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## Austerity and the “sector-wide approach” to health: The Mozambique experience

James Pfeiffer, PhD, MPH <sup>a, \*</sup>, Sarah Gimbel, RN, PhD, MPH <sup>b</sup>, Baltazar Chilundo, MD, PhD <sup>c</sup>,  
Stephen Gloyd, MD, MPH <sup>a</sup>, Rachel Chapman, PhD <sup>d</sup>, Kenneth Sherr, PhD, MPH <sup>a</sup>

<sup>a</sup> Department of Global Health, University of Washington, Seattle, WA, 98195, USA

<sup>b</sup> Department of Family and Child Nursing, University of Washington, Seattle, WA, 98195, USA

<sup>c</sup> Department of Community Health, University of Eduardo Mondlane, Maputo, Mozambique

<sup>d</sup> Department of Anthropology, University of Washington, Seattle, WA, 98195, USA

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### ABSTRACT

Fiscal austerity policies imposed by the IMF have reduced investments in social services, leaving post-independence nations like Mozambique struggling to recover from civil war and high disease burden. By 2000, a sector-wide approach (SWAp) was promoted to maximize aid effectiveness. ‘Like-minded’ bilateral donors, from Europe and Canada, promoted a unified approach to health sector support focusing on joint planning, common basket funding, and streamlined monitoring and evaluation to improve sector coordination, amplify country ownership, and build sustainable health systems. Notable donors – including US government and the Global Fund – did not participate in the SWAp, and increased vertical funding weakened the SWAp in favor of non-governmental organizations (NGOs). In spite of some success in harmonizing aid to the health sector, the SWAp experience in Mozambique demonstrates how continued austerity regimes that severely constrain public spending will continue to undermine health system strengthening in Africa, even in the midst of high levels of foreign aid with the ostensible purpose of strengthening those systems. The SWAp story provides a poignant illustration of how continued austerity will impede progress toward Sustainable Development Goal 3 (SDG 3); “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”. However, the SWAp continues to offer an alternative model to health system support that can provide a foundation for resistance to renewed austerity measures.

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### 1. Introduction

The “sector-wide approach” to planning (or SWAp) concept emerged in health and development circles in the mid- 1990s to address growing concerns in recipient countries about uncoordinated foreign aid flows, NGO proliferation, and competing donor interests that were leading to fragmentation and disruptions in health sectors, especially in Africa (Sweeney and Mortimer, 2015). In most developing countries, the health sector is constituted by a “global assemblage” of health agencies, sometimes numbering in

the hundreds, that include bilateral donors, UN organizations, NGOs, foundations, universities, and international financial institutions headquartered in the developed world but engaged with local public national health systems in substantially different ways (Collier and Ong, 2005; Garrett, 2007; Janes and Corbett, 2009). As interest has increasingly turned to “health system strengthening” in global health practice (WHO, 2007), the question of how these assemblages impact local systems has drawn increasing scrutiny. The specific orientation of these agencies to each other and to their in-country counterparts is influenced and determined by the enduring politics and debate about how to best invest in the public sector. The extent to which these actors can coordinate their resources and activities with each other and their national hosts often depends on their own ideological orientation as well as the macroeconomic structuring of foreign aid flows into partner countries. The SWAp concept emerged out of struggles to forge common

\* Corresponding author. Department of Global Health, Box 357965, University of Washington, Seattle, WA, 98195, USA.

E-mail addresses: [jamespf@uw.edu](mailto:jamespf@uw.edu) (J. Pfeiffer), [sgimbel@uw.edu](mailto:sgimbel@uw.edu) (S. Gimbel), [Baltazar.chilundo@gmail.com](mailto:Baltazar.chilundo@gmail.com) (B. Chilundo), [gloyd@uw.edu](mailto:gloyd@uw.edu) (S. Gloyd), [Rrc4@uw.edu](mailto:Rrc4@uw.edu) (R. Chapman), [ksherr@uw.edu](mailto:ksherr@uw.edu) (K. Sherr).

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purpose out of what some have called “anarchy” in global health among these assemblages (Fidler, 2007). But the struggles to maintain viable SWAp arrangements and rein in this global health anarchy bring into high relief the difficulties of strengthening health systems when public spending is severely restricted through austerity measures imposed on heavily indebted poor countries.

The advent of the SWAp idea and its importance to health system strengthening can only be understood within the broader context of the austerity policies operationalized through World Bank/IMF promoted structural adjustment programs (SAPs) across the continent since the 1980s during the neoliberal era of state contraction, privatization, and market fundamentalism (Kentikelenis et al., 2015; Pfeiffer and Chapman, 2010; Rowden, 2009; Stuckler and Basu, 2009; Stuckler et al., 2010). In other words, the emergence of the atrophied public sectors and the anarchic global health assemblages that characterize health sectors in so much of the developing world has identifiable causes and beginnings. SAPs often led to reductions in state health budgets that created stark gaps in services to the poor majority, especially at a time when many governments were still hoping to build out their fledgling primary health care systems to improve coverage and access. To fill these service gaps and promote privatization, leading global donors, including USAID and the World Bank, channeled aid to non-governmental actors (Buse and Walt, 1997). The SWAp approach was borne out of frustration at the uncoordinated and “unruly mélange”, as Buse and Walt have called it, of these proliferating NGOs and agencies landing on struggling African health sectors (Buse and Walt, 1997; Peters et al., 2013; Sweeney and Mortimer, 2015).

