community-based radio programmes are often quite critical when they bring up issues like health on the agenda.

- *Informal community or village-level civil society* continues to play an important role in people's lives. Informal associative forms are evolving in keeping with the new economic environment, such as new kinds of markets and credit associations, and new donor- or foreign NGO-inspired forms of participatory mechanisms, committees and activist groups. However, the channelling of relatively large amounts of external resources into some forms of organisations no doubt contributes to shift local power balances, and may in turn disrupt functional local structures and associative forms.

- With increasing funds becoming available to combat *HIV/AIDS*, both foreign NGOs and new CSOs have started to train and support activists to work specifically with this problem. There is, however, a great deal of concern among CSOs related to the possibility to keep up voluntary or activist work without substantial resources available for "incentives" and other benefits for activists. There is at present a tension between organisations trying to stick to an ideal of *voluntary civil society work* and primarily use "symbolic" incentives for local activists, and organisations that are convinced that effective work on the ground depends on the employment of paid activists.

- *Paid activism* vs. *membership* is more generally coming up as an issue of debate among CSOs. Most activists, particularly in rural areas, are young people with few employment prospects. At present, CVM probably has the most solid and long-standing voluntarist base – *voluntarism* being one of the pillars of its operational philosophy and strongly emphasised when the Red Cross mobilise supporters. The organisation's high profile, incentives such as caps and T-shirts that enhance the members' visibility in the community, and the services they provide in emergencies or as 1st aid workers, all provide the incentive of enhanced social status. At the same time, it is recognised that many young people hope that their voluntary work might eventually facilitate access to paid

employment or some kind of training or educational opportunities. Still there are indications that even Red Cross activists get de-motivated and give up their role as civil society volunteers.

At the national level, there are several ***CSO networks*** that to some extent serve as umbrella organisations. The most inclusive among these networks is *LINK* – a general forum of NGOs, which includes both national and foreign organisations working in Mozambique. Its work is reflected at the provincial level, with corresponding Provincial NGO forums. *MONASO* – the Mozambican network of organisations working to combat AIDS – is becoming increasingly important as an umbrella organisation, providing a meeting place, training, and financing opportunities for other CSO, in addition to MONASO's own work in HIV/AIDS advocacy. MFS (*Medecins Sans Frontiers)* in Mozambique, on their part, established NAIMA as a network of professional NGOs working with HIV/AIDS. There is also the Children's network, *Rede da Criança,* and *Forum Mulher* – organised as a women's network. All of these could be potential and relevant dialogue partners in a process aiming at a strengthened involvement of CSOs in health sector programmes and activities.

2.6 The role of CSOs in the area of health

With regard to present CSO-involvement in health and health-related activities, we will make the following observations:

- Among the about 145 ***foreign NGOs*** that are at present working in Mozambique, relatively few are specifically dedicated to health. Most have a broader rural development mandate that might include an occasional health input, e.g. building/supporting a health post. However, there is now a strong across-the-board tendency to include systematic work on AIDS in all NGO work. The more specific health NGOs tend to concentrate their work on AIDS or on one specific area of health: MSF and PSI focus on HIV/AIDS; HAI work in community health advocacy; Marie Stokes focuses on reproductive health.

- A number of foreign NGOs working in general development provide *target funding* to *national and local organisations* that work with health issues or HIV/AIDS prevention. Usually they will fund local CSOs that are in line with their priorities, or they subcontract local organisations to work within the framework of their own projects.

- Large foreign NGOs, as a result of the AIDS epidemic, are now also forced to *address health issues as employers* – this is the case of Norwegian People's Aid (NPA); with its demining programme in Tete and a total of 520 employees, it is at present the second largest employer in the province.

- The foreign NGOs, together with the more formal and professional national CSOs often *provide training*, either directly to people at the community level, to informal health-service providers such as *curandeiros,* community health workers and TBAs, or they provide training to local organisations closer to the 'informal' end of the CSO spectrum.

- At the ***community level***, many NGOs now place much emphasis on consciousness-raising linked to *participatory approaches* and *empowerment*. Larger, more formal CSOs work with 'empowerment' through training directed at locally based, more informal organisations; or they include 'participatory appraisals' in local project preparation. But the follow-up of the local expectations raised through consciousness-raising and

participatory exercises is sometimes insufficient. There is also a need for more coordination among different CSOs/NGOs, and between civil society-initiatives and public-sector activities in the field.

- A relatively limited number of ***national/local CSOs*** are specifically dedicated to health or health-related issues. Among these are the following four interest organisations: ANEMO – the Association of Nurses, which so far is not very active, but with a potential role to play as a CSO; AMETRAMO – the interest organisation for traditional health-service providers; ADEMO – the Association of Disabled Persons (in addition there is a number of small specialist organisations for the blind, deaf, disabled soldiers etc.). In the AIDS field there is *Kindlimuka*, a Maputo-based organisation for people living with AIDS, but helping to promote the creation of similar but autonomous organisations in the provinces.

- At present *CVM* (Mozambican Red Cross) appears to be the main CSO in the area of health in Mozambique, with a national base as well as provincial representation. Although CVM's prime focus is emergency relief and first aid, its programmes also include health advocacy and cross-cutting issues such as HIV/AIDS prevention. CVM is also playing a role as innovator in primary health care through e.g. a pilot project in Matutuine District (Maputo Province), aimed at training community health and sanitation activists, and strengthening the links between the formal health sector services (represented by the local health centre) and CSO activities and activists' work at the local level.

- AMODEFA (Mozambican Association for the Defence of the Family) was created in 1989 by MoH staff. It is a member of the International Planned Parenthood Federation, and works with family planning, maternity control and HIV/AIDS prevention, running its own clinic in Maputo – with support from e.g. UNFPA.

- FDC (Community Development Foundation) has recently taken several initiatives to improve health-sector services. FDC has e.g. an agreement with MoH to develop a pilot project to reduce infant mortality, and has focussed on improving the cold chain (for vaccines). In collaboration with the North-American NGO Village Reach, an innovative system based on a gas-powered cold chain has been developed and tried out in the Province of Cabo Delgado. There are also plans to extend the system to other provinces.

- *Progresso,* working in the Province of Cabo Delgado, has also carried out some experimental innovative programmes in rural development – including health advocacy and work supporting the traditional birth attendants that are not linked up with the formal health system.

- AMOSAPU (*Associação Moçambicana de Saúde Pulica)* is a relatively small and little known CSO, working with public health advocacy. It has a number of influential members, e.g. former health officials, a contract with MoH to serve as a focal point in advocacy against the use of tobacco, and is also involved in training of local health activists. The organisation is considering to become a member of LINK, and sees the need to create some form of a NGO health forum.

- Especially in rural communities, *traditional health service providers* such as *curandeiros,* prophets, and herbalists are beyond doubt the key informal players in the area of health. Many are organised in the national association AMETRAMO, but at the local level many

curandeiros also belong to old, traditional forms of associations – and these sometimes have greater legitimacy at the local level than the more formal and modern AMETRAMO.

- The Provincial Directorate of Health often lacks necessary information on NGO programmes being planned or carried out in the province. This makes it more difficult to involve the NGOs and include information on the resources they can make available for health-related activities at the district level in the annual Integrated Provincial Planning exercises.

- The key role in taking initiatives to promote a more active involvement of civil society actors in health sector programmes and activities lies with the public sector and the Ministry in particular – and there are expressed needs, especially at the provincial level, for the MoH to elaborate guidelines concerning CSO involvement in the health sector.

3. NEW FRAMEWORKS FOR DEVELOPMENT AND PUBLIC SECTOR REFORMS

We will here focus on processes related to two key documents that have been worked out within a framework of broader strategic and program-oriented approaches to development:

(i) the process of elaborating a Mozambican PRSP, the *PARPA 2001–2005*, where the Ministry of Planning and Finances (MPF) played the key coordinating role, and

(ii) the process leading up to the formulation of the Strategic Plan for the Health Sector, *PESS 2001–2005*, where the Ministry of Health (MoH) has performed the key coordinating role at the national level.

