Expenditure Tracking and Service Delivery Survey
The Health Sector In Mozambique

Survey Information and Status Report

August 2002

Survey Background

During the consultation phase of the ongoing PER, the Government of Mozambique and the World Bank agreed that a Public Expenditure Tracking Survey (PETS) would be carried out as a component of the Public Expenditure Review (PER). A proposal for an Expenditure Tracking and Service Delivery Survey (ETSDS) in the health sector was presented to Ministry of Planning and Finance (MPF) and the Ministério de Saúde (Ministry of Health) (MISAU) in February 2001. Agreement concerning the broad scope and objectives of the survey was eventually reached in August 2001. The survey will be implemented as a component of the ongoing Department for International Development, UK (DFID)-financed project of support to the Planning and Budgeting Directorate (DNPO) of the Ministry of Planning and Finance (MPF). However, in order prevent inordinate disruption of DNPO and MISAU activities, separate administrative and management arrangements will be put in place. Oxford Policy Management (OPM), in collaboration with Austral Consultoria, will be the implementing agencies for the survey.

The Basic Concept

The National Health System (NHS) is the main provider of allopathic health services in Mozambique. The level I of the NHS—health centers and health posts—deliver a sizable proportion of the total volume of health services in the country and comprises the first (and often only) point of contact with the health system for a large part of the Mozambican population.

The current approach to delivering primary-level health services in Mozambique has been quite successful. In a context of very limited human and material resources, the NHS has managed an increase in the coverage of the health system over the last decade through an expansion of health facility infrastructure and health sector staff. This has permitted a considerable expansion in aggregate service outputs. However, there is also evidence of notable problems in service delivery, such as low technical quality, lack of drugs and equipment, low staff morale, and informal charging. In addition, due to poorly functioning Management Information Systems, little is known about the process by which resources are allocated—between districts, as well as between facilities within districts.
In view of these issues, the objective of the ETSDS is to provide quantitative and qualitative evidence on how current systems and procedures impact on efficiency, equity, and quality in the delivery of primary health care. In this way, the survey comprises an input into the design of strategies to improve the development impact of public spending. It is also expected to provide valuable baseline data against which progress in the implementation of the Plano Estratégico do Sector Saúde (Health Sector Strategic Plan) can be assessed.

In order to meet the stated objectives, the survey approach must reflect the complex institutional setting for delivery of health services. Health services delivered by the NHS are almost fully subsidized from general revenues and aid financing. However, individual facilities do not hold their own budgets. Rather, financial resources are allocated to administrative units above the facility—the Ministry of Health, Provincial Directorates of Health, and District Directorates of Health—which are responsible for contracting and payment of staff, procurement and distribution of key recurrent inputs, as well as for supervision and inspection of staff and facilities. Some resources also flow in the reverse direction, specifically in the form of revenues from charges for consultations and medicines.

In order to capture these respective resource flows, data will be collected through structured interviews and record reviews at Provincial and District Directorates. At the facility level, a detailed questionnaire will be administered to the facility director. In addition, a sample of staff and clients will be interviewed. The survey will cover approximately 100 health centers and posts in 32 urban and rural districts nationwide. The questionnaires cover five main areas that are seen as particularly important in the delivery of primary-level health services: (a) non-wage recurrent budgets; (b) donor support to primary health care; (c) contracting, deployment, and payment of staff; (d) supply management (including drugs); (e) and, user payments and perceptions. In each of these areas, there are established norms and rules for the allocation and distribution of resources. The survey will assess the extent to which these norms and rules are being adhered to, and what impact the actual distribution of resources has on efficiency and equity in service delivery. In order to capture relevant information concerning the respective areas, different types of data will be collected, including data on actual allocations and distribution, on the availability of essential inputs at the facility level, as well as staff and user perceptions about both systems and service outcomes.

**Progress to date**

Since agreement on the scope and general objectives of the survey in August 2001, a series of steps have been taken towards implementation.

1. The design of survey instruments was initiated in the fall of 2001. This work was led by Magnus Lindelöw (ML), with support from Patrick Ward (PW-Oxford Policy Management) and Nathalie Zorzi (NZ), as well as staff from MISAU and MPF staff. A first draft was ready for piloting in early 2002. However, due to difficulties in coordinating work schedules, the first pilot was delayed until April 2002.

2. The first pilot was carried out in Maputo Province (Moamba and Magude districts), with support from Eduardo Macuacua (EM) from Austral and Manuel Ndimande, Gabriel Domingos, and Ms. Eleuteria from MISAU. Following the pilot, survey questionnaires were revised extensively and circulated to MISAU, MPF, and other stakeholders for comments.

3. During the first pilot, the sampling procedure was also established. It was decided that a sample of districts will be selected, but that the selection of facilities will be carried out by
the enumerators as part of the fieldwork. This sampling strategy reflects the difficulty in establishing a comprehensive list of primary-level facilities for the country as a whole.

4. Subsequent to the first pilot, the Austral team responsible for survey implementation was defined. This team will be led by Jeramy Gottwals (JG) and EM, with support from Chissomo Chilemba (CC). A team of enumerators was also identified.

5. A second pilot was implemented during the period July 6 - July 19. Following two days of training with the six lead enumerators, survey piloting was carried out in Maputo City and Gaza (Xai-Xai and Mabalane districts), again with valuable support from Manuel Ndimande, Gabriel Domingos, and Ms. Eleuteria from MISAU. A total of 3 facilities were visited during the second pilot, and approximately 30 clients and 8 facility staff were interviewed. Although the piloting was successful, it revealed a number of problems relating to the questionnaire design and sampling strategy. These issues are currently being addressed, and the final questionnaires will be completed by July 26. In addition, as part of the second pilot, the sample of districts was defined, and administrative and logistical arrangements for the survey were initiated.

6. Following the second pilot, administrative and logistical arrangements—including the revision of questionnaires and the preparation of an enumerator manual—were finalized. During this period, a data entry program was also designed.

7. One full week of enumerator training was carried out in Maputo in early August. This included all 12 enumerators, and was led by EM and CC, with some participation from ML.

8. Following the enumerator training, the fieldwork was launched. This was, however, done on a “pilot” basis, with the full team starting in a single province (Inhambane). This provided the opportunity for the survey managers (EM, CC, ML) to closely monitor the work of the enumerators, and to agree on a common approach in case of ambiguities.

9. The survey is expected to be in the field from mid-August to mid- or late-October.

**Next steps**

1. After the completion of the fieldwork and data entry, ML and PW will return to Maputo to work with the Austral team on the preparation of the final database and to begin the data analysis. A first draft report is expected to be available by mid-December, although this is contingent on the timely implementation of the fieldwork.

2. The survey is designed to provide a representative picture of key issues in the delivery of primary health care in Mozambique. In order to properly interpret the findings and design appropriate strategies to address problems identified in the survey, it will be important to provide the lower levels of administration—provincial directorates of health and finance, and district directorates of health—with opportunities to respond to issues that the survey brings to the fore. With this in mind, it is expected that a broad dissemination process will follow the presentation of results.

**Analysis Plan: A Preliminary Proposal**

**PART I. Introduction**

1. Background and objectives of the survey
2. Discussion of survey design and implementation
An overview of primary health care in the National Health System, including a review of previous studies that are relevant to the ETSDS
PART II. District level: resource allocation, implementation, and support systems

1. How is the system supposed to work?
2. The evidence: district-level allocations
   a. General characterization of districts
   b. Variations in the level of resources in different areas (staff, non-wage recurrent budget, drug kits, via classical drugs, medical supplies, other supplies) allocated to the districts?
   c. What level of support are different districts receiving in the respective areas from donors, NGOs, church organizations, etc.?
   d. How important are user fee revenues as a source of financing?
   e. What is the nature and intensity of general support and control activities by the provincial authorities?
3. Are allocations efficient (in the sense that there is an appropriate mix between different inputs)?
   a. Comparisons of allocations (input mix) across districts.
   b. Perceptions of “need” in different areas by district directors.
   c. Trend in the last three years.
   d. Stock-outs and temporary shortages
4. Are allocations equitable?
   a. Comparisons across districts of total resources available as well as specific resources, relative to population to be served and total service outputs in the respective districts.
   b. Trend in the last three years.
5. Are allocations a good guide to final outturn?
   a. Discussion of areas where clear allocations are absent.
   b. Evidence of areas where outturns are different from allocations:
      i. drug kits
      ii. non-wage recurrent budget (delays and shortfalls)
6. Analysis
   a. Human resources—discussion of:
      i. main constraints that the provinces are facing in mobilizing resources for and recruiting new staff
      ii. process for coordinating human resource planning between provincial and district level
      iii. criteria and procedures for allocating staff to different districts.
   b. Drugs, vaccines, and medical supplies—discussion of:
      i. process for determining need and for allocating resources to districts.
   c. The non-wage recurrent budget—discussion of:
      i. the importance of the non-wage recurrent budget for district operations
      ii. process for coordinating planning and budget formulation between provincial and district level
      iii. criteria for allocating resources across budget lines and across districts
      iv. perceptions of problems in budget execution (staff of both DPS and DDS)
      v. source of general problems in budget execution
      vi. source of differences across districts in budget execution
   d. Functioning of support and control systems: supervision, compliance with reporting and accounting procedures

PART III. Facility-level outcomes and the role of the district

1. How is the system supposed to work?
2. The evidence: facility level conditions
   a. General characterization of primary-level facilities
b. The availability of material inputs
   i. equipment and instruments
   ii. drugs and vaccines
   iii. other consumables

c. The availability and perception of facility staff

3. Facility activities and service outputs
   a. Quantity of outputs and its relationship with inputs
   b. Quality of outputs – including the client perspective
   c. User fees: levels, exemptions, and revenues

4. An assessment of efficiency
   a. Is there an appropriate mix of inputs?
   b. Evidence of stock-outs and temporary shortages of necessary inputs?
   c. Evidence of leakage: drugs and ghost-workers.
   d. Comparisons across facilities.

5. An assessment of equity
   a. Are drugs allocated according to need? (measured by service outputs; measured by population)
   b. An exploration of patterns across regions and types of facilities in the availability of inputs.

6. Analysis
   a. Human resources
      i. What are the procedures and criteria used for allocating staff across facilities in districts?
      ii. What is the extent of understaffing (and under-qualified staff) in facilities? Are there any systematic differences?
      iii. Are problems of under-staffing in certain facilities due to a lack of financial resource, lack of trained health workers, or administrative barriers? Are differences across facilities due to decisions taken at district or provincial level? What is the scope for influence by individual health workers?
      iv. How do health worker experiences vary in respect of pay, timeliness of pay, benefits, access to training and promotion, workload, etc. Are there any systematic differences?
      v. What is the level of staff satisfaction? To what extent are staff seeking transfers and why?
      vi. What is the level of staff turnover and how are districts and facilities coping?
   b. Drugs, vaccines, and medical supplies
      i. What is the relationship between de jure and de facto procedures and criteria for allocating drugs and other supplies across facilities? If established procedures are not followed, why is this so?
      ii. How well is system working in terms of allocation of resources according to need?
      iii. Is inadequacy of resources in some facilities due to allocation decisions taken at district or provincial level? Is it due to poorly designed systems, or low level of adherence to systems and procedures?
   c. The client experience
      i. Characteristics of clients and alternative sources of care
      ii. Evidence on patient-provider interaction
      iii. Client understanding of diagnosis and treatment
      iv. Evidence on informal payments
      v. How does the client experience relate to characteristics of the facility and district?
d. User fees
   i. How much is being collected in facilities?
   ii. Is there any evidence of informal charging or leakage of user-fee revenues? Are there any systematic patterns in this regard?
   iii. How are user-fee revenues used?
   iv. Are current practices consistent with established norms?
   v. Does the current institutional framework for collecting user fees and using revenues make sense?

e. Support and control systems
   i. Does the frequency and intensity of supervision and inspection have any effect on facility-level outcomes?

PART IV. Emerging issues and conclusions
1. Efficiency issues in the delivery of primary health care
   a. Salient findings in respect of efficiency
   b. Reasons of inefficiency—discussion of relative importance of:
      i. inappropriate mix of inputs
      ii. stock-outs, shortages, equipment breakdown, etc.
      iii. leakage
   c. Source of the problems
      i. problems of rigidities, lack of transparency, and poor predictability arising from the design and functioning of administrative systems
      ii. incentives and scope for corruption arising from existing systems
2. Equality and equity in the delivery of primary health care
   a. Salient findings in respect of equality and equity
   b. Reasons for inequality and inequity—discussion of relative importance of:
      i. absence of clear policy, norms, and procedures resulting in discretionary powers in the allocation of resources at provincial and district level
      ii. non-adherence to norms and procedures in the allocation of resources
3. Proposals for discussion

Survey Instruments

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>Level</th>
<th>Interviewee</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility questionnaire (U1)</td>
<td>Facility</td>
<td>Facility director</td>
<td>Approximately 100 facilities</td>
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<tr>
<td>Staff questionnaire (U2)</td>
<td>Facility</td>
<td>Health workers in the facility</td>
<td>Facility manager + two sampled staff members</td>
</tr>
<tr>
<td>User questionnaire (exit poll) (U3)</td>
<td>Facility</td>
<td>Outpatients</td>
<td>Sample of 8 users in each facility</td>
</tr>
<tr>
<td>District questionnaire (D1)</td>
<td>District</td>
<td>District Director of Health</td>
<td>32 urban and rural districts</td>
</tr>
<tr>
<td>District questionnaire (annex) (D2)</td>
<td>District</td>
<td>Administrative staff in the District Directorate of Health</td>
<td>32 urban and rural districts</td>
</tr>
<tr>
<td>Province questionnaire (P1)</td>
<td>Province</td>
<td>Provincial Director of Health and administrative staff in the Provincial Directorate of Health</td>
<td>11 (all) provinces</td>
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