The critical reflection offered below provides an historical rendering of the SWAp process in Mozambique’s health sector to illustrate how these continued austerity measures impede efforts to coordinate aid and maximize the value of foreign aid investment in the health sector. It is argued here that the SWAp effort has had important successes in harmonizing aid in Mozambique and should continue, but overly restrictive constraints on public spending imposed by international financial institutions on health workforce and long-term system building remains the greatest challenge to meeting SDG health goals, defeating HIV/AIDS, and expanding health care coverage. Over the last two decades Mozambique, still one of the very poorest countries in the world, has been among the major recipients of health aid in Africa (IHME, 2016). Yet its primary health care system still has low population coverage and is desperately understaffed. The huge surge in funding for HIV/AIDS in the 2000’s has not resolved these challenges. After 10 years and hundreds of millions in new funding, mostly for HIV, the health worker per population ratio remains mired at 71/10000, among the five worst in the world (MISAU, 2015). The ratio of health facilities per capita has actually worsened since 2009 to reach only 1 per 16,795 inhabitants by 2014, also among the very lowest in the world (MISAU, 2015). The SWAp story in Mozambique exposes the extraordinary barriers that austerity regimes create for health system strengthening in Africa, even in the midst of high levels of foreign aid for health that has the ostensible purpose of strengthening those systems. Sustainable Development “Goal 3” includes a specific target to, “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (UN, 2017). In spite of the SWAp, more austerity will make it virtually impossible for indebted poor countries such as Mozambique to approach SDG goals.

## 2. Source materials

In order to reconstruct and provide an historical narrative of the

SWAp process in Mozambique a variety of information sources were consulted. All of the authors have worked extensively in the National Health System in Mozambique and were present at many of the events, meetings, and conferences through which the SWAp process was developed and rolled out. These included numerous meetings of the national NGO consortium, donors, Ministry of Health, and provincial health directorates over 20 years. The authors also conducted a policy review by accessing a wide range of policy documents referenced in the narrative below that provide data, describe policy decisions, and track spending in the health sector in Mozambique. The documents included official Ministry of Health reports, donor technical working group reports and minutes, and World Bank and IMF reports and policy statements.

## 3. The SWAp, health systems, and austerity

### 3.1. Health and independence

Soon after independence in 1975, Mozambique’s new socialist government began the design and development of a primary health care (PHC) system drawing on Alma Ata principles to scale-up basic services to its largely rural impoverished population (Walt and Melamed, 1983). Most Mozambicans had no access to western biomedical care during the Portuguese colonial period and Mozambique’s first president, Samora Machel (a former nurse), and his independence party known as FRELIMO (the Mozambique Liberation Front) made creation of a national health system a top priority. The new public system drew the attention of the World Health Organization which heralded it as a model for PHC in the developing world (Walt and Melamed, 1983). The design centered on an integrated public sector system of health posts, health centers, rural hospitals, provincial hospitals together with development and training of a health workforce. However, after successful initial rollout of the system, including construction of over a thousand health facilities and health workforce training, Rhodesia and later apartheid South Africa funded and trained an insurgency, the Mozambique National Resistance (or MNR, known by its Portuguese acronym RENAMO) that waged a war of “destabilization” with attacks on government infrastructure including the health system, schools, roads, and civilian communities in rural areas (Cliff and Noormahomed, 1988). Despite the ongoing instability, the government was able to maintain a functioning health system even while hundreds of health posts were attacked and health workers injured or killed. However, the conflict lasted over a decade leaving the country nearly bankrupt and much of its public infrastructure in ruins.

By the late 1980s, the heavily indebted government’s commitments to socialist principles began to wane, leading it to sign onto a structural adjustment program in 1987 imposing severe austerity measures on an already devastated public sector. By the end of the decade, workforce had been cut, salaries slashed, and the state health budget radically scaled back (Beste and Pfeiffer, 2016; Cliff, 1993; Marshall, 1990; Pfeiffer, 2003). As the government moved from a statist model to a privatized market economy in the late 1980s foreign aid began to arrive in the form of “projects” rather than budget support to build the health system itself. A broad array of donors supported these projects, including USAID and European bilaterals, that increasingly directed aid through international non-governmental organizations (NGOs) that operated independently of government plans or finances, and sometimes openly against the government initiatives (Wuyts, 1996). With the end of apartheid, financial support for RENAMO disappeared and a ceasefire was signed in 1992 followed by elections in 1994 won handily by FRELIMO. The combination of public sector spending caps imposed by the SAP along with major donor commitments to strengthen so-

called “civil society” and promote privatization, meant that foreign aid was increasingly channeled toward NGOs rather than public systems. The 1990s witnessed a deluge of NGOs and other organizations in the health sector with little programmatic or financial coordination as the nation struggled to rebuild (Cliff, 1993; Pfeiffer, 2003). By the end of the 1990s, dozens of donors were funding hundreds of health projects across the country with only perfunctory linkages and coordination with the Ministry of Health while the building blocks of the national health system remained starved for support. A growing chorus of frustration at the lack of coordination prompted the enactment of a 1998 law which introduced stricter registration and monitoring of NGOs by the government (Brown, 1999). With continued austerity conditionalities that constrained public spending and undermined local health sector leadership, a vigorous debate emerged by the end of the decade in Mozambique about how to better harmonize aid and reign in NGO “one-off health projects” that produced little if any sustainable impact on population health (Batley, 2002; Beste and Pfeiffer, 2016).

### 3.2. Health sector financing

As in many African countries, Mozambique's health “sector” is financed through a dizzying array of donors, agencies, foundations and local government funding managed in varying degrees of collaboration with the Ministry of Health, overseen by the Ministry of Finance, and surveilled by the IMF. The term “austerity” refers to national macroeconomic strategies and medium term planning strategies deployed by heavily indebted countries to reduce or curtail government spending, including social programs, ostensibly to stabilize national economies, rectify balance of payment problems, and help pay back creditors (Stuckler and Basu, 2013). To track how austerity policies constrain health system financing in Mozambique it is important to distinguish between foreign aid that flows “on-budget” into the health “system” itself, that is into the public/government budget, and aid that remains “off budget” in the health “sector” and spent separately from the MOH budget and planning, for example resources that flow to NGOs for specific projects. (See Fig. 1). The scenario is further complicated by two different ways funding can be counted as “on-budget”. Finances can be considered “on-CUT” (*Conta Única do Tesouro*) that flow through the treasury and the government financial system, or “off-CUT” but still included in the State Budget, therefore part of sector planning and managed separately from treasury funds. The SWAp common fund, as described below, was moved “on-budget” but “off-CUT”, along with the Global Fund, some bilaterals including Canada (CIDA) and IrishAID, and UN support. Fully “off-budget” support has included most PEPFAR funding and a wide range of funding to NGOs that is outside the scope of government-led health sector financial planning (MISAU, 2015; UNICEF, 2015).

A further set of categories and terms is helpful in describing the health sector landscape and the global assemblage that populates it. “Vertical” funding refers to resources used to address a specific disease or health problem such as HIV/AIDS or TB (Ooms and Schrecker, 2005). Vertical funds are generally not used for long term system building but can be placed “on-budget” and earmarked for certain programs. A significant level of vertical funding for HIV, TB and malaria programs from a variety of donors has been placed on-budget but off-CUT, but vertical funds are more generally channeled to NGOs outside the health system (although those NGOs may work in collaboration with the health system usually at lower administrative levels such as provinces and districts) (MISAU, 2015; UNICEF, 2015). Nearly all funding that goes to NGOs is considered vertical and “off-budget”. On the other hand, “horizontal funding” focuses on the strengthening of basic health system

building blocks and recurrent costs, and is not earmarked for specific programs. This type of funding, with some rare exceptions, is almost always by definition “on-budget”, where it can be folded into annual and long term planning to keep the system running and to further extend coverage by the system. These distinctions are enormously important within the context of austerity. The SAP placed caps on how much funding can be placed “on-budget” and therefore how much can be invested in long term system building (Hanlon, 1991; Ooms and Schrecker, 2005). Such caps are normally defined using the concept of “fiscal space”, the estimation of which indicates how much public spending can be allowed in a government budget that is considered “sustainable” (Heller, 2005; UNICEF, 2014). The IMF definition and calculation of fiscal space is in part determined by very controversially low inflation targets and conservative estimates for projections of future funding which lead to reduced fiscal space, and in this way provides the foundation for austerity. The fiscal space calculation becomes the upstream planning tool used to cap public spending on the basis of the IMF's macroeconomic objectives, such as keeping inflation very low (Kentikelenis et al., 2015). A high debt burden will reduce fiscal space for public spending for example. Debt relief then has the potential to increase fiscal space allowing for increased public budgets. So even with large scale increases in foreign aid for health, SAPs, (which later were replaced by “Poverty Reduction Strategy papers” or PRSPs discussed below), constrain how much of that aid can be placed “on-budget”. With these limits in place, donor funding must seek external partners, typically NGOs, to channel their resources (Hanlon, 1996; Wuyts, 1996). Therefore, while total funding for health “sectors” in Africa may have increased substantially, austerity regimes prevent many of those resources from flowing to government budgets and being invested in long term public national health “systems” growth and development (Kentikelenis et al., 2015; Turshen, 1999).

Certainly, there are funders and NGOs that would still choose to channel their support away from government budgets even if there were few or no fiscal constraints or budget ceilings imposed under austerity. SAPs and PRSPs are not the only reason there has been a proliferation of NGOs and vertical projects conducted outside of national systems, but it is argued here that the imposition of SAPs and later PRSPs encouraged and abetted the redirection of funding away from the state sector further weakening local control and undermining system strengthening. According to the WHO, by 2007 only 20% of global health aid was going to general government health system budget support and 50% of aid flowed off budget in the developing world (WHO, 2007). Similar experiences around the developing world in the neoliberal era had generated interest in the SWAp concept in the 1990s among concerned development actors; the WHO took the lead in defining the sector wide approach for health (Cassels, 1997). Frustrated by the unruly donor and NGO *mélange*, but still constrained by the SAP, the Ministry of Health and a number of key bilateral donors in Mozambique turned to the SWAp framework for guidance.

### 3.3. SWAp principles

A sector-wide approach (SWAp) is a generic partnership agreement among national and international agencies which acts as a mechanism to promote broad-based sectoral development. The components of a SWAp generally include, a) widely agreed upon sectoral policies and strategies; b) resource projections, preferably within a multi-year expenditure framework; c) institutional capacity appraisal; and d) common management arrangements (shared by the MOH and donors) using national systems (Ortiz et al., 2008; Technical Advisory Group, 1998). In 2000, the SWAp for health financing was initiated in Mozambique, as a means to

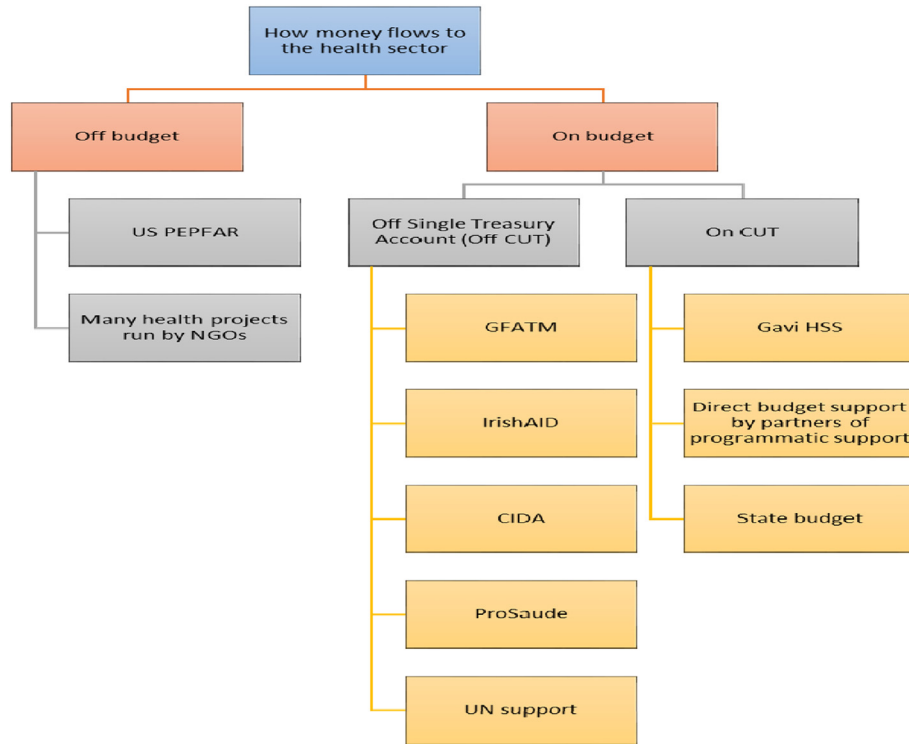


Fig. 1. Health sector financial flows “on-budget” and “off budget”.

reinforce government autonomy and accountability by streamlining support for the health sector into a common basket. This was 13 years after the Mozambican government began experiencing austerity measures through its commitment to structural adjustment programs. It began with development of a code of conduct and a clear donor coordination mechanism, and subsequently a health sector strategic plan was developed followed by establishment of basket funds. Joint annual reviews and biannual sector coordination committees were employed to assess progress toward goals and facilitate joint planning. The autonomy promoted by the SWAp process was intended to strengthen the management capacity of the Mozambican state and the unifying of aid support was meant to rationalize an often divisive and fragmented financial support-giving process by multiple donors, with multiple evaluative frameworks (Baser and Morgan, 2001). Over the course of the next 15 years the SWAp process experienced multiple reforms, driven by the politics of global aid institutions and continued macroeconomic austerity measures, which have ultimately diluted its impact and its sustainability as a mechanism to channel and rationalize foreign aid.

### 3.4. Moving towards the SWAp in Mozambique

As peace and stability were returning to Mozambique by the late 1990s, the foreign aid paradigm began to shift from emergency medical relief to “sustainable development” (Ooms, 2006, 2008). In principle, the former builds on the premise of emergency and exceptionality, while the latter focuses on self-determination and sustainability. Over the longer term, effective health systems cannot be sustained without “on-budget” investments in health systems building blocks and fundamentals such as training, workforce, infrastructure, medicines, and effective monitoring and evaluation systems (WHO, 2007). In Mozambique, the adjustment program effectively capped hiring (in spite of MoH resistance),

restricted infrastructure investment, and slowed quality improvement efforts within the health system itself.

The SAP’s stringent austerity measures were able to control inflation, an IMF priority, from 70% to 7% between 1994 and 1999, and achieve relative short term economic stability (Brown, 1999). However, due to the austerity measures which froze investments in the social sector, health and other related indicators remained flat, while a nascent HIV/AIDS epidemic loomed and economic inequality deepened (De Renzio and Hanlon, 2007). At the same time, within the MOH the relationship with what became known as the “like-minded” donor group was positive, with Nordic countries and later the Netherlands, Switzerland and Canada supporting the government’s intention to move toward a pooled funding model to address frustrations around poor coordination (Batley, 2002; De Renzio and Hanlon, 2007). A pooled fund with joint MOH and donor management held promise as a way for the public system to capture and coordinate the use of foreign aid more effectively. In order to develop more sustainable and efficient aid support packages, these ‘like-minded’ stakeholders together with the MOH, began to identify and implement common approaches to resource programming, including provision of funding under matching sets of conditions with joint evaluations. Under this approach donors would focus on macro-economic policies and targets as conditions for support rather than detailed directions on how funds are used (De Renzio and Hanlon, 2007; Technical Advisory Group, 1998.)

Moving toward the pooled approach, especially when it was delivered directly to target funding baskets (e.g. specific health sectors or provinces), was viewed advantageously by the MOH as they would manage the aid monies, whereas under the project or emergency structure aid mostly bypassed the public sector leading to implementation gaps and inefficiencies (MISAU, 1997). In 1996 the earliest common pooled arrangement for technical assistance was established in the health sector in Mozambique. It was managed by the MOH and administered via the UNDP with funding

from a number of bilateral donors including the Netherlands, Norway and Switzerland (Martinez, 2006). Subsequently in 1998 a pharmaceutical common fund was established, following an initial program initiated a few years earlier by the Swiss Agency for Development and Cooperation (SDC). This earmarking approach to specific common baskets protected the health sector from competition from more influential ministries for Treasury funds but at the expense of bypassing the Ministry of Planning and Finances as most of aid funding could not flow through public accounts as per SAP conditionalities. The introduction of these mechanisms to pool funds, leading up to the establishment of SWAp, had the added benefit of exposing more donors to MOH processes, as well as the MOH being more accountable to donor requirements. More communication amongst the donors created less inefficiency as gap analysis was conducted jointly, and transparency and accountability improved, all creating momentum towards implementing the SWAp in order to bolster informed decision making by all stakeholders in the health sector (Cassels, 1997). Ministry of Health strategic planning documents from this period note that the SWAp was a preferred mechanism which was appropriately designed in the medium term to ensure a substantial rise in efficient coordination of health resources (MISAU, 1998). The SWAp could provide a model for the MOH to lead and invest donor funding in health system fundamentals rather than fragmented projects and disease-specific vertical projects.