3.1 PARPA – The Poverty Reduction Strategy Paper

In 2000, the Mozambican Government presented an *Action Plan for the Reduction of Absolute Poverty – PARPA*. The same year the World Bank/IMF made the preparation of a Poverty Reduction Strategy Paper (PRSP) a requirement for a new package of concessional loans and HIPC debt relief. While the 2000 PARPA became referred to as the "Interim PRSP", the Government initiated a process of developing a "Full PRSP" – that is, a revised poverty-reduction strategy that fulfilled the specific requirements defined by the IMF/WB. One of the requirements for being endorsed by the Joint Boards of the international financial institutions was that the PRSP went through a fairly comprehensive *consultation process* with stake-holders and institutions at different levels of Mozambican society.

The Ministry of Planning and Finances (MFP) presented drafts of a new *PARPA 2001–2005* for a series of consultations from December 2000 onwards. The first of these rounds of consultations was to include civil society, and meetings were held between Government and civil society representatives in Maputo and in two provinces – Sofala and Nampula. After new drafts had been presented for more restricted consultations, e.g. with the Ministries of Health and Education, a final version was approved by the Council of Ministers in April 2001. In September 2001, IMF and the World Bank endorsed the *PARPA 2001–2005* as Mozambique's PRSP (Falck & Landfald 2003).

Through media coverage, information about the PARPA to a certain extent has reached CSO representatives in provinces such as Tete, which was not included in the consultation process. However, knowledge tends to be limited to the title and the fact that it is a poverty reduction plan, rather than its content. But the Children's Network, *Rede da Criança,* has in collaboration with another civil-society network, *Grupo Moçambicano da Dívida,* and Save the Children UK and Norway, taken an initiative in this regard. A booklet has been published on how PARPA priorities are reflected in the Mozambican State Budget, focussing specifically on the health and education sectors (Rede da Criança *et al*. 2001).

The PARPA (2001–2005) contains analyses of poverty and poverty indicators in the Mozambican context, and presents action plans for *fundamental areas of action*, such as education and health. The objectives defined within the *area of health* largely correspond to those of the Strategic Plan for the Health Sector (PESS), which was also finalised in 2001. According to the PARPA, health "occupies a vital place in the social sector", and the PARPA's priority poverty reduction components in the health field are:

- primary health care (target groups: women, children, youth/adolescents) and nutrition
- fighting serious diseases (diarrhoeal diseases, malaria, TB, leprosy) and HIV/AIDS
- improving the health network
- human resource development
- improving planning and management of the sector.

Under the last bullet point, the PARPA defines the following principal measures to be undertaken in the health field:

- Finalise and approve the national Health Sector Strategic Plan
- Develop and approve the provincial health strategic plans
- Develop a provincial financial information system and develop evaluation and management tools for primary level care

The *Mozambican Parliament* was not formally involved in the formulation of the PARPA. Later a system was established for the Parliament to play a role in the monitoring of the Poverty Reduction Strategy, and a first presentation and discussion in Parliament was held in March 2002. Still it must be recognised that the *PARPA 2001–2005* as a general policy document was approved by the executive Council of Ministers and, finally, endorsed by the international financial institutions, well ahead of being presented for discussion in the Mozambican Parliament – e.g. the national representative-democratic assembly.

What the PARPA does envisage is a poverty monitoring and evaluation strategy that should include civil society representatives. A *Poverty Observatory* was established in April/May 2003 to act as a consultative body including representatives from Government, donors, international organisations and Mozambican civil society. With regard to information sharing and a strengthened involvement of civil society representatives in monitoring health indicators in the context of poverty-reduction initiatives more generally, the Poverty Observatory can potentially become an interesting arena of debate. But this is still an open issue.

3.2 The Health SWAP process and the Strategic Plan – PESS

When the notion of *SWAP* – as *sector-wide approaches* to policy-making, programming and planning – was introduced in Mozambique as a general framework for sector reforms and strengthened donor coordination, the collaboration between major donors and MoH was already a priority on the health sector agenda. As soon as peace was restored in 1992, work began on the preparation of a Health Sector Reconstruction Programme (HSRP). However, it became less effective than it could have been since many of the NGOs that arrived to help in the reconstruction process rather worked with their own project activities without much sector coordination. The HRSP was used as the base document for a Sector Investment Programme with World Bank support, and the concept of *focal donor* was introduced, with the role first being given to SDC (Switzerland) – with the mandate to facilitate interaction between the MoH and the group of health-sector donors.

At the same time a number of donors decided to provide targeted comprehensive *assistance to specific provinces* – such as DANIDA in Tete, Finland in Manica, and later Holland in Nampula and Ireland in Niassa. Meanwhile SDC initiated a broader innovative programme of providing recurrent budget support to provinces, which has significantly expanded health care financing at provincial level. A basic objective was to contribute to a *more equitable distribution of resources* between provinces (e.g. those with major donor programmes and

those without), and between districts and health facilities within a province, linking resource allocation to activities and performance. The programme also promoted the introduction of district-based annual Integrated Provincial Planning (IPP) exercises in each province. Based on the assessment of past activities and the funds used, the IPP exercise plans the coming year's priority activities, identifying inputs and financial needs, and indicating what will be covered by donor and larger NGO programmes.

In 1996, the Ministry of Health and a number of donors agreed to start a process leading to a more unified programming and a strengthened collaboration in the health sector – through the pooling of funds and increasing on-budget funding. Two major pooling arrangements were soon established. The *Pooling Arrangement for Technical Assistance* started operations in 1996, with Swiss, Dutch and Norwegian funding, channelled through a Trust Fund administered by the UNDP. Its primary objective has been to fund the salaries of (mainly) expatriate staff in the SNS – since the number of national specialists is still insufficient to fill the needs in the health sector. The *Pooling Arrangement for Drug Imports* was also initiated in 1996, in order to simplify administrative arrangements and provide more rational purchasing procedures at reasonable prices in the international market. The Government of Mozambique (GoM) is now a major contributor to the pool, together with SDC, Denmark, Norway, and Ireland. The SDC-initiated budget support for recurrent costs to provinces has also evolved into a Pooling Arrangement, including funds from Switzerland, Norway, and Finland.

The Ministry has tried to improve its internal organisation through the transformation of a proliferation of autonomous externally funded vertical programmes into two integrated national programmes: *Community Health*[12] and *Communicable Diseases*[13]. A programme for financial management reform (*PERMAS*[14]) was introduced in order to redefine central functions, objectives, systems and procedures, as well as to improve provincial capacity – all of which have been identified as crucial elements of a SWAP process in the health sector in Mozambique (TAG 1998).

Another aspect of the reform process has been moves towards a clearer separation of roles and functions within the health sector. A basic idea is that the Ministry's function as a service provider, through the SNS, should be more clearly separated from its policy-making, regulatory, and financing functions –following up key elements in *New Public Management* ideas. In practice, this means a delinking of the *provision of health services* from the *regulation and financing of health services*, with the potential for basing the relationship between the two functions on performance-based contracts, e.g. between the Ministry and CSO or private-sector health service providers.

In 1998 a Technical Advisory Group (TAG) review was commissioned to respond to rising donor interest in SWAPs, as well as a felt need to assess the process towards more comprehensive joint programming arrangements in the health sector. The TAG report recommended that a gradualist approach should be adopted, using the existing collaborative and planning mechanisms as "building blocks". It further recommended a series of steps towards increased coordination of financing arrangements, together with a strengthening of MoH budget planning, management, accounting and auditing practices (TAG 1998). But not

[12] Integrating Mother and Child Health/Reproductive Health, an Expanded Immunisation Programme (EIP/PAV), Nutrition, Adolescent Health, Mental Health, and Health Advocacy.
[13] Focussing on malaria, TB, leprosy, and endemic diseases.
[14] Plano Estratégico para a Reforma e Modernização Administrativa na Saúde.

all stakeholders in the health sector would necessarily support such a gradualist approach towards SWAP.

However, towards the end of 1998 there were a number of developments in the SWAP process: In the MoH a Technical Planning Office was established, combining formerly separate programming and financial planning teams; a Sector Coordination Committee (SCC) including MoH and donors met for the first time. A first proposal on a financing strategy was discussed with donors at a National Financing Seminar in Inhaca in December 1998. The process produced a *Medium Term Expenditure and Financing Scenario 2001-2005,* elaborated by the Technical Planning Office and presented to external partners/donors in June 2001 (GTP 2001).

