

# 2014

This report brings key information publicly available in the State Budget Law 2014.

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## Budget Brief

### Health Sector in Mozambique



#### KEY MESSAGES:

- ▶ In 2014 the Health Sector has been allocated MT 19.1 billion (USD \$635.8 million), a 21% increase from the 2013 Health Budget. This allocation represents a 7.9% share of the total State Budget.
- ▶ The Health Sector plans to spend MT 762 per Mozambican in 2014. This is equivalent to USD \$42, PPP. Despite the record-high per capita allocation, the country is still far from attaining the SADC average of USD \$266 per citizen.
- ▶ The Health Sector has only managed to execute, on average, 80.1% of its budget over the past seven years, significantly below the average State Budget execution of 85.4% over the same time period.
- ▶ Internal resources represent an unprecedented higher portion of the budget. Out of every 100 Meticaís destined for the Health Sector in 2014, 78 Meticaís are internal resources, demonstrating a large increase from the 48 Meticaís share in 2010.
- ▶ Health figures from the past five years clearly indicate financial deconcentration from the Provincial to the District level, however very little from the Central to the Provincial/District level.
- ▶ The two provinces demonstrating the most need for increased funding in order to address the greatest threats to child health, Zambezia and Tete, are the same two Provinces that are the least per capita-funded in the Health Sector.

### 1. How is the Health Sector defined?

The “Health Sector”, in the broadest sense, involves the provision, distribution, and consumption of health services and related products. For the purposes of this budget analysis, the Health Sector is defined as the group of health-related institutions that receive allocations in the Mozambican State Budget. Accordingly, the health institutions appearing in the 2014 Budget are presented below, organized by territorial levels: ■ Central, ■ Provincial and ■ District.

The Health Sector is one of the “Priority Sectors” of the Action Plan for Poverty Reduction (PARP) in Mozambique. These Sectors reflect the public services that affect the lives of the most vulnerable groups, in particular, women and children. As priority sectors it is expected that they receive the largest portion of the budget.

- Ministry of Health (MISAU)
- Centre of Medicines and Medical Articles (CMAM)
- Maputo Central Hospital (HCM)
- National Council for the Fight against HIV/AIDS (CNCS)
- (11) Provincial Health Directorates (DPS)
- (7) Provincial Hospitals
- (4) General Hospitals
- (2) Central Hospitals
- Nacala-Porto District Hospital
- Infulene Psychiatric Hospital
- (131) District Services of Health, Women, and Social Action (SDSMAS)

Additionally, a new Strategic Plan for the Health Sector (PESS), which aims at addressing programmatic deficiencies for the main public health challenges (i.e. HIV/AIDS, Maternal/Child Health, Malaria, Nutrition, etc.) and building capacity within the various health institutions, began this year and will continue until 2019<sup>1</sup>. **The implementation of the PESS is estimated to require between USD \$800 million and USD \$1 billion in 2014 if the sector is to achieve the set targets.**

1) Specifically, the PESS objectives are: (1) accelerate progress in reducing maternal mortality; (2) accelerate progress in reducing chronic malnutrition; (3) reduce endemic diseases, such as malaria, HIV and tuberculosis; (4) sustain progress in reducing under-five child mortality; and (5) sustain or reduce non-transmittable diseases and trauma.



**\$635.8** Million USD have been allocated to the Health Sector in Mozambique for 2014

For example, in 2012, the Parliament approved a Health Sector budget of MT 11.4 billion, then MT 17.3 billion were allocated to the various health institutions, of which MT 15.7 billion was actually spent. These differences illustrate the necessity for improved financial planning for the State Budget as a whole and for the Health Sector particularly. Mindful of the variance, the remainder of this report will compare the 2014 *initial budget allocations* to the 2010-2013 trend in *expenditure*— the accounting category that most impacts results in the Sector.

It is important to note that the annual totals for the Health Sector can vary significantly depending upon the components considered in the calculation. Historically, three health-related elements have been left out of the total health expenditure figure represented by the Ministry of Finance in the General State Account (CGE) sectorial summary maps, namely: SDSMAS, Vertical Project Funds (usually provided by Bilaterals/NGOs/Private Sector/etc. for interventions usually considered “off-budget”), as well as In-Kind Donations of goods, medicines, etc.<sup>4</sup> Inclusion of these elements in the CGE totals would portray a fairer picture of the size of the Health Sector. This report includes SDSMAS in its totals, but excludes Vertical Project Funds and In-Kind Donations for lack of available information for the entire five-year time series considered.

## 2. What trends are observed in the 2014 State Budget?

**The total value of the State Budget for 2014 is MT 240.8 billion (USD \$8.03 billion<sup>2</sup>), of which MT 19.1 billion (USD \$635.8 million) have been allocated to the Health Sector (Table 1).** Compared to 2013, this is a 21% increase from the revised initial allocation, or a 54% increase from actual expenditure<sup>3</sup> (see *Glossary* for definition of terms). *This difference demonstrates a reality of the Health Sector: vast differences exist between the initial budget allocation, the updated final budget allocation, and actual expenditure.*

**TABLE 1** Health Sector 2010-2011: Budget Allocations vs. Expenditure in MT (no rounding)

	2010 (CGE 2010)	2011 (CGE 2011)	2012 (CGE 2012)	2013 (REO 2013)	2014 (LOE 2014)
Health Sector Initial Allocations	8,531,921,870	9,513,952,680	11,357,032,330	15,731,599,580	<b>19,073,482,880</b>
Health Sector Updated Allocations	10,331,569,410	11,131,234,840	17,309,441,640	15,021,235,070	
Health Sector Expenditure	<b>8,402,057,160</b>	<b>9,470,375,527</b>	<b>15,659,745,812</b>	<b>12,354,824,880</b>	
Health Sector Expenditure Corrected for Inflation	12,141,701,098	11,563,340,081	16,966,138,475	13,087,738,220	
Per Capita Health Sector Expenditure (Real Values)	542	502	716	537	<b>762</b>

**Source:** CPI estimates: World Bank Data (2010-2012); African Development Bank (2013). Population projections by the Mozambican National Institute of Statistics (INE) based on the 2007 Census.

**Note:** The 2014 per capita value is an estimate based on the initial allocations. As SDSMAS was not included in CGE totals prior to 2012, the totals represented above for 2010 and 2011 were calculated taking the 2010 and 2011 CGE Health Sector totals (CGE Mapa I-1-1) and adding SDSMAS initial allocations (MT 437 mn in 2010 and MT 1.2 bn in 2011) because there is no information on SDSMAS budget execution before the CGE 2012.

2) This report uses an exchange rate of: 30MT = 1USD for 2014 conversions.

3) The 2013 values are based on preliminary information. This is expected to change once the CGE 2013 is finalized. For example, whereas the REO 2012 reported MT 9.3 billion in total Health Sector spending, the later released CGE 2012 reported MT 15.7 billion.

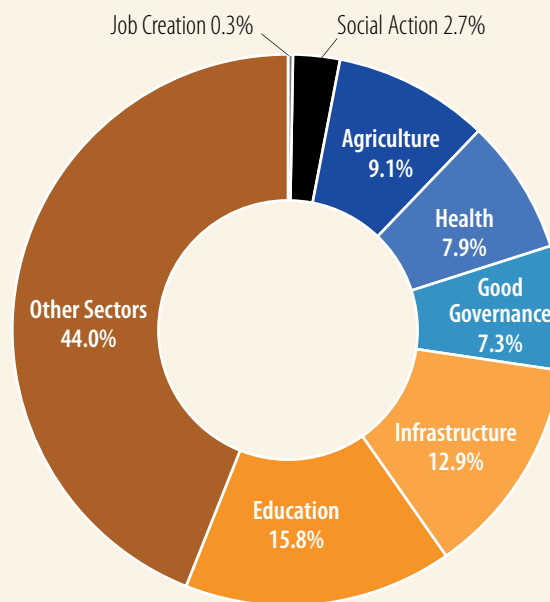
4) SDSMAS has appeared in the accompanying documents (Acompanhantes) of the LOE for, at least, the past seven years which are publicly available, but entered the accounting documents for the first time as a Beneficiary Management Unit (UGB) with the CGE 2012 and REO 2013, both of which were published in the first quarter of 2014. Vertical Project Funds and In-Kind Donations appear in the Health REOs (e.g. see REO 2013 Health pg. 9), however these reports are not publicly available. **For the rest of this report, it is necessary to keep in mind that for 2010-2011, SDSMAS initial allocations were used, for 2012-2013 SDSMAS expenditure was used, and for 2014 SDSMAS initial allocations were used.**

**The 2014 initial allocations to the Health Sector represent 7.9% of the total State Budget<sup>5</sup> (Figure 1).** Having reached 12.2% in 2007, this proportion has decreased to a mode of 7% in the past years (Figure 2). To comply with the Declaration of Abuja of dedicating 15% of its State Budget to health, Mozambique's allocation would need to reach a total of MT 39.1 billion. The expected weight of the sector relative to GDP in 2014 is approximately 3.8 per cent<sup>6</sup>.

Adjusting Health Sector spending for inflation, with 2014 as a base year, reveals an unsteady trend (Table 1). From 2010 to 2011 there is a decrease of 5%, from 2011 to 2012 there is an increase of 47%, and from 2012 to 2013 there is a decrease of 23 per cent. Whereas the nominal values grow 127% from the 2010 expenditure figure to the 2014 initial allocation, the real values grow just 57 per cent. While this trend is important to keep in mind, the remainder of the report will focus on purely nominal values.

**Although the 2014 allocations suggest a record high in Health Sector financing, Mozambique is still far from attaining the per capita financing of its peers.** If the government manages to fully execute the MT 19.1 billion initially budgeted for health, it will account for the highest per capita expenditure in the Mozambican Health Sector to date of 762 Meticaís. This represents approximately USD \$42 based on the Purchasing Power Parity (PPP). While this reflects an all-time high, Mozambique is still far from reaching the average per capita government health expenditure of USD \$266 in the SADC countries.<sup>7</sup> To reach this level, Mozambique would need to increase health spending by 529% to a total of MT 119.9 billion.

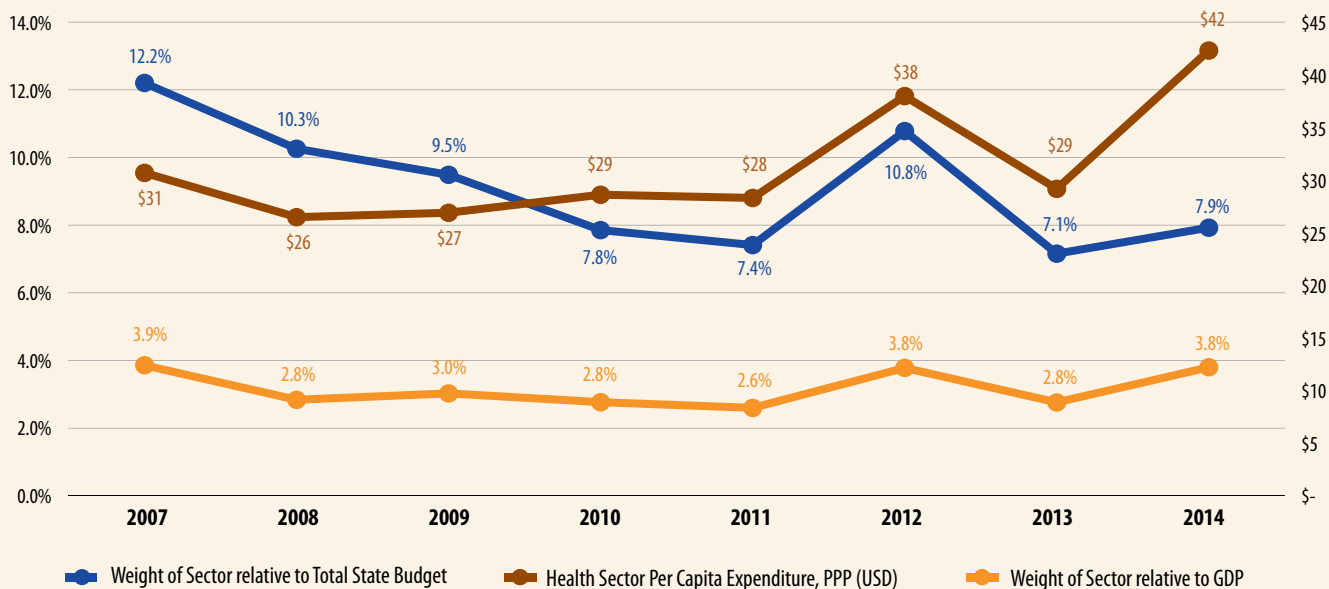
**FIGURE 1** Proportion of State Budget by Priority Sector (PARP) in 2014



Source: LOE 2014, "Quadro 11", pg.38

Note: The percentages were calculated as a proportion of the entire State Budget: MT 240,891,431,840. (The "Other Sectors" portion represents non-priority sectors: General Public Services, Defense, Security and Public Order, Economy, Environmental Protection, Housing and Collective Development; and Recreation, Culture, and Religion)

**FIGURE 2** Trends in the Weight of the Health Sector (2007 - 2014)



Source: GDP values: World Bank Data (2007-2012); African Development Bank Projections (2013, 2014). "PPP Conversion Factor (GDP) to Market Exchange Rate Ratio" figures from World Bank Data. The 2012 conversion factor was used for 2013-2014.

Note: The 2014 State Budget is exactly MT 240,891,431,840. The nominal values represented were converted into MT using the standardized exchange rate of the CGE 2010, 2011, 2012; REO 2013. For all 2014 values, initial allocations were used to show what the tendency would be if 100% of allocations were spent. For years 2007-2009, SDSMAS is not represented in the figures.

5) This proportion was calculated considering a total State Budget figure which includes "Financial Operations" and "Debt Service". Excluding these two categories, the Health Sector would represent 9.1% of the total State Budget with a total State Budget denominator of MT 210,088,500,000.

6) This considers the initial allocations from LOE 2014 and an African Development Bank estimate for GDP in 2014.

7) WHO Global Health Expenditure Database. "General Government Expenditure on Health - Per Capita PPP, USD". 2012. (Most recently available statistic).

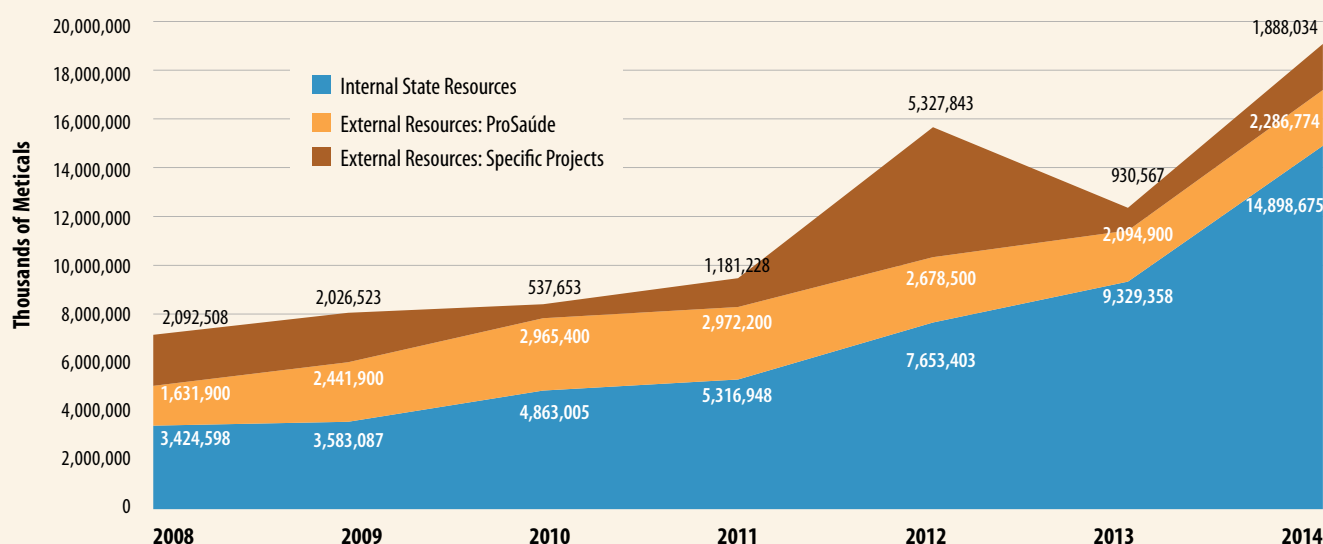
### 3. Where do the Health Sector resources come from?

The resources destined for the Health Sector are classified in the Budget as either Internal Resources or External Resources. Internal Resources are those that have been collected through taxes, tariffs, and duties as well as through the loaning of national assets, referred to as "internal credit". In Mozambique, Internal Resources are supplemented by General Budget Support.<sup>8</sup> External Resources concern donations, foreign aid, and external credit. Particular to the Health Sector, External Resources are sub-categorized into "Prosaúde" donations and "Specific Project" funds; Internal Resources stands as a single category. Prosaúde donations come from a group of nine bilateral and two multilateral partners. Specific Project funds are grant and loan money provided to vertical health-related projects.

**The share of Internal Resources to External Resources has increased from 45%/55% in 2009 to 78%/22% in 2014** (Figure 3). This shows an increasing commitment from the government to self-financing the Health Sector and mirrors the macro phenomenon of increased internal to external funding of the entire State Budget, now 64%/36%, due to capital gains tax revenues linked to the expectations of the country's extractive industries market.

The large single-year increase in External Resources for Specific Projects in 2012 was registered at the Central level, specifically under MISAU. Whereas MISAU recorded MT 2.7 billion in external investment in 2011, it accounted MT 6.7 billion in 2012. However, the large surge in expenditure occurred between the publication of the 2012 REO and the 2012 CGE, thus it is not possible to discern on which projects these funds were spent, given the publicly available information.

**FIGURE 3** Health Sector Resources: Internal & External



**Source:** Prosaúde values come from CGE 2007 (Quadro 6, pg.36), CGE 2009 (Quadro 6, pg.48), CGE 2010 (Quadro 8, pg.38), CGE 2011 (Quadro 13, pg.45), CGE 2012 (Quadro 13, pg.44), REO 2013 (Quadro 7, pg.17), and the 2014 Donor Commitment Letter with an exchange rate of MT 30 to USD 1.

**Note:** The 2013 account has yet to be finalized, thus expenditure in the sector for the year can be expected to grow. The internal resources includes Recurrent Expenditure and the internal component of Investment. For external resources, Specific Projects is derived by subtracting Prosaúde from the total Health Sector budget. For 2008 and 2009, SDSMAS values are not included in the internal resources total as they are in the other years represented.

**Prosaúde has been a stable source of funding for the Health Sector, averaging MT 2.57 billion (USD \$ 85.8 million) per year, over the past five years.** Prosaúde donations reached a peak value of MT 2.97 billion in 2011, declined in 2012 and 2013, and are budgeted slightly higher in 2014, however to an amount still shy of the 2011 benchmark. Specific Project funds, on the other hand, have been a relatively unstable resource, having fluctuated over the past few years from MT 0.57 billion in 2010 to MT 5.33 billion in 2012.

**More than one-third of the resources destined for health purposes in Mozambique are "off-budget".** Many bilaterals, NGOs, and private sector entities contribute to health with off-budget, vertical funding. Although these resources do not appear in the State Budget Laws or the General State Accounts<sup>9</sup>, they make a weighty contribution to preventative and curative interventions in the Sector. For example, health spending by the United States Government (USG), the largest contributing bilateral entity, traditionally does not enter the CGE.

8) General Budget Support (GBS) is un-earmarked aid given to the Mozambican Government, from a group of 19 foreign governments (G19), on the condition that it be utilized for poverty reduction in priority sectors.

9) Vertical Project Funds in the Health Sector appear in the Health Sector specific REOs (e.g. see Health REO 2013 pg. 7), however do not enter into CGE totals.

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Of the Resources destined for Health Purposes in Mozambique are "off-budget"

For 2014, the USG estimates to spend approximately USD \$315 million on health-related projects, equivalent to MT 9.5 billion.

Including health projects funded with "off-budget" resources in the State Budget is important for several reasons: (1) it would allow for parliamentary supervision of development aid as recommended by the Declarations agreed on in Paris, Accra, and Busan; (2) would contribute to the transparency in the use of the funds in support of the Sector; and (3) would give the government a clearer vision of the volume of resources needed to maintain the current level of health services.



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## 4. How are the Health Sector resources spent?

### 4.1. RECURRENT EXPENDITURE COMPARED TO INVESTMENT

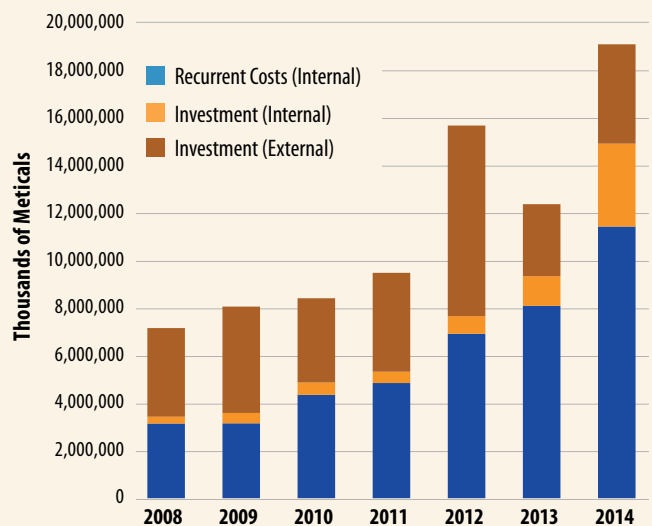
Expenditure in the Health Sector budget is categorized as either Recurrent or Investment. Recurrent is sub-classified into salaries/remunerations, goods/services, or financial operation costs; Investment is sub-classified as either Internal or External. Recurrent Expenditure, otherwise known as "operating costs", purely Internal by source, represents the spending necessary to "keep the Health Sector machine running". Investment, on the other hand, describes the funds used to increase future productivity and efficiency in the Sector. This includes the construction of new health facilities, the renovation of older ones, the acquisition of medical equipment, etc.

Historically, this classification has not been rigorously followed, especially within the external resources category. Oftentimes, expenditure documented in the REO as External Investment, is in fact by definition, Recurrent Expenditure, for example the payment of salaries & services or the purchase of medicines. In order to effectively plan for the expansion of services –often done based on the knowledge of the incremental cost of one hospital bed or one health post– it is important that the Health Sector has a fair idea of the breakdown between the two categories.

**Recurrent Expenditure growth has outpaced Investment growth by 16% over the past seven years** (Figure 4). The ratio Recurrent Expenditure to Investment has increased from 44%/56% in 2008 to a proposed 60%/40% in 2014. The relative growth trend in Recurrent Expenditure can be partially explained by the 31% single year increase in MISAU salaries/remunerations from 2012 to 2013 and the 71% increase in the 2014 allocations for the MISAU procurement of goods/services.

While External Investment has fluctuated over the past years, Internal Investment has gradually grown from a 7% share of total investment in 2008 to a 45% share according to the 2014 allocation.

**FIGURE 4** Recurrent Costs vs. Investment in the Health Sector (2010 - 2014)



Source: CGE 2008, CGE 2009, CGE 2010, CGE 2011, CGE 2012 (Mapa I-1-1); REO 2013 (Mapa PARR); LOE 2014.

Note: For 2008 and 2009, SDSMAS allocations were not included.

### 4.2. DISTRIBUTION AMONGST THE HEALTH INSTITUTIONS

**In 2014, the three largest allocation-receiving health institutions are MISAU, SDSMAS, and DPS;** which respectively correspond to the three levels of health direction in the country at the Central, District, and Provincial levels (Figure 5 with the color-coded territorial levels). MISAU commands MT 9.15 billion (USD \$305 million). SDSMAS has MT 3.14 billion (USD \$104.7 million), and DPS has MT 2.99 billion (USD \$99.9 million). Interestingly, in 2014, SDSMAS replaces DPS as the second-most-financed health institution for the first time.



Photo: ©UNICEF/Mozambique/NameLastname/Year

**Health Sector expenditure over the past few years, when grouped by major institution, demonstrates a deconcentration of financing from the Provinces to the Districts (Figure 6).**

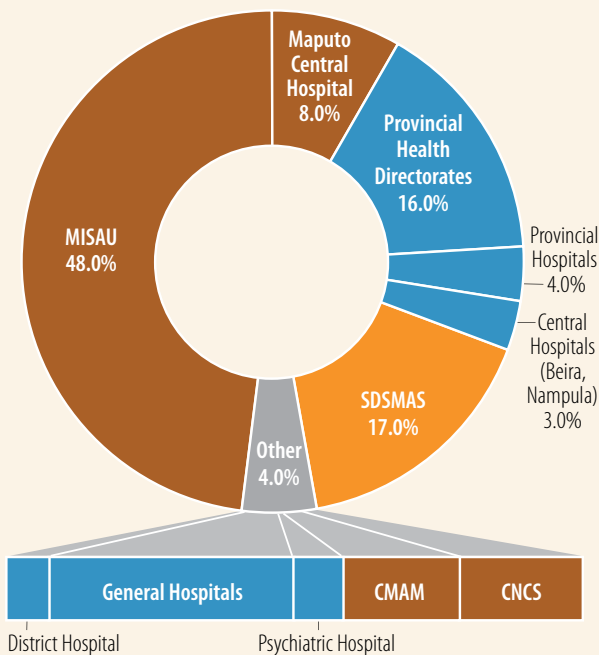
There is a clear growth trend in the SDSMAS proportion, which went from a 2010 initial allocation of MT 437.4 million (USD \$14.6 million) to MT 3.14 billion (USD \$104.7 million) in 2014, representing a growth of 618% compared to the Health Sector's growth of just 127% over the same time period. Concurrently, there is a notable decrease in the weight of the DPS allocation. In nominal terms, the value increased 23% from MT 2.43 billion (USD \$80.95 million) in 2010 to MT 2.99 billion (USD \$99.98 million) in 2014. However, when the figures are adjusted for inflation, the value, in fact, decreased by 15% from 2010 to 2014. Unambiguously, there is a deconcentration of funding from the Provinces to the Districts.

*“The alignment of the budget with the PESS 2014-2019 can contribute to improve allocation and accountability”*

**The CNCS share of the Health Sector budget has gradually decreased from 3% to 1% over the past five years.** CNCS receives an initial budget from the State Budget and then allocates a portion of the funds to the 11 Provincial Nuclei for the Fight against HIV/AIDS (NPCS). CNCS utilization of this initial budget decreased 79% from MT 500.7 million in 2008 to MT 104.4 million in 2012, it however increased slightly in 2013, and is projected to increase again in 2014 to MT 195.3 million (USD \$6.5 million) according to the LOE initial allocation. *While the total envelope of CNCS funds at the Central level has decreased over the past few years, the funds it has allocated to the NPCS have increased 473% from MT 13.8 million in 2010, when NPCS was first deconcentrated from CNCS, to MT 79 million in 2013.* In fact, the proportion that CNCS allocates to NPCS has increased from 5.4% of its budget in 2010 to 52.7% of its budget in 2013. This trend clearly demonstrates deconcentration of funding from the Central to the Provincial levels.

Finally, more useful analysis, in terms of directing resources to specific priorities, would be possible once the budget is organized for example around levels of care (community, primary and secondary) or public health and health care. **The alignment of the budget with the PESS 2014-2019 can contribute to improve allocation and accountability.**

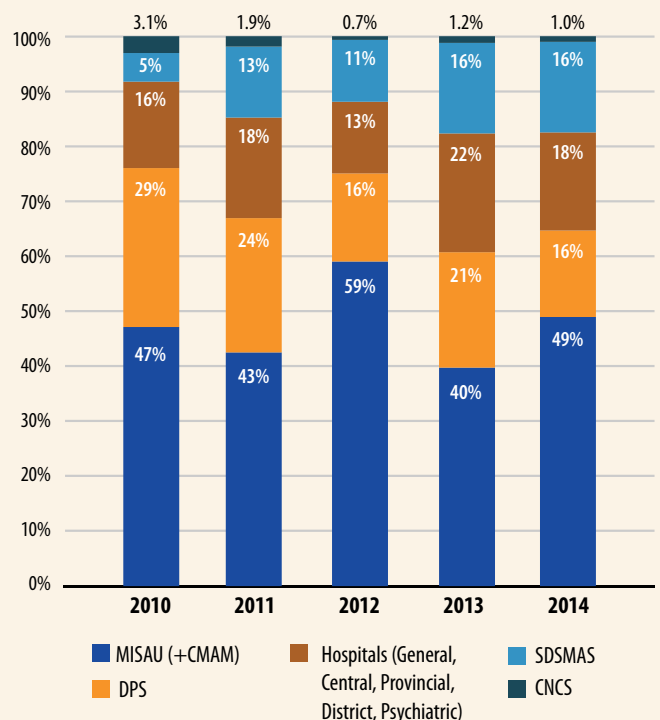
**FIGURE 5 Components of the Health Sector: 2014**



Source: Initial allocation from the LOE 2014.

Note: The various proportions are organized by territorial level: **BROWN** = Central; **BLUE** = Provincial; **ORANGE** = District. All territorial classifications were made based on the LOE 2014.

**FIGURE 6 Historical Weight of the Components of the Health Sector**



Source: CGE 2010, CGE 2011, CGE 2012, REO 2013, LOE 2014.

### 4.3. BUDGET EXECUTION

**The Health Sector has underperformed the State Budget, in terms of budget execution, in six of the past seven years.** As mentioned in Section 2, large differences are often observed in the total amount of funds allocated and the total amount of funds spent in the Health Sector; a ratio of the two gives the “budget execution”.

**82.2%** Was the Health Budget Execution Rate in 2013

**TABLE 2** Health Sector Budget Execution compared to total State Budget Execution

	2007 (CGE 2007)	2008 (CGE 2008)	2009 (CGE 2009)	2010 (CGE 2010)	2011 (CGE 2011)	2012 (CGE 2012)	2013 (REO 2013)
State Budget Execution Rate	83.2 %	78.3 %	86.5 %	87.2 %	86.4 %	87.8 %	88.1 %
Health Budget Execution Rate	81.4 %	70.4 %	69.9 %	81.3 %	85.1 %	90.5 %	82.2 %
Health Sector's Relative Budget Execution Performance	-1.8 %	-7.9 %	-16.6 %	-5.9 %	-1.3 %	2.7 %	-5.9 %

**Source:** The State Budget execution rates come from CGE 2007 (Quadro 2, pg.23); CGE 2008 (Quadro 2, pg. 21 | Quadro 8, pg. 42); CGE 2009 (Quadro 2, pg.28); CGE 2010 (Quadro 2, pg. 22); CGE 2011 (Quadro 7, pg. 27); CGE 2012 (Quadro 6, pg. 28); REO 2013 (Quadro 2, pg.9). The Health Sector execution rates come from computations made with CGE 2007-2012, REO 2013.

**Note:** The figures consider the percentage of financial execution relative to the final updated budget allocation. The State Budget Execution Rate includes the Health Sector.

As observed in Table 2, the Health Sector has varied from year to year, recording its worst execution of 69.9% in 2009<sup>10</sup> and best in 2012 of 90.5 percent. *The Health Sector entity displaying the poorest average budget execution over the time series is MISAU with 76.3%.* In the end, while more resources are needed to improve health access and coverage, a priority should be the effective execution of the currently available resources. Notwithstanding, improved execution will require the easing of burdensome bureaucratic spending procedures and the necessary introduction of spending waivers on life-saving procurement such as medicines.

## 5. Decentralization and Deconcentration of the Sector

The decentralization of planning, implementation, budget management and execution has long been a priority across all sectors. The Health Sector has slowly demonstrated its intention to conform to this same goal. In 2013, CMAM was deconcentrated from MISAU to stand as its own financial entity and the Nacala-Porto Hospital was recognized as the first District Hospital.<sup>11</sup>

In the coming years, the Government aims to deconcentrate the National Laboratory for the Quality Control of Medicines; the National Laboratory of Hygiene, Water, and Food; the Centre for

Regional Health Development; the Maputo Institute of Health Sciences; the National Institute of Health; as well as 12 District Hospitals and 14 Rural Hospitals.<sup>12</sup>

**The empirical evidence clearly suggests a large degree of deconcentration from the Provincial to the District level, however little from the Central to the Provincial/District levels (Figure 7).** With the exception of CNCS/NPCS, the Provincial level exhibits a decreasing trend in health resource allocation, while the District level shows an increasing trend. As mentioned in Section 4.2, whereas the DPS (Provincial) resources have decreased as a share of the total Health Sector, the SDSMAS (District) resources have grown exponentially. Seemingly, SDSMAS resources have been deconcentrated from the DPS share.<sup>13</sup>

In fact, *in relative terms, the Central level seems to be receiving a sustained or even larger share of Health Sector financing.*

In 2012, the most recent year for which all accounts have been finalized, the Central level share of 65% is the largest of the time series. (For 2013, it is too early to judge as the totals will change for the release of the CGE 2013<sup>14</sup>). And the 58% share, according to the 2014 Central level initial allocations, is greater than the 56% registered in 2010. Therefore, with the minor exception of CNCS (see Section 4.2), there is no evidence that the Health Sector, in relative terms, has deconcentrated from the Central to the Provincial/District level.

10) Budget Execution was especially low in 2009 because of poor execution by MISAU (59%), DPS (50%), and CNCS (50%) of the external component of investment.

11) Although it is still financially managed on the Provincial level within the Nampula Province.

12) 2013 Health REO, pg. 23.

13) This phenomenon is to be partly associated with the transfer of health workers' salaries/remunerations from the DPS budget to the SDSMAS budget.

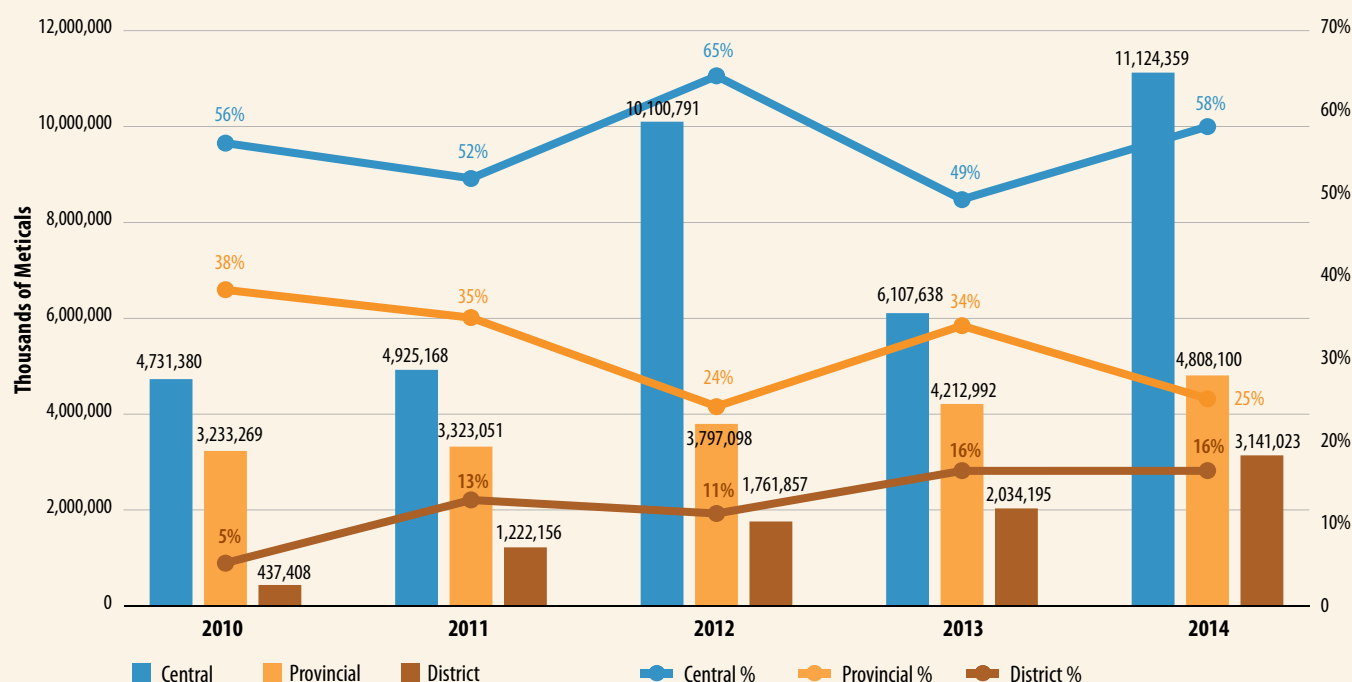
14) The growth in the executed budget between the REO and release of the CGE usually occurs in the External component of Investment and in Financial Operations. As there is no history of external investment at the District level, the adjustments will either enter at the Central and/or Provincial levels.

## 6. Equity Considerations:

**The three provinces with the largest population (Nampula, Zambezia, and Tete) are the same three provinces with the lowest health spending per Mozambican.** Moreover, per capita allocations vary significantly, from MT 487 (USD \$ 16) in Sofala to MT 234 (USD \$ 8) in Zambezia. Considering the importance of issues of equity this year the budget brief brings a special breakout where we look more closely into it.

*The three provinces with the largest population (Nampula, Zambezia, and Tete) are the same three provinces with the lowest health spending per Mozambican where the per capita allocations vary significantly, from MT 487 (USD \$ 16) in Sofala to MT 234 (USD \$ 8) in Zambezia*

**FIGURE 7** Expenditure by Territorial Level (2010 - 2014)



Source: CGE 2010, CGE 2011, CGE 2012, REO 2013, LOE 2014.

Note: The graph compares expenditure in 2010-2013 with the initial allocations for 2014. For definitions of Central/Provincial/District levels refer to Section 1. CMAM became a deconcentrated entