RSSH Gaps and Priorities Annex – Mozambique

**Section 1 – Analysis of RSSH priorities, including those related to community systems strengthening, based on programmatic gaps**

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| Disease component (based on allocation letter) | Top three RSSH priorities (by module), including those related to community systems | Link with specific programmatic challenges and/or priorities to ensure quality |
| HIV | 1. Health Products/Logistics 2. Laboratory Systems 3. Health Information System and monitoring systems 4. Human Resources and quality of care 5. Community Systems strengthening | 1. Frequent stakeouts of HIV related drugs at facility level, including insufficient NCD related drugs (blistered) for ensuring multi-month drug dispensing to people living with HIV and TB, which compromises provision of quality services. Availability of drugs with short expiration date also increases stakeouts and drug waste. 2. Low coverage of testing capacity for diagnosing and following-up patients (Viral load, CD4, DPI, complete blood count, biochemistry, syphilis and hepatitis rapid tests), including at community level. This is exacerbated by an inadequate functioning of the sample referral systems (untimely and heavily dependent on implementing partners), frequent breakdowns of laboratory equipment, and untimely retro-information to health facilities and patients 3. There is a limited capacity to produce high quality and complete data due to heavy reliance on paper-based information systems for an ever-increasing volume of patients, and difficulties in getting data from private sector providers of HIV services. Highly fragmented electronic health information systems that are mainly managed by implementing partners aggravates these programmatic challenges, which in turns undermines MoH ability to use data for strategic decision-making; lack of data on behaviour patterns and risks of key population to support the program in decision making 4. Gaps in knowledge of updated clinical standards among newly trained health professionals resulting from failure in timely inclusion of updated procedures or guidelines in training curricula; at community level, there is limited availability of CHW (APES), whose scope does not cover HIV and TB services. In addition, the existing CHW are demotivated due to low salaries and inadequate equipment, which contributes to a fragmented and verticalized approach to community actors’ management as a way to respond to the specific programs’ needs. 5. The community subsystem is characterized by multiple actions implemented by a multitude of community actors (CHWs / volunteers used by programmes) who are funded by a variety of partners (HIV/TB/Malaria) that carry out their own training and remuneration packages. |
| TB | 1. Health Products/Logistics 2. Laboratory Systems 3. Health Information System and monitoring systems 4. Human Resources and quality of care 5. Community Systems strengthening | 1. Frequent stakeouts and/or accumulation of TB related drugs at facility level, resulting from a variety of reasons, including non-compliance of distribution plans, SIGLUS’s failure to report TB specific consumption drugs, TB supervisor difficulty in filling out the LRD TB at Health Facility level, poor quantification of TB drugs due to poor coordination between TB and pharmacy managers at HF level, and availability of drugs with short expiration date. 2. Low coverage of testing capacity for diagnosing and following-up patients (GeneXpert, microscopy, blood count, biochemistry, ECG). This is exacerbated by an inconsistent delivery of test results by implementing partners through the sample referral systems, frequent breakdowns of laboratory equipment, and untimely retro-information to health facilities and patients 3. Limited capacity to produce high quality and complete data due to heavy reliance on paper-based information systems for an ever-increasing volume of patients, and difficulties in getting data from private sector providers of TB services. Deficient implementation of TB electronic information systems due to insufficient resources and non-integration into other electronic systems 4. High TB staff turnover, combined with the vertical approach to training and supervision undermines their technical quality 5. In addition to fragmented approach to the management of community actors (CHA, TMP, CHW/APS), there is also a reported data discrepancy between them |
| Malaria | 1. Health Products/Logistics 2. Laboratory Systems 3. Health Information System and monitoring systems 4. Community Systems strengthening | 1. Malaria drugs stakeouts at facility level resulting from distribution delays 2. Insufficient equipment for the microscopic diagnosis of malaria (microscopes, blades and reagents) 3. Insufficient record books (CE, CCD, CCS, Child Cards); Poor data quality and use due to the use of paper based systems (routine and campaign data); lack of prevalence studies to generate evidence (neonatal mortality anthropological study, malaria and anaemia indicators survey) 4. Lack of a functioning community surveillance system; Weak CHW/APS capacity to deliver malaria services in sufficient quality and quantity; Weak expansion and consolidation of community information system (UPSCALE or others) |

**Section 2 – Prioritization process**

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| The prioritization process started with individual discussions with diseases programs to identify their top RSSH programmatic challenges and/or priorities by module. Then, joint discussions with the 3 diseases programs managers and their staff to identify common system bottlenecks that negatively affect program performance. This process took into account the results of the National dialogue, and the RSSH strategic focus recommended by Global Fund in several portfolio reviews reports and guidance documents, in particular the new 2023-2028 Global Fund Strategy, TRP clarifications form, Mozambique Portfolio Analysis, as well as the 2023-2025 allocation letter.  As a result of the above process, 5 key RSSH areas/modules to addressing key systems challenges for programme delivery and quality were prioritized and validated by MISAU and CCM: (1) Health Products/Logistics with focus on drugs stockouts of programmes’ related drugs at facility level, including insufficient NCD related drugs (blistered) for ensuring multi-month drug dispensing to people living with HIV and TB, supply of drugs with short expiration date, and LIS failure to report some specific consumption drugs; (2) Weak Laboratory Systems characterized by Low coverage of testing capacity, dysfunctional sample referral systems, frequent breakdowns of laboratory equipment, and untimely retro-information to health facilities and patients; (3) M&E systems with emphasis on poor data quality and use, heavy reliance on paper-based information systems, fragmented electronic health information systems, insufficient record books, lack of data on key population behaviour patterns and risks to support decision making, and limited prevalence studies to generate evidence for strategic decision making; (4) poor Human Resources and quality of care management resulting from late update of clinical guidelines in pre-service training curricula, high staff turnover, vertical approach to training and supervision, and fragmented and verticalized approach to community actors’ management; and (5) Poor Community Systems management which is characterized by a multitude and fragmented management approaches, reported data discrepancy, dysfunctional community surveillance system, insufficient quality and quantity of CHW/APS services, and fragmented community information systems  *Then, based on programmatic challenges identified and prioritized modules, discussion with related RSSH MoH departments were held to identify the root causes of theses programmatic challenges, and to select key investments needed to overcome or minimize them, while contributing to broader RHSS. Efforts were made to ensure that selected investments were aligned with national health sector strategy and other sub-sectorial policies and strategies (diseases, lab, supply chain, community subsystem, ANARM, etc). Throughout this exercise, particular attention was paid in developing a more holistic and systemic approach to health system strengthening, including consideration of the investment and critical approaches recommended in the RSSS information note. In addition, the discussions held sought to identify potential synergies between the RSSH modules (p.e., the HRH department DRH committed to developing and approving the APS statute to ensure their legal framework and payment of a fair salary; likewise, anticipated ICT investments will ensure smooth integration and interoperability of existing health information subsystems). Important to note that the results of these discussions served as the foundation to inform the development de RSSH Funding Request narrative.* |

**Section 3 – Funding gap analysis**

The funding landscape table below provides information about the relevant RSSH prioritized modules that are the main cost drivers in the funding request, the complemental funds from other donors, and the remaining funding gap, if applicable. The purpose is to analyze the funding landscape and gaps for the key modules and show Global Fund contribution to address the funding gap. GF related data is aligned with amount requests in the narrative and budged annex table, including consideration to the HRH matching funds.



This analytical process faced some challenges in collecting data: few sub-sectorial strategies or plans are not costed or the costing approach does not facilitate extraction of the necessary data or information, nor the definition of the necessary amounts per module. This situation is further aggravated by the absence of a comprehensive and costed plan to strengthen the health system that would show the sector's strategic vision for RSSH, as well as the required investments for this purpose; most donors find it difficult to provide granular data or information on specific RSSH investments, as well as future funding scenarios. Notwithstanding these limitations, the RSSH gap analysis took as reference the estimated costs of the current National Strategic Plan (NSP), which also entails a certain number of issues:

* the costing methodology used was *OneHealth*, but the description has no enough detail to understand what inputs are covered in each cost category, thus hampering alignment with GF categorization
* no funding landscape or fiscal space is presented to comprehend how the NSP will or is financed
* community systems costs are not clearly defined.

For the purpose of this analysis some assumption were made:

* the estimated amount needed was based on annual average of NSP cost, then projected for the 2024-26 CG7 period
* surveillance and public emergency costs were added up to M&E costs as most of NSP activities under this category are HIS related
* the laboratory systems includes only clinical labs because it is unclear were public labs run by INS fit in.

However, and taking into account the above caveats, some conclusions can be drawn from the table above:

* Considerable volumes of investments take place in the area of RSSH, although it would be important to distinguish supporting activities from strengthening ones
* Despite these huge investments, huge gaps still remaining (~ 90%) based on the NSP cost estimates for RSSH
* The Global Fund appears to be the health sector's biggest partner in this RSSH area covering 36% of available funding
* The main RSSH cost drivers are HRH, followed by health products and laboratory systems.
* The areas of governance and community subsystem appear to be the least funded, despite their fundamental role in catalyzing any reform