In January 2000, the Ministry informed external partners that it would proceed with the WHO/WB-proposed global approach to a health policy and strategy, with the production of a *strategic plan* that contemplated civil society involvement in ownership and implementation, with health advocacy roles both for other ministries and civil society, joint evaluation and monitoring mechanisms, and formal donors-MoH coordination mechanisms. In June 2000, MoH and a group of donors signed a first *Code of Conduct – The Kaya Kwanga Commitment*, outlining the basic principles that would underpin the process. The document aimed to define principles and mechanisms to orient and regulate the relations between the MoH and external partners/donors. It stated that there was general agreement between donors and MoH to develop a SWAP in the health sector as a mechanism for managing national and international participation in support of sector development (Kaya Kwanga Code of Conduct 2000).

The document established a joint MoH-donor commitment to:

- Establish a common vision for reform as the basis for sector policies and strategies.
- Set priorities and improve the allocation of resources, using standard national planning and budgeting mechanisms, and strengthening MoH financial management systems.
- Rationalise and improve the co-ordination of external assistance, moving the maximum support possible towards budget support, and develop multi-year indicative plans in support of the reform agenda.

In order to implement this partnership, the following framework documents and forums were identified as central mechanisms:

- The *National Health Policy* and the *Strategic Plan for the Health Sector*
- The *Sector Coordinating Committee* (SCC) as a forum for information sharing, coordination and dialogue
- Annual Workplans elaborated by the MoH
- Annual meetings between MoH and partners to review the implementation of workplans and identify priorities, needs and areas of collaboration in the following year's workplan.

In April 2001, the ***Strategic Plan for the Health Sector (PESS) 2001 – 2005*** was finalised by the MoH. The Minister's preface presents the plan as an instrument for change, and for transforming ideas and strategic options into concrete, visible activities that can be appreciated by Mozambican citizens. The Strategic Plan identifies SWAP as the Ministry's preferred mechanism for collaboration with external and internal partners, and also as a way of working with all the sector's participants under the government's leadership. The vision of the Health Sector over the coming 25 years is defined as "achieving health levels for

Mozambicans that approach the average in Sub-Saharan Africa, with access to good quality basic health care through a Health System that meets citizen's expectations" (PESS 2001).

The Strategic Plan states that the Ministry will emphasise *improving quality* and creating *more equitable access to health care*, but that expansion of health services should only take place for reasons of equity. There are a number of references to the need for increased civil society involvement in the health sector. The PESS identifies both community participation and communication/alliance building with other sectors, institutions, and NGOs in order to address *reproductive health problems.* It also highlights the key importance of *health advocacy*, involving intersectoral collaboration, partnership development, alternative medicine, and community participation. With regard to *partnership development between the Ministry and NGOs*, the Strategic Plan states that:

> In recent years, interaction between MISAU and NGOs has increased. Generally speaking, the experience of working with NGOs has been positive but there are fundamental issues which need to be debated and agreed upon. For example, the NGOs do not always seek agreement about the geographical areas in which they plan to work. For this reason, many actors work in the same areas and rules established concerning collaboration between SNS and NGOs are often not applied (PESS 2001, p. 35).

In this regard the PESS considers the adoption of a new Code of Conduct to be a crucial mechanism for implementing partnerships between MISAU and the NGOs.

The PESS notes that many NGOs have a great deal of experience in *community participation* activities, but also that the practice of providing "incentives" to stimulate activists and community involvement may create problems of both of paternalism and unsustainability. More generally, it is stated that the role of communities in health sector activities is often one of passive collaboration with little interaction between the providers and beneficiaries. "Up till now, community participation has implied collaboration in the execution of health programmes rather than in planning, monitoring, assessment of management ..." (PESS 2001, p. 37). In order to address this situation the PESS identifies several strategic actions to promote community participation:

- Dissemination of community participation principles and mechanisms of involvement to promote health in coordination with partners and NGOs in a manner that permits sustainability
- Ensuring that basic aspects of community participation are implemented by the various health programmes
- Coordinating and harmonising community participation with/through NGOs or directly with community leaders and councils or similar existing organisations
- Encouraging more active participation in health units by community representatives in order to promote transparency and accountability
- Stimulating community co-management of health units and disseminating the results of pilot projects

The preparation of the Strategic Plan itself involved *consultations* including all the provinces in early 2000. Meetings were held with local SNS service providers; there were meetings with other public entities that work with health, with the commercial/private sector (e.g. employers with health clinics), and with civil society representatives, including religious congregations. Civil society contributions pointed to the need for community participation, advocacy and co-management in health, the need to develop policies on relations between formal and informal

medicine, and the need for greater cooperation and coordination with NGOs (MISAU 2001a). These recommendations are, as indicated above, also reflected in the final PESS document.

The national PESS process was followed by the preparation of Provincial Strategic Plans that also involved consultation processes. The provincial processes seem to have produced somewhat variable outcomes. In Tete there was a two-tiered civil society consultation process that started with district/regional workshops with local leaders and representatives from different walks of life, followed by a more restricted and "professional" provincial session to study the results and define strategic priorities and actions. The consultation process in Tete was in practice directed at the *district* and *local community level* rather than at the formal CSOs/NGOs at the provincial level. For this reason, in the provincial capital we found that province-based organisations were largely unaware both of the process and of the PESS itself. With regard to the follow-up of the process, we also found that there had, in fact, been no provision for feedback to participants at community level about the outcome of their contributions to the planning process.

3.3 Further mechanisms of communication and coordination

At the central level, MoH and external partners (donors) in April 2001 agreed to establish a joint *SWAP Working Group (GT- SWAP)*. The crucial role of external partners in financing development and reform in the health sector had made it clear that a forum for regular and open dialogue was required. Its specific objectives were to include: information sharing, establishment of a joint monitoring and evaluation system, discussion of financing and resource allocation mechanisms and policies for resource pooling. It was agreed that the Permanent Secretary of MoH would chair the GT-SWAP, assisted by the Director for Planning and Cooperation, and that membership should not be exclusive, but in principle not exceed 10-12 permanent MoH and partner members in order to ensure smooth functioning, with the permanent partner members selected to represent the donor community in general (MISAU 2001b).

It was also agreed that the permanent members of the Working Group should be the main health donors: the Netherlands, the World Bank, DFID, Norway, Switzerland, EU, and USAID. On the MoH side permanent members would come from the Directorate of Planning and Cooperation, with other health officials invited according to the topic under discussion. The GT-SWAP should meet once every two weeks, and further interact with CCS (the Sector Coordinating Committee), which only meets once every six months.

In practice, the SWAP Working Group has held regular twice-monthly meetings since it started. Meanwhile both its composition and the number of people attending have risen considerably[15]. Apparently the GT-SWAP meetings have also become important as an arena for information sharing within the Ministry itself. More recently the question has been brought up if both (foreign) NGOs and Mozambican civil society representatives should also be included in Working Group's discussions and information sharing. At present, the GT-SWAP is recognised as the main mechanism in the relations between MoH and external donors, and as an important forum to discuss the SWAP process and bring it further. But given that the Health SWAP is defined not only as the Ministry's preferred mechanism for collaboration with external partners, but also as a way of working with all the sector's

[15] Participants at present include 11 bilateral donors (sometimes with more than one representative) and 6 multilaterals, in addition to a number of MoH advisers and officials – depending on the topic under discussion.

participants under the government's leadership, the question of including CSOs as more active partners is highly relevant.

Opinions differ, however, regarding the workability of expanding the membership in an already large, and sometimes unwieldy, GT-SWAP working group. To a great extent, discussions in this working group have so far tended to concentrate on financing mechanisms, and on technical issues with considerable financial implications. Issues related to the provision of health care, the qualitative content of policies and programmes, have been more marginal on the agenda. The discussions regarding the inclusion of CSO representatives as more active partners in the SWAP process, also suggest that a certain revision of the respective roles of the CCS and GT-SWAP could be useful, perhaps in combination with a division of GT-SWAP functions into e.g. different categories of meetings.

In July 2002 a first *Joint Annual Review of the Health Sector* (MISAU 2002) was carried out and later presented to the SCC (Sector Coordination Committee). The review team gave a brief appreciation of the status of what it considered to be the main components of a Health SWAP, and concluded that a number of these were already in place. Considering the SWAP planning processes, the Joint Review team pointed out that:

- The Provincial Strategic Plan process is a useful start for defining directions, strengths and weaknesses, and for promoting further dialogue with communities. Here the IPP can be built on to provide a framework for annual provincial planning. This will, however, require the development of a common, simplified format related to outputs.
- The great challenge is, however, operationalising the PESS into annual workplans that truly reflect its orientation and content.

The last point was repeated and confirmed in the interviews carried out during the case study preparing the present report. The annual budget for the health sector in 2004 will be based on the PESS. This means that the strategic objectives formulated in the PESS in the course of 2003 must be translated into operative plans and concrete actions; and this is a real challenge. As one of the CSO informants said when interviewed for the present case study:

> "The strategic plans in this country are very good! The problem is the implementation, and the commitment to concrete results!"

At present, the challenge of operationalising the PESS into annual workplans, and the question of including CSOs/NGOs in SWAP discussions should both be seen in connection with the general challenge for MoH to play a more active leading role in the sector. This also includes developing partnerships and coordinating NGO activities at both central and provincial levels.

In March 2003, it was decided to revise the *Kaya Kwanga Code of Conduct* that was signed by the Ministry and external partners in 2000. With reference to later developments in the health sector – the finalising of the PESS in 2001, the establishment of the CCS (*Comité Coordenador de Saúde)* and the GT-SWAP – and more general public sector reforms, it was in this context suggested that a revised Code of Conduct should be signed by all partners working in the health sector, including NGOs. Over the last couple of years a number of CSOs/NGOs have also been involved in a separate process of preparing a Code of Conduct orienting the partnership between MoH and NGOs (*Código de Conduta para Orientar a Parcería entro o MISAU e as ONG's).* However, in the National Coordinating Council of the Health Sector (*Conselho Nacional Coordenador de Saúde)* in May 2003 it was decided that

the role of NGOs in health should in integrated into the general revision of the Kaya Kwanga Code of Conduct – possibly with a separate annex on NGOs' roles and functions. The revised Code of Conduct is expected to be finalised by June 2003.

4. ASSESSMENT OF CSO ROLES IN THE HEALTH SECTOR

A modern and formal science-based system of health care is usually built on strong cultures of professionalism among key service providers, such as doctors and nurses. Crucial decisions within a modern health system are based on the medical profession's specialist knowledge. A SWAP approach brings with it increased emphasis on budget planning and expenditure control in the health sector. Among other things this means that a SWAP process, in line with New Public Management ideas, draws other types of professional knowledge (e.g. on management, financing, and accounting procedures) into key planning, priority-setting, and decision-making processes. Since the SWAP process aims at increased coordination of external donors' assistance, it counts on the development of common perspective on main objectives, roles and challenges in the sector among the executive *Ministry* and the *external partners/donors.*

However, with the broad sector perspective that is implied in the Mozambican Health SWAP process, at some point it also becomes necessary to address the roles of other stakeholders in health: Do the SWAP processes and arrangements provide frameworks for a more active and accountable role for the professional NGOs that at present work in Mozambique, as well as for more informal CSOs that potentially can represent key target groups and beneficiaries? This chapter discusses civil society roles and CSO involvement so far, while chapter 5 raises some questions concerning new roles and future potentials for increased involvement of Civil Society in Health Sector reform and development.

4.1. Degree of involvement of CSOs in the Health SWAP process

Both the preparation of the *Strategic Plan for the Health Sector (PESS) 2001 – 2005* and the consultation processes associated with the formulation of Provincial Strategic Plans reflect a concern for greater civil society involvement, both in discussing health problems and in addressing them. The question is not so much the central authorities' intention of providing for a certain involvement of civil society in health sector development; the question is rather one of degree and forms of involvement, and the roles civil society actors can, will, and are actually given the opportunity to play.

- ***Has there been an increased degree of involvement of CSOs in SWAP processes?***

- New policies and strategic plans (PARPA 2001, PESS 2001) clearly envisage CSO involvement. In the health sector, greater involvement is foreseen particularly at the *implementation level*, whereas the PARPA in principle also provides for civil society involvement in monitoring and evaluation of results. Most is of this, however, has yet to be applied in practice.
- Centrally based CSOs, which to some extent have been discussion partners for the Ministry on policy and strategic-planning issues, have mixed feelings about their experiences so far. Both *institutionalised mechanisms* (such as an adequate forum, feedback, and clear procedures) and a MoH *organisational culture* oriented towards dialogue with CSOs so far seem to be missing, especially at the central level. However, a formalisation of mechanisms of cooperation and coordination should be provided for in the revised Kaya Kwanga Code of Conduct. In this context it should be noted that at the provincial and district level, health sector authorities have often been relatively open, both to discussion and experiments with new approaches in the field.

- At the central level CSOs have been involved in discussions on a new Community Health Policy/Strategy. A workshop attended by representatives of various government sectors, foreign and national NGOs and church organisations was held in 2002 in order to exchange experiences and draw lessons from their varied community participation experiences.[16] Later the same year a draft policy document, *Política de Envolvimento Comunitário para a Saúde,* (Martins 2001) was distributed for comment. A summary version of this proposal was distributed to the participant in the *Conselho Nacional Coordenador de Saúde* in May 2003. The issue was also on the agenda for discussion at the meeting, where it was decided that what was needed was a *Community Health Strategy* rather than a new policy. It remains, however, to be seen what roles CSO representatives will have in the elaboration of this new Strategy.
- There is strong CSO involvement in *AIDS*-combat planning and activities. There are both sector ministry and civil society representatives in the National AIDS Council. At the provincial level Nuclei have been established to channel funding for AIDS-prevention activities to locally based CSOs. These activities have so far principally been directed towards public education, using activists that belong to local organisations, or counting on the recruitment of activists to new HIV/AIDS-oriented CSOs.
- At the provincial level, foreign NGOs are involved in the annual Integrated Planning (IPP) exercises – mainly to inform about their past and future activities and resources so that these can be taken into account in the provincial plans and budget support allocations.
- *The initiative* to involve CSOs in sector programmes generally lies with the government. It is the Health Authorities that invite civil society to participate in certain kinds of programmes and plans, and it is the Government that organises the modalities or fora for this. Very few local organisations have so far, on their own initiative, been involved in the implementation of health programmes or activities defined in the PESS. Exceptions are CVM, CDF, and Progresso, which also work with some experimentation in the field.

➢ ***What knowledge do CSOs have about health sector programmes?***

- There is in practice virtually no knowledge of the Health SWAP process as such at any level of CSOs, although a couple of the people interviewed for this case study have heard about SWAP principles. More people have heard about the PESS. Whereas the SWAP process has centred on plans, policies, coordination, and financing mechanisms, most people are much more concerned with how plans are put into practice.
- The few interviewees in our case study that had some knowledge about SWAPs, saw it as basically an external donors' concern. Health sector policies and plans are, with the exception of AIDS, not at the forefront of civil society activism and associativism in Mozambique, and there are actually few organisations specifically dedicated to health.
- There seems to be a general feeling that health is a specialist area, with key debates requiring specialist technical knowledge in modern science-based medicine. At the same time it should be recognised that roughly 50% of the Mozambican population actually seek the assistance of traditional/alternative health service providers without such specialist knowledge – most of them basing their activities on local knowledge of medicinal plants and the assistance of ancestral spirits.
- National CSOs have virtually no knowledge of the formal plans produced in the Health Sector. Knowledge about the final product is lacking even among those who were consulted during the preparation of planning documents.

[16] MISAU/UNICEF/JSI/SDC (2001c) *Relatório do Workshop "Participação Comunitária",* Feb/March 2001.

- There is, however, a general awareness of and *agreement with the principal priorities* that (following up those defined shortly after the independence of Mozambique) have been formulated in the *Strategic Plan for the Health Sector:* i.e. primary health care, and the priority given to the health challenges of AIDS, malaria, TB, and cholera.
- There is at the same time much questioning of the way basic health services are being provided, the quality of the services provided by the SNS, and how health problems are being tackled *in practice*.
- One of the main areas of debate in the CSOs is the approach to *community level health care* and the relative advantages/disadvantages and effectiveness of TBAs, APEs and other community health workers/activists, along with the related issues of community contributions, and the use of various material/economic incentives to promote *voluntarism/activism*.
- Other concerns relate to how *in practice* to involve essentially illiterate communities in the management of sensitive services such as health, and how to promote a positive relationship with traditional healers without sanctioning certain problematic aspects of their practices.