### 3.5. SWAp – the early years

The SWAp itself officially commenced in 2000 in Mozambique with the signing of the “Kaya Kwanga” code of conduct agreement for government and development partners in the health sector (Ministry of Health, 2000). This institutional commitment was intended to be eventually signed by all cooperating partners and taken into consideration in all future bilateral and multilateral agreements. It essentially established basic principles and guidelines for collaboration among the parties and strengthened the government’s leadership role in the health sector through the increasing use of national management structures for planning cycles and priority setting, which would also eventually align it with the 2005 Paris Declaration on Aid Effectiveness that also sought to “harmonize” donor efforts in the developing world (Directorate of Planning and Cooperation, 2007; OECD, 2005). The specific terms of reference for the SWAp technical group were detailed followed by the development of a health sector strategic plan in 2001. These coincided with the completion of the Heavily Indebted Poor Countries (HIPC) Initiative and the finalization of the Government of Mozambique’s Action Plan for the Reduction of Absolute Poverty (PARPA) to international financing to the IMF and World Bank (De Renzio and Goldsbrough, 2007; Martinez, 2006). The PARPA signaled the shift within the World Bank and IMF away from the structural adjustment paradigm to new “Poverty Reduction Strategies” or PRSPs, derived from the Poverty Reduction and Growth Facility (PRGF) that formally replaced the Enhanced Structural Adjustment Facility (IMF, 2002). In principle, the new PRSP process would be coordinated by the World Bank and IMF but would focus on transparency and inclusion of government and civil society actors to develop macroeconomic strategies over specified periods. Critics suggested that the shift was in response to the broad outcry among humanitarian agencies against SAPs (Wamala and Kawachi, 2007). However, the new approach retained debt restructuring and forgiveness conditionalities that still led to austerity in participating countries (De Renzio and Goldsbrough, 2007; Independent Evaluation Office of the IMF, 2007; Ooms and Schrecker, 2005). While modest increases in public spending on social sectors were sometimes allowed, tight public spending

limitations were still imposed (De Renzio and Goldsbrough, 2007; Ooms and Schrecker, 2005). Previous SAP and PRSP arrangements had included explicit wage bill ceilings but by 2006 the IMF dropped the formal caps. Observers noted however that broader government budget envelop limits still constrained public sector hiring in both educational and health sectors leading to anemic health workforce growth (Beste and Pfeiffer, 2016; De Renzio and Goldsbrough, 2007). For many, the PRSF was a rebranding of structural adjustment that rhetorically deployed a new emphasis on “poverty reduction” (Pfeiffer and Chapman, 2010).

The Code of Conduct in the Health Sector was later revised and updated in July 2003 (Ministry of Health, (2008)). Also that year, a new “common fund” arrangement was developed called *Prosaúde*, that replaced the first common fund for the MOH strategic plan (Martinez, 2006). In fact three related common funds mechanisms were created; one for drugs (that replaced a previous fund managed by Swiss Cooperation), a second that focused on Provincial support (Mozambique has 10 provinces plus the city of Maputo), and the third *Prosaúde* account.

Collaborating partners at the time included the bulk of ‘like-minded’ donors as well as a number of multilateral institutions including UNFPA and WHO. The leadership structure included a bilateral representative, a multilateral representative, and the Ministry of Health. Conspicuously absent from this process was the United States government, the largest single partner and called by some observers “the single-minded donor”. This work was conducted under an accountability structure which included joint annual review and biannual meetings of the sector coordination committee to ensure smooth coordination between cooperating partners and the Mozambican MoH (Ortiz et al., 2008). Importantly, it was agreed that the new common fund arrangement would be “off-CUT” but “on-budget”, that is included in the broader State Budget. The funding therefore had to be included and counted within the PARPA conditionalities. The Common Fund contribution had to be consistent with the “Medium Term Expenditure Framework” (or MTEF), a basic planning tool used by the IMF to define spending limits.

Over the first several years, the arrangements seemed to be working as the proportion of vertical funding to the health sector declined somewhat as a result of the arrangements (Visser-Valfrey and Umarji, 2010). However, the landscape would soon change dramatically with the arrival of large-scale new vertical funding for HIV/AIDS from the U.S. Government.

### 3.6. The SWAp and President’s Emergency Plan for AIDS Relief (PEPFAR)

In 2004, the United States government introduced a new disease-specific financing mechanism, PEPFAR, to address the HIV/AIDS epidemic. PEPFAR constituted by far the largest increase in health aid in the country’s history (Embassy of the United States in Mozambique, 2016). The arrival of PEPFAR funding in Mozambique underscored the strategic consequences of the U.S. choice to stay out of the SWAp, and was marked initially by considerable controversy that landed on the front page of the New York Times in 2004 (Sontag, 2004). The Mozambique government and its Ministry of Health had developed a national HIV/AIDS care and treatment scale-up plan with the “like-minded donors”, and others including the Clinton Foundation, who focused on common fund support and purchase of generic drugs to reduce costs. PEPFAR’s plan for Mozambique on the other hand included use of expensive brand name drugs and channeling of funding to U.S. NGOs for implementation. A series of confrontational meetings ensued, and with the backing of the common fund donors Mozambique succeeded in pushing back and achieved a compromise with the U.S. Generic

drugs would be purchased but PEPFAR funding would still mostly flow off-budget to NGO “implementing” partners through vertical projects, with a trickle of funding to the MOH through CDC for blood bank work and to cover other small gaps. As part of the compromise PEPFAR would adhere to treatment targets already set forth in the MOH plan. But PEPFAR was allowed to support NGOs to provide “technical assistance” as long as they adhered to the MOH care and treatment plan.

During the same time period other initiatives deriving from the global emphasis on HIV/AIDS, including the Global Fund to Fight AIDS, Malaria and TB (GFATM) in 2002 and the World Bank in 2003–4, introduced large disease specific vertical financing for Mozambique (Høg, 2014; Mussa et al., 2013; Visser-Valfrey and Umarji, 2010). By 2007 external health funding in Mozambique had reached \$400 million USD per year, with just 26% of the foreign aid in health received from 26 donors entered into the common fund (Agence Française de Développement, 2008). These financing initiatives returned to the emergency medical relief model and away from the paradigm of self-determination and sustainability (Høg, 2014). The sheer increase in absolute dollars was dramatic and could potentially have altered the health sector development course for the country which had until then been on a steady path of consensus building toward a common approach to health system strengthening.

The GFATM funds, at the behest of the MOH and the donor community, were introduced into the common fund in 2004, the first country to successfully lobby for this (Martinez, 2006). However, World Bank and more importantly, PEPFAR funds, were channeled through non-governmental organizations, therefore “off-budget”, that were identified as “implementing partners” (Mussa et al., 2013). Many of these have U.S. University affiliations including ICAP (the International Center for AIDS Care and Treatment Programs) at Columbia University, The Vanderbilt Institute for Global Health, and Health Alliance International (HAI) at the University of Washington, while other NGOs included the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Family Health International (FHI), Abt Associates, and a range of others. The surge in funding therefore spurred another proliferation of NGOs in the health sector across the country and further shifted the power dynamics of the aid community where NGOs became more influential than bilateral donors, due to large influxes of PEPFAR dollars.

Without a doubt the advent of PEPFAR and other larger global initiatives have been successful in bringing about expanded access to HIV care and treatment. However, these influxes into the health system, contributed in part to the weakened state of the SWAp in Mozambique. The argument of HIV exceptionalism allowed for the reintroduction of the foreign relief model, which brought about a return to parallel vertical funding with opaque allocation practices. The focus was shifted to getting more patients on lifesaving treatment with limited consideration of long term support to strengthen the system itself.

In 2008, to address these concerns, the Ministry of Health together with the expanded donor community, who had jointly invested tremendously in the establishment of the SWAp, produced the “Mozambique Compact” under the “International Health Partnership (IHP+)” (Ministry of Health, (2008)). This was 21 years after the first structural adjustment program and its implied austerity measures (1987), 8 years after the beginning of the sector-wide approach to health and the partnership agreement in 2000, 6 years after the first disease-specific funding initiatives for HIV and AIDS in 2002 and 4 years after the largest donor commitment to HIV in 2004. The agreement sought to once again align donor efforts, reign in the numerous global health financing initiatives, and attenuate the unintended negative consequences of their massive and rapid influx of disease-specific vertical funds. These

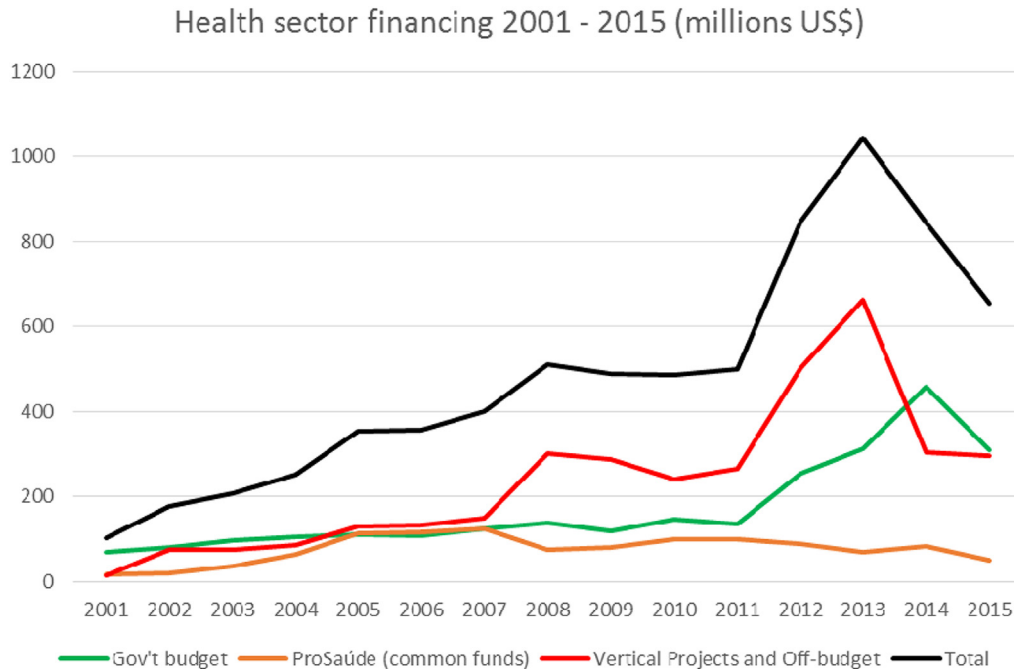
unintended negative consequences included the migration of skilled health workers out of the public sector to NGOs with higher pay and the increased MOH donor-induced management burden, with over 250 NGO partners with varying planning cycles and implementation strategies and policies (Mussa et al., 2013; Sherr et al., 2012). The Compact was intended to provide a unifying framework for all health partners in Mozambique for increased and more effective aid through promotion of common financing, planning and evaluative efforts (Ministry of Health, (2008)). The new framework was also meant to be complementary to the Kaya Kwanga agreement, which had helped establish the SWAp mechanism by defining alignment of funding to the common fund mechanism, and promoting the use of one plan and one set of metrics. Kaya Kwanga is a Mozambique-specific document. The IHP + on the other hand was a multi-country attempt to improve aid effectiveness in countries with SWAps using similar principles, seeking to be catalytic in two senses. First, to mobilize resources for key countries to meet the MDGs, and secondly, to align funding that would not go through the SWAp and common fund with the SWAp principles (overall alignment, one plan, one M&E system). For example, GAVI, the Global Fund, and PEPFAR were all huge funds that were vertical or off-budget and lessened the impact on strengthening of health systems, and ‘aid effectiveness’ more broadly. The IHP + effort sought a more comprehensive approach to donor coordination.

However, challenges to coordination and management of multiple donors persisted however. For example, GFATM funds were disbursed in the third or fourth quarter in contrast to the other common fund arrangements. As a result, in 2009 then Minister of Health, Dr. Ivo Garrido, recommended that GFATM funding be transferred to a separate bank account with a separate management unit in order to meet the donor requirements. PEPFAR funding continued to be channeled to a range of NGO implementing partners often with only perfunctory engagement of health system leadership and national planning efforts.

### 3.7. Consequences and new challenges

In the ensuing years, the SWAp process continued its efforts to harmonize donor support but huge levels of HIV funding, mostly PEPFAR, continued to flow to international NGOs while basic health system funding still languished. As a recent UNICEF report (2015) pointed out, there was some progress incorporating vertical funds on-budget, but a large portion of health sector funding remained off-budget. In 2013, off-budget expenditure was about 33 percent of total sector expenditure (US\$ 360 mn) compared with 2009, when it constituted 45 percent share (US\$ 241 mn) (UNICEF, 2015). The decreasing share of off-budget expenditure coupled with the corresponding increasing share of vertical funds, again, reflected the increasing positive tendency of donors to put their projects on the budget (UNICEF, 2015). And Prosaúde has remained an important mechanism for public system health interventions. Since 2009, it has funded on average about 22% of the Health Budget each year. Importantly, “recurrent expenditure”, those expenses related to keeping the system functioning, such as workforce payroll, has grown more than three times its value between 2008 and 2015, assuming an average annual 18 percent rise in wages/salaries (UNICEF, 2015). (See Fig. 2).

But the population has been growing rapidly as well, so despite the wage growth, the ratio of physicians per 1000 people increased just slightly from 0.03 to 0.04 over the same time period, and the ratio of nurses/midwives per 1000 people increased just 0.34 to 0.4117, far from the government’s current five-year target of 1.13 health professionals per 1000 people (UNICEF, 2015). In spite of the SWAp arrangements, modest increases in public on-budget



**Fig. 2.** Health sector financing 2001–2015.

Source: CEPISA Report and MOH financial reports (CEPSA, 2016; MISAU, 2016b).

spending, and the huge surge of health aid funding over the last decade, not only did a majority of health support continue to be channeled outside of government budgets as vertical funding, but the actual total government budget allocation for health expenditure as a proportion of overall government expenditure declined from 13.4% in 2006 to 11.9% in 2009, 7.8% in 2014, and 9% in 2015, thus veering away from the Abuja target of 15% (UNICEF, 2015; Visser-Valfrey and Umarji, 2010; WHO, 2011). As discussed above, by 2014 the workforce for health per population ratio remains mired at 71/10000, among the five worst in the world (MISAU, 2015). The ratio of health facilities per capita has actually worsened since 2009 to reach only 1 per 16,795 inhabitants, also among the very lowest in the world (MISAU, 2015). As the recent MOH report (2016) on health financing indicates, distance to health care facilities remains a great challenge for Mozambicans many of whom live in dispersed and largely rural areas. In 2011, 65% of the population lived more than 45 min walking distance from the closest health facility. While estimates vary, this is barely better than health system population coverage in 1980 before the start of the RENAMO attacks. Many health facilities lack basic infrastructure for quality health care. Almost 50% of health centers don't have access to electricity and 60% don't have access to water (MISAU, 2016a).

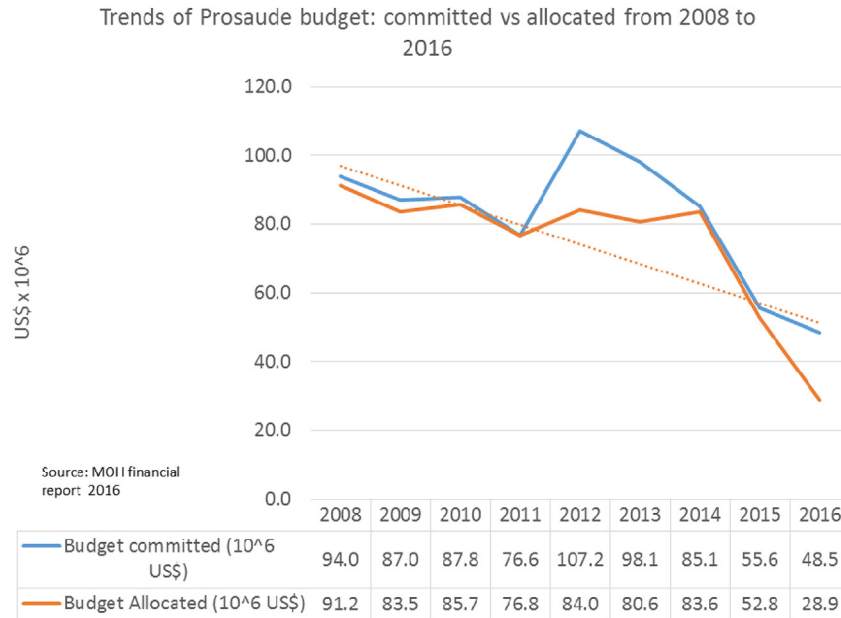
In recent years, Mozambique has experienced a deepening economic and political crisis provoked by accumulation of new debt and renewed instability with RENAMO militants. Alongside the current crisis has come a reduction in funding for the health sector by “Prosaúde” partners as illustrated in Fig. 3. From 2008 to 2016 there is a clear negative trend of both funds committed and allocated with the acceleration of the negative trend during the past 5 years. This leaves the MOH with little ability to cope with the current national economic crisis and the consequences to the population health are expected to get worse.

The last PARPA agreement ended in 2014 and the IMF will not renew its lending until agreement is reached on the new debt circumstances (AllAfrica.com, 2016). Intensified austerity is likely and

the current SWAp arrangements are in jeopardy due to decreased levels of funding amidst concerns about how the growing economic crisis will be addressed. However, while the U.S. was not involved in the beginning of the common fund experiment, the SWAp has become more of a coordinating mechanism and the U.S. has increasingly participated in the planning process and recognized by the MOH as a “focal donor”. In fact, the U.S. and MOH recently agreed to move substantial USAID resources “on budget” but “off-CUT” in 2016 in a positive sign of increased cooperation (MISAU, 2016a), and the U.S. has become the lead for bilateral lenders. Substantial PEPFAR funds however continue to flow to NGO implementing partners outside the management purview of the MoH and remain “off-budget” (more recent reliable figures are not publicly available).

#### 4. Discussion

The SWAp history in Mozambique captures the central challenge faced by the global health community seeking to “end aids”, adhere to the Paris Declaration, achieve the MDGs, and now take on the “Sustainable Development Goals”, within continued austerity conditionalities in their third decade in Mozambique. Since the initiation of structural adjustment in 1987 through the more recent Poverty Reduction Strategy (PRSP) approach, public spending constraints have fluctuated, with modest spending increases allowed into the 2000s, but hiring caps and spending limits have continued. The SWAp that started in 2000 has also ebbed and flowed in its effectiveness, detailed above, as it has struggled with the arrival of very large new aid flows to the health sector from PEPFAR, GAVI and the Global Fund that flowed outside the Common Fund and off budget, therefore undermining SWAp influence and coordination. To be sure, the SWAp had meaningful successes in channeling resources effectively into the struggling health system. The basic SWAp principles that emphasize establishment of shared goals among donors and ministries of health combined with a respect for national ownership of planning and budgeting have



**Fig. 3.** Trends of Prosaúde budget 2008–2016.  
Source: MOH Financial Report 2016 (MISAU, 2016b).

helped focus foreign aid on the challenges of health system building. Recent history in Mozambique can point to some modest successes that the SWAp produced in reining in and coordinating key actors among the still unruly global health assemblage. While donor and NGO behavior have created ongoing challenges to coordination, the primary structural cause of these difficulties derives from public sector spending limits imposed on this heavily indebted poor country. The underlying austerity imperative that runs through the structural adjustment experience to PRSPs, and now to the current period of new political uncertainty will continue to undermine the ability of the Ministry of Health to lead the development and implementation of long-term health system building, finance significant workforce expansion, and improve donor and NGO coordination. The most recent data outlined earlier on health system coverage, performance, and financing provide a grim reminder of structural adjustment's failure.

Another round of austerity measures on the struggling public system will present nearly insurmountable obstacles to reaching SDG health goals. Any meaningful population health improvement, including the SDG 3 target of universal health service coverage, will be elusive unless the basic health infrastructure can be built out, system fundamentals supported, and workforce dramatically expanded accordingly. The cacophony of NGO activity, vertical projects, service fragmentation, and parallel systems only serve to distract and divert the global health project from these basic goals. Such system fundamentals will only improve across the country if long-term “on-budget” public investments can increase substantially. To be sure, even if austerity constraints were relaxed many donors and their NGO partners would still continue to work outside national plans and priorities. But a stronger better-funded Ministry of Health, with backing from major like-minded donors, is far more likely to be able to track, manage, and monitor NGO activity, and steer it toward more constructive ends. While the SWAp cannot sufficiently redress or remedy the impact of adjustment on health system building it can continue to provide a model of good donor behavior, as well as a vision of what genuine partnership might look like with the Ministry of Health in the driver's seat. While some form of renewed austerity is nearly certain in Mozambique

over the next five to ten years, the future of the SWAp is less clear. While the practicing global health community is increasingly convinced that sector-wide approaches to planning for health system strengthening are vital to achieving SDGs, policymakers at international financial institutions and many major donors lag far behind and must be pressured to join the effort.

The turmoil in Europe and the political pushback against austerity has recently led to a growing consensus, even among elements of the so-called “Troika” (The IMF, the European commission, and the European Central Bank) that austerity in Europe was a mistake in both humanitarian and economic terms (Goodman, 2016). Latin America rejected the “Washington Consensus” many years ago (Grugel and Ruggirozzi, 2012). In 2017, with the future of the SWAp process in Mozambique in doubt will Mozambique (and Africa) finally have its turn to reject austerity and embrace genuine health system strengthening? Much will depend on the donor willingness to challenge the imposition of conservative public spending constraints on health in exchange for debt relief and insist on investing in the national health system building blocks, most urgently workforce. Continued support for the SWAp can provide a foundation for resistance to renewed austerity on the part of donors who share the values of universal health care, human rights, and national sovereignty.

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