4.2. What roles do Civil Society Organisations (CSOs) play?

➢ ***Do CSOs contribute to policy/strategy formulation and discussion in the health sector?***

- In policy and strategic planning discussions, external donors in the health sector have been much more involved than civil society organisations.
- At the same time, the corollary of the heavy donor dependence of national NGOs is that the areas they work in (and the very existence of many of them) reflects the civil-society areas of most interest to their donors – women, human rights, rural development, children. At the same time, the constituencies that informal and local CSOs represent will probably be much more concerned about the on-the-ground nuts and bolts effectiveness of the health services they receive than with policy formulation.
- Some civil society representatives were, as described in chapter 3.2, consulted in the development of the PESS – the *Strategic Plan for the Health Sector 2001 –2005.* In the formulation of the *Provincial Strategic Plan* in Tete, CBOs, and local community representatives were consulted, but not provincial-level organisations.
- *Policy formulation* itself is very centralised, and there is little feedback to civil society either about the processes as such or about the final policy documents, even to those who are invited to make contributions.
- Few health policy issues have so far come up for discussion with civil society representatives themselves taking the initiative (this aspect is not unique to the health sector, such initiatives have not appeared in other sectors either, possibly because NGOs tend to be more involved or interested in service delivery, education and awareness raising than advocacy). One exception may be the topical and fairly complex issue of making *anti-retroviral drugs*[17] – and the required medical follow up – available through the National Health Service (SNS) in Mozambique. There is some internal discussion within the CSOs, but strong hesitation to proceed with public debate because of the sensitive nature of this issue – in particular the conflict between the practical inability to ensure total coverage and follow-up, and the elitist implications of any kind of selection mechanism. The position of CVM on this issue e.g. reflects International Red Cross

[17] *Anti-retrovirals* are drugs that are used to treat HIV/AIDS infections; they alleviate AIDS-related illnesses, and thereby make it possible to live longer with HIV/AIDS.

general positions and principles, rather than the very concrete dilemmas in the Mozambican situation. MSF have on their part started local programmes providing anti-retrovirals without linking their initiatives in the field to the larger policy issues and sector-coordination efforts. Here MSF see their role rather as one of initiating what they see as a necessary commitment to make treatment opportunities available at least to some people, rather than assuming the overall responsibility to follow up the general and long-term commitments involved in AIDS treatment with anti-retrovirals.

- As already mentioned, one area where CSOs have been invited to contribute to policy formulation, is the development of a new Community Health Policy/Strategy, with a first draft with a strong emphasis on *community involvement* being presented in 2001. In this area, many CSOs both have experience and opinions that can make important inputs to the planned strategy. But at present they do not seem to be well informed about the on-going process in the MoH.
- With regard to CSOs' possibility to influence policy formulation, a relevant question that should also be asked is: *What is the legitimate basis for such involvement within a democratic framework*? One answer will be that democracy can be conceived in terms of a *representative democracy* with general elections in a defined geographical area (nation-state, province, municipality) as providing the legitimate basis for representing the people. But in addition, democracy can also be conceived in terms of *participatory democracy* – which also gives civil society organisations legitimate and important roles to play on arenas where policies are formulated and discussed. There are, however, different opinions as to the roles to be played by foreign-based NGOs (who predominate in the health sector in Mozambique) in relation to national-based CSOs.
- Central government institutions may want to deal with a single "voice" representing civil society, in order to reduce the number of interlocutors and make planning processes less complex and time-consuming. On the other hand, in order to *represent the diversity* of interests, problems, opinions, and cultural backgrounds in Mozambique, civil society organisations need to speak with many voices.
- Policies and strategies are usually formulated in a general and abstract language that is far from the daily language of most people – especially for people without formal schooling. Furthermore, political documents in Mozambique are written in Portuguese, which is not the first language for the majority of the population. Female illiteracy in the rural areas of Mozambique is still around 80%. Language and literacy are no doubt factors with practical implications for the involvement of informal CSOs in policy formulation and discussion.

➢ ***What roles do CSOs play in health advocacy, and in mobilisation and lobbying for specific issues?***

- When the country's main cross-sectoral CSO network/umbrella organisation, LINK reorganised itself recently, in order to ensure more effective action with its limited resources, it identified six major areas of concentration that it felt reflected the main concerns of the country and the organisations members. Health as such is not one of the six, although *AIDS* is, together with *poverty reduction* more generally.
- The Children's Network is active in AIDS related advocacy and mobilisation, but its main social emphasis is education.
- The main impetus for mobilisation and lobbying has come from the HIV/AIDS situation. At the central level there has been pressure for special labour legislation to protect workers and for the right to anonymity, and local lobbying has been concerned with protecting workers and avoiding stigmatisation in general.

- The more specialised groups work to protect the interests of their constituencies and members. AMETRAMO seeks to strengthen the formal health sector's recognition of traditional medicine. ADEMO works to get disabled children into school, fight prejudice, and in general has raised the issue of lack of government attention to the disabled.
- There are general initiatives, such as study on corruption commissioned by the new anti-corruption organisation ÉTICA Mozambique (*Estudo sobre a Corrupção, 2001)*, which identified the health sector as a major problem area.

➢ ***What roles do CSOs play in monitoring and as 'watchdogs' of rights?***

- There are no doubt still serious problems concerning the quality of treatment and health care offered, especially by many of the basic-level units of the SNS. How do individuals and communities address these problems? As noted insistently in a relatively recent Beneficiary Assessment study (CASE 2000), there are no mechanisms for channelling complaints about the health services. In rural areas, many seek the assistance of traditional healers as an alternative to formal-sector health services. In border areas, some people may even choose to seek assistance in the neighbouring country. But *no civil society actor* has so far assumed a significant role in *providing informed criticism* on the performance of the health sector with the aim of making health service providers more accountable.
- According to the Manhiça District Director of Health, all the health units have a complaints book and complaints are acted upon, but it has not been possible to verify how widespread this practice is. Although complaints books are mandatory in all public services as part of the new public sector reform, their viability especially in rural areas is certainly questionable.
- Where they exist, the new municipal assemblies have potentials to become a local forum for voicing concrete complaints and getting them dealt with. In both Tete and Manhiça the team was informed of cases where constituents' complaints on health services actually had been investigated by their elected representatives.
- As part of its work of monitoring the condition of prisoners, the Mozambican Human Rights League also includes prisoners' health situation in its work.
- In order to make health service providers more accountable to people – as beneficiaries – community involvement in the management of health units has been proposed in the PESS, but the idea needs further concretisation. A number of donors/NGOs are piloting experimental schemes (e.g. SDC, CVM), but more systematized knowledge is no doubt still needed in this field.

➢ ***What is the role of informal civil society in relation to the health sector?***

- Informal civil society is dynamic, with both static and changing elements interacting at the local level. But decision-makers know little about it – neither government nor donors are well informed. Informal associations have an important role in the life of communities, but we know nothing about their role in health. At the same time, foreign NGOs are creating new local-power structures for mobilisation and development in the form of various committees, but their integration into the local communities and hence their sustainability is questionable. In this field, there is a need for more studies, resulting in approaches that are appropriate to the specific conditions of each province.
- Everyone – including the PESS – refers to the importance of building relations with traditional medicine practitioners. But this is a complex field, and in the formal health sector no one has so far seems to have come up with a well-thought, knowledge-based and

consistent approach. The main points of contact so far have arisen around AIDS – with some education programmes and training for *curandeiros* on hygiene.

- What is clear, according to various informants and studies, is that the local health unit (usually the health post) and its workers have a key role to play in formal–informal relations in the health sector, and the success of community-based programmes very much depend on these relations. An important aspect in this regard is community involvement in the management of health units – and it must be recognised that this will be a slow, step-by-step process that does not fit well with demands for simple indicators of success and fast results of resources invested in health.

➢ ***How is HIV/AIDS influencing sector coordination efforts and CSO activities?***

- The HIV/AIDS pandemic is the first health issue to mobilise not only all Government sectors but also civil society across the board. All the main ministries have established AIDS focal points, and include AIDS awareness in their programmes. Their efforts are backed up by donor programmes that incorporate HIV/AIDS concerns as cross-cutting issues.
- Similarly, many CSOs are taking up the issue in their programmes – training activist and producing educational materials. MONASO, the AIDS network involving a wide range of organisations, has fast become one of the best-known umbrella organisations among fellow CSOs.
- The existence of relatively large sums of money for AIDS work may result in a proliferation of new "so-called" NGOs in this field (or existing ones changing direction) mainly for opportunistic (financial) reasons.
- Internationally the HIV/AIDS pandemic has also mobilised a great number of donors to channel resources into *Funds* for the combat of HIV/AIDS. The Government/MoH is now working with plans for the management of these funds at the national level – coordinating priorities and procedures with the already established arrangements and commitments of the Health SWAP process. Since the Funds (including the *Global Fund, MAP* and the *Clinton Fund*) represent relatively large sums of money in the Mozambican context, it has become increasingly important that key actors in the field, both foreign NGOs and national CSOs, become informed and, when required, participate in a transparent and well-coordinated decision-making process.

➢ ***What is the involvement and role of Norwegian NGOs?***

Redd Barna is working with advocacy on children's rights, including the promotion of the Children's Network of NGOs working in this field. Through the Network it is encouraging civil society to monitor macro-economic policies and government decisions relating to poverty and children, such as the budget resources being allocated for the benefit of children, with particular focus on the sectors of education, health and social action.

Redd Barna's main activity is support for basic education, including some school construction and rehabilitation, teacher training, and the promotion of school clubs. In addition to the health aspects of the children's budget, its main engagement in health has been though support for better integration of disabled children in schools, training teachers of the disabled, promoting community discussions on child health and supporting training for TBAs.

The **Norwegian Association for the Blind** has for some years been supporting the Ophthalmic Department in the Chimoio hospital with technical assistance and funds for an

outreach programme for eye health education and building diagnosis capacity in the districts. It is also supporting the activities of the headquarters of the Mozambican Association for the Blind in Beira and its training activities.

Norwegian People's Aid is heavily involved in demining. It primarily concentrates its work to the Tete province, employing a huge contingent of 520 deminers. NPA also has a development programme that involves providing vocational skills training and employment promotion trough the creation of small productive enterprises. It has a strong participatory approach, working with communities on the identification of needs and possibilities.

5. IMMEDIATE AND FUTURE CHALLENGES

What are at present potential, promising, and realistic approaches to strengthening the involvement of the people the health services are there to serve – in planning, prioritisation and implementation of plans within the framework of the Mozambican health sector? What are the potentials for transforming the role of beneficiaries from relatively passive health system *patients* to more active *partners* in defining priorities, managing the use of resources, and making health service providers more accountable? What are the potentials for increased participation of civil society representatives at different levels of the health sector? Do SWAP arrangements, public sector reforms, and new planning processes also provide frameworks for making the health services more accountable to people?

A point of departure here is that civil society in Mozambique is only to a certain, limited degree organised as such – that is, in formal associations. Among the variety of CSOs that exist, essentially only the research-based CSOs have the capacity to seriously address policy issues at a general level. Such capacity entails not only profound knowledge of developmental processes in Mozambique, but also access to international information sources and debate on these processes. At the provincial level, the most relevant issue is how the relations and communication between the Provincial Directorate of Health and civil society actually work. Compared to the past, there has been an opening up with regard to involving CSOs in health sector activities, as exemplified principally by the PESS consulting process – with potential major future implications at the health post–community relations level.

- It appears to be necessary to *share information* on health policy issues, as well as SWAP processes in general, more widely than has up to now been the case. The *media* have an important role to play here, but also networks such as *LINK* could have a role to play – in order to open up a space for civil society interest and public debate on health-related issues.

- The central partners in health should also take further initiatives to *spread information*, both in order to provide CSOs with a firmer knowledge-base for being involved as well-informed participants in debates – and criticism, but also to mobilise the interest of CSOs in health issues beyond the HIV/AIDS pandemic. The easy-to-read documents prepared by the Children's Network or the Debt Group may be one model for public education in this field. The community radios also provide interesting examples with regard to bringing up health issues for public criticism and community debate. The present report could also be used to inform a wider audience about some of the issues and problems in the area of health.

- A key role in taking initiatives to promote a more active involvement of civil society actors in health sector programmes and activities, no doubt lies with the public sector and the Ministry in particular. At the provincial level there is an expressed demand for MoH to provide *guidelines* concerning CSO involvement in the health sector. At the national level the *Code of Conduct* revision process will hopefully create functional mechanisms for partnership, and at the same time include mechanisms that promote transparency and accountability on health issues – within and across the health sector as such.

- There are reportedly plans concerning the Government/MISAU *subcontracting NGOs to carry out programmes in the health sector*. Such subcontracting will have to go to the large and professional foreign NGOs. But there are, in fact, very few such health NGOs in Mozambique, and they so far tend to focus on very limited themes and limited geographical areas. Foreign NGOs subcontracting smaller national NGOs/CSOs to carry out specific tasks also raises questions of accountability that have to be addressed. Subcontracting – with Government money – may, however, place NGOs in an ambiguous role with regard to the critical monitoring and 'watchdog' roles they as civil society organisations in principle are also supposed to perform.

- *The HIV/AIDS pandemic* is both a health challenge and a huge overall, crosscutting issue. It should, however, be recognised that the large *global/international funds* that at present are becoming available to fight HIV/AIDS in Mozambique will also present considerable organisational challenges to the Mozambican health system and the health sector as such. In the present situation it is important that the funds that is channelled into the health sector to fight AIDS, do not produce unintended consequences; in terms of weakening the overall sector policy, discounting the widely agreed priorities on *improved quality* and *more equitable access to health care for all Mozambican citizens*; or in terms of putting aside functioning coordination arrangements that have been established as part of the Health-SWAP process. Several CSOs/NGOs rightly see their legitimate role as one of fighting for the special rights of the HIV-infected and the people suffering from AIDS. The corresponding role on the part of the Government and the Health Sector as such is, however, to deal with the AIDS challenge and provide care for the people living with AIDS within a more encompassing policy framework, involving an overall policy vision of both improving the general health situation and targeting the most vulnerable in Mozambique – where e.g. malaria is still a larger health problem than AIDS.

- There is a general need *to make health service providers more accountable to people*. Civil Society has a role to play here, but different mechanisms need to be established:
    - at central level: where new fora for dialogue involving more partners now seem to be required
    - at provincial level: building on the consultation forums and processes that exist, such as consultations on provincial multi-year plans, but so far entail mainly exchanges of information and improved general awareness about health priorities and problems among the provincial civil society community and local leaders
    - in municipalities: where the Assemblies may function as fora for public debate
    - at the local level, where several models for community participation have been proposed and/or tried out by different CSOs – but where there is a need to try out models more systematically, and further systematise existing knowledge and practical experiences with:
        - various kinds of participatory committees
        - community management of health units
        - mechanisms for community redress and action on corruption
        - links between formal and informal medicine
        - community health agents and traditional birth attendants
        - building links between formal health-sector programmes and CSO/ informal-sector activities at the local level
        - involving CSOs in Hospital Management Boards.

- Both LINK, other networks, CSOs such as CVM, AMODEFA, FDC – and possibly others – may have an interest in participating in a *Civil Society Health Forum*, looking at general problems and analytical issues or discussing provincial health budgets on the basis of annual plans and other prepared material. However, great care should be taken not to push CSOs from the outside for something for which there is no real demand and for which "the ground" is as yet unprepared, as all partners in health should definitely try to avoid window dressing and clearly unsustainable arrangements.

6. LITERATURE AND DOCUMENT REFERENCES

Austral/DPS Tete/DANIDA (2001) *Estudo sobre Atitudes na Saúde em Tete.* Relatório final. Maputo: Austral Consultoria e Projectos.

Brochmann, Grete & Arve Ofstad (1990) *Mozambique: Norwegian assistance in a context of crisis.* Bergen: Chr. Michelsen Institute.

CASE (2000) *Beneficiary Assessment in Four Mozambican Provinces.* Community Agency for Social Enquiry/SDC Maputo, June 2000.

Cassels, Andrew (1997) *A Guide to Sector-Wide Approaches for Health Development: Concepts, issues and working arrangements.* November 1997.

Comaroff, John L. and Jean (1999) Introduction. *Civil Society and the Political Imagination in Africa: Critical perspectives.* Chicago & London: University of Chicago Press.

Country Profile (2002) *Mozambique.* London: Economist Intelligence Unit.

Country Report (2002) *Mozambique.* October 2002. London: Economist Intelligence Unit.

Cristensen, Tom & Per Lægreid (2001) New Public Management i norsk statsforvaltning. In: B.S. Tranøy & Ø. Østerud (eds.) *Den fragmenterte staten: Reformer, makt og styring.* Makt- og demokratiutredningen 1998-2003. Oslo: Gyldendal.

DPS Tete (2001) *Relatório da Auscultação da Sociedade Civil.* Plano Estratégico do Sector Saúde (PESS – Tete). Tete, Julho 2001.

ÉTICA Moçambique (2001) *Estudo sobre a Corrupção.* Maputo.

Eys, Tinie Van (2002) Solidariedade com os pobres ou comércio no mercado do desenvolvimento? *Lusotopie* 1 : 145 – 159.

Falck, Hans and Kåre Landfald with Pamela Rebelo (2003) Mozambique. *Development Policy Review* 21 (2) 235 – 252.

GTP (2001) *Cenário de Despesa e Financiamento de Médio Prazo 200 –2005 para o Sector Saúde.* Ministério da Saúde, Direcção Nacional de Planificação e Cooperação.

Hann, Chris (1996) Introduction. In: *Civil Society: Challenging western models.* C. Hann & E. Dunn (eds.) London and New York: Routledge.

Hodne Steen, Sissel *et al.* (2001) *Review of the Norwegian Health Sector Collaboration with Mozambique.* Report, 2nd draft. Oslo: HESO.

Honwana, Alcinda M. (2002) *Espiritos Vivos, Tradições Modernas.* Cooperação Suíca, Moçambique & PROMÉDIA.

Hood, Christopher (1991) A public management for all seasons? *Public Administration* 69 (3 – 9).

INE (1999) *II Recenseamento Geral de População e Habitação 1977.* Maptuo: Instituto Nacional de Estatística.

Kaya Kwanga Code of Conduct (2000) *The Kaya Kwanga Commitment: A Code of Conduct to Guide the Partnership for Health Development in Mozambique.*

Kruse, Stein-Erik (2002) *SWAPS and Sivil Society: The roles of Civil Society Organisations in Sector Programmes.* Oslo: Centre for Health and Social Development.

Kruse, Stein-Erik (2003a) *The Role of Civil Society Organisations in Malawi's Health Sector Programme.* Oslo: Centre for Health and Social Development.

Kruse, Stein-Erik (2003b) *The Role of Civil Society Organisations in Uganda's Health Sector Programme.* Oslo: Centre for Health and Social Development.

Kaarhus, Randi *et al.* (2001) *Utviklingssamarbeid med det sivile samfunn.* Referat fra seminar i NORAD, Oslo 15.01. – 16.01.2001: NIBR & NORAD.

Lexow, Janne (2003) *The role of civil society organizations in Zambia's Basic Education Sub-Sector Investment Programme.* Draft Report, April 2003.

Luedke, Tracy (2001) Report of Research Findings Concerning Traditional Medicine and Health Decision Making in Northern Tete Province. Bloomington: Indiana University, Department of Anthropology.

Martins, Helder (2001) *Proposta de "Política de Envolvimento Comuntário para a Saúde".* Relatório de Consultoría. Maputo.

MISAU (2001a) *Plano Estratégico do Sector Saúde (PESS) – Relatório final da consulta às provincias.* Maputo: Ministério da Saúde, Direcção de Planificação e Cooperção – GTP.

MISAU (2001b) *Terms of Reference for the MISAU – Partners SWAP Working Group.* Ministério da Saúde, Direcção de Planificação e Cooperção.

MISAU/UNICEF/JSI/SDC (2001c) *Relatório do Workshop "Participação Comunitária",* Feb/March 2001.

Norwegian Ministry of Foreign Affairs and NORAD (2001) *Humanitarian assistance and development cooperation by Norwegian and international voluntary actors: Guidelines for the grant schemes.* Oslo: Utenriksdepartementet.

PESS (2001) *Strategic Plan for the Health Sector 2001–2005(2010).* Republic of Mozambique, Ministry of Health. Approved by the Council of Ministers April 2001.

Pfeiffer, James (2003) International NGOs and primary health care in Mozambique: the need for a new model of collaboration *Social Science & Medicine* 56: 725–738.

Rebelo, Pamela et al. (2002) *Study of Future Norwegian Support to Civil Society in Mozambique.* NORAD Report.

Rede da Criança *et al.* (2001) *O Orçamento da Criança em Moçambique.* Maputo: Rede da Criança, Save the Children da Noruega, Save the Children UK, Group Moçambicano da Dívida.

Republic of Mozambique (2001) *Action Plan for the Reduction of Absolute Poverty 2001 – 2005 (PARPA)*. Final Version Approved by the Council of Ministers April 2001.

República de Moçambique (2002) *Plano Operacional do MISAU para 2003.* Maputo: Ministério da Saúde, Direcção de Planificação e Cooperação.

Scuccato, Rino & Isabel Soares (2001) *Provedores Privados Não-lucrativos de Serviços de Saúde em Moçambique.* Maputo: Agência Suíça para o Desenvolvimento e a Cooperação.

Serra, Carlos (2001) *Em cima de uma lâmina: Um estudo sobre precaridade social em três cidades de Moçambique.* Maputo: Imprensa Universitária, Universidade Eduardo Mondlane.

TAG (1998) *Towards a Sector-Wide Approach in Programming in the Health Sector: Options for Dialogue and Action.* Technical Advisory Group, March 1998.

Tranøy, Bent Sofus & Øyvind Østerud (2001) En fragmentert stat? In: B.S. Tranøy & Ø. Østerud (eds.) *Den fragmenterte staten: Reformer, makt og styring.* Makt- og demokratiutredningen 1998-2003. Oslo: Gyldendal.

Vala, Salun C. (2000) *Relatório de Seminário de Auto-Avaliação do PPCS.* Programa de Participação Comunitária em Saúde (PPCS). Maputo: Cooperação Suiça.

ANNEX 1

Terms of Reference for a case study on relationships between health sector programmes and civil society in Mozambique: *Focusing on a strengthened target-group involvement in national and local planning processes*

Background

The first phase of the NORAD-funded study on the roles of civil society organisations in sector programmes produced an overview of general questions and key issues to be addressed more in depth in a second phase of the study. The first phase of the study was basically a desk study. The first report from this study, *SWAPS and Civil Society* (Kruse 2002), defines key concepts in this field in the following way:

- With ***SWAPs*** all public funding for the sector supports a single sector policy and expenditure programme under Government leadership. This means that all development partners must direct their work towards adopting common approaches to planning, management and monitoring arrangements across the sector.
- ***Civil society*** refers to one of three *arenas of development*: the state, the private sector, and civil society.
- ***Civil society organisations*** – ***CSOs*** – refers to a broad range of organisations and associations in civil society. The term refers to a broader range of organisations than "*NGOs"*, including churches, trade unions, local self-help groups, independent media, and professional/academic institutions.

The second phase of the SWAPs and Civil Society study will consist in case studies to be carried out in three African countries, Mozambique, Zambia, and Malawi, addressing key questions relating to the ***interface*** (contact and interaction) between civil society organisations and sector programmes in these countries. The present proposal delineates a set of questions and approaches that will be of particular relevance to a case study focused on the health sector in Mozambique.

In 2001, the Norwegian Embassy in Maputo decided to initiate a study of civil society in Mozambique, in order to provide necessary inputs to future cooperation and support to civil society in the country. This study resulted in a report that describes important civil society actors and their activities. But it also addresses the more complex question of *how* the concept of civil society relates to the social realities of Mozambique today, and discusses key factors in the country's historical, economic, political, and socio-cultural contexts of development in this regard (Rebelo et al. 2002). The proposed case study seeks to combine some crucial insights from this Mozambican study with a number of key questions from the first-phase report from the *SWAPS and Civil Society* study.

Focus of the case study in Mozambique

The following are the ***key issues to be addressed*** in the planned case study of interactions at the interface between health sector programmes and civil society in Mozambique, focussing on approaches to strengthen target-group involvement in local planning and priority-setting processes:

- What are the characteristics of civil society organisations (CSOs) with particular relevance for health sector programmes?
    - Who are the key formal *players* at central, provincial and local levels?
    - What are the key roles of CSOs in health sector programmes in Mozambique?
    - What is the basis of the CSOs' involvement as *legitimate participants* in such programmes and processes according to the CSOs themselves? According to the Government? According to other 'players' in the field?
    - How do CSOs see their roles and how do they carry out the (ideal) function of providing an informed criticism of the government and thereby making government more accountable?
    - What characterise the relationships of *formal and modern* CSOs with *informal and traditional* associations and/or authority structures?

- How are interactions between the Government and the civil society organised at present with regard to the health sector?
    - Have CSOs participated in the *PRSP processes* related to health sector programmes? How are they participating in PRSP implementation?
    - What are the most important roles of CSOs in relation to decentralised government institutions?
    - Do CSOs see the Ministry of Health as a real leader in the sector? How is the MoH operating to contract CSOs to implement specific activities in the annual plans? Is the MoH actively coordinating CSO activities to avoid gaps and/or duplication, and maximise impacts?
    - Are CSOs at present involved in planning and prioritisation on the use of established and planned *funds* in the health sector? How are they involved in planning and/or discussing the use of funds for medicines, HIV/AIDS-related funds, and funds for current costs at the provincial and central levels?
    - Are relationships between the Ministry and CSOs likely to change as a result of large funds being channelled through the Government to civil society organisations?

- What are the characteristics of the *informal civil society* with particular relevance for health sector programmes?
    - What are the roles of 'informal' associations in urban and rural areas?
    - How is the formal state system in the health sector interacting with traditional authority structures and traditional specialists especially in rural areas?
    - What are the most crucial among the formal/informal and modern/traditional relationships affecting priorities, planning, implementation of plans, and use of resources in the health sector?

- What are in the present situation potential, promising, and realistic approaches to *strengthening the involvement of the primary target groups* at the local level in planning and prioritisation of scarce resources in the health sector?
    - What are the potential roles of *informal associations* in urban and rural areas?
    - What are the potential roles of *traditional specialists* and *traditional authorities*?
    - How is it possible to increase local participation in planning the use of scarce resources in a priority field such as HIV/AIDS?

- How are participatory processes involving different *partners* and *target group representatives* at present conceived and provided for by Government institutions?
- What is the potential for strengthening participatory processes at different levels in the health sector to involve both partners and representatives of target groups?

Work plan for the study

The study will be carried out in February/March 2002 by Pamela Rebelo from Mozambique in collaboration with Randi Kaarhus from Norway. Information will primarily be collected during a two-weeks study period in Mozambique from February 10 to 21, including:

- a desk study (of policy and planning documents)
- key informant interviews and participation in meetings in Maputo
- key informant interviews and participation in meetings in one or two provinces, including visits to urban and rural localities.

Key informants will be sector representatives, international partners, NGOs and CBOs at the central and provincial/local levels. The consultants will produce a report with recommendations focussing on possibilities for increased target group involvement in planning and priority setting.

ANNEX 2

LIST OF CSOS/NGOS WORKING IN HEALTH

Foreign NGOs working in health

Organisations dedicated only to health
African Medical Research Foundation
Health Alliance International – HAI
Medecins Sans Frontiers – MSF
Marie Stopes International (Tete)
Population Service International – PSI
(John Snow Inc. – not non-profit)

Organisations with substantial health activities
World Vision
Save the Children Fund
Hope
CARE

Mozambican CSOs/NGOs working in health

Organisations working mainly in health
Mozambican Red Cross – CVM
Mozambican Association for the Defense of the Family – AMODEFA
Association of Traditional Doctors – AMETRAMO
Mozambican Association for the Disabled – ADEMO
Mozambican Association of Public Health – AMOSAPU

Organisations working with HIV/AIDS
MONASO (AIDS network)
Kindlimuka

Organisations engaged in some health work
Community Development Foundation – FDC
Progresso
Africare
ACORD

ANNEX 3

LIST OF PEOPLE MET AND CONSULTED

Ministry of Health

Moises Ernesto Mazivila	Coordinator GT/SWAP, MISAU
Dulce Mucache	National Directorate of Planning, MOH
Martinho Djedge	Head of Community Health Department
Laura Mabota	Community Health Department
Ana Mateleza	UNICEF Community Health adviser

Maputo Civil Society/NGOs

José Negrão	Cruzeiro do Sul
Fernanda Teixeira	General Secretary, Mozambique Red Cross (CVM)
Abel Antonio Machavete	ADEMO Secretary, Maputo City
Álvaro Casimiro	LINK
Elizabete Sequeira	General Secretary, PROGRESSO
Arlindo Augusto Fernandes	Kindlimuka, Interim President
Sheik Cassimo David Dáfine	Muslim Association
Dr. Fernando Vaz	2025 Commission, Head of Health Group
Marta Cumbi	Community Development Foundation/CDF
Erik Charas	CDF, Endowment and Investments Director
(Blaise Judja-Sato	CDF-Village Reach, President)
(Didier Lavril	CDF-Village Reach, Program Manager Energy)
Rev. Dinis Matsolo	Christian Council of Mozambique, General Secretary
Boaventura Zita	Christian Council of Mozambique (CCM)
Salomão Moyana	Ética
Maria dos Anjos Machonisse	AMODEFA, Executive Director
Eduarda Cipriano	FDC Kulhuvuka Project
Francisco Cabo	AMOSAPU
Carlos Serra	Eduardo Mondlane University

Mozambique Red Cross Project, Matutuine district, Maputo province

Ilda Lumbela	Project Coordinator
Jaime Malate	President, Matutuine Red Cross Committee
Matilde Ubisse	Deputy President, Maputo Red Cross
Carlos Mabote	Project Administrator

Donors/Foreign NGOs

Kirsi Viisainen	Finnish Embassy
Marcia Sousa	Swiss Development Cooperation
Carin Salerno	Swiss Development Cooperation
Guilio Borgholo	Italian Cooperation
Allison Beattie	Health and Education Adviser, DFID
Paulo Gentil	Senior Programme Officer, DFID
Vivian van Steirteghem	UNICEF
Aida Girma	UNAIDS
Beatrice Crahay	UNFPA
Christian Barrat	USAID
Helena Andersson Novela	Redd Barna, Norway

Birgitte Jallov	CTA UNESCO Media Development Project
David Melody	Medecins Sans Frontieres, Deputy Coordinator

Manhiça District, Maputo Province

Agostinho J.C. Faquir	District Administrator
Armando Manuel Timane	District Director of Health Manhiça
André Manhiça	Regulo
Laura Tamele	Mayor, Manhiça town
Dr. Eusébio Macete	Manhiça Centre for Health Research, Coordinator
Gonzalo Vicente	Manhiça Centre for Health Research, Administrator
F. Xavier Gomez Olivé	Manhiça Centre for Health Research, Epidemiologist

Tete Province

Frederico João Brito	Provincial Director of Health
Paula Adondo	DPS, Tete
Manuel Roberto Catkueta	Head, Paralegal Centre, Human Rights League
Marta Zimba	OMM, Provincial Secretary
Lurdes Bomba	OMM secretariat
Albano Alfaiate	AMETRAMO, Head of the General Office
Isabel Dique Mateus	AMETRAMO, Head of Administration
Helder White	MONASO, Regional Coordinator
Telles Sendela	MONASO, Executive Director Tete
Alex Nhambir	Provincial AIDS Nucleus, Coordinator
Isabel Labra	NPA, Coordinator
Frank Phiri	NPA, Development Programme Manager
Tiago José Maria	Mozambique Red Cross, Provincial Secretary
Narelle Bowman	World Lutheran Federation, Assistant Coordinator, Australian Lutheran World Service
Maria Jonas	World Lutheran Federation Acting Project Coordinator
Ermelinda Rodolfo	Provincial Director of Social Action
Ussumone Hassane Aligy	Muslim Association of Tete
Aslif Jafar Maund	Muslim Association of Tete, Vice President
Albino Jeque	Marie Stopes Clinic, Finance Manager
Sureia	Marie Stopes Clinic, nurse
Janasse	Marie Stopes Clinic, nurse
Luiís José Campos	ADEMO, President of the Fiscal Council
Cristiano Maibeke Mafala Dzombe	ADEMO
José Manuel Freitas	OTM
Guilherme Sevene Joaquim	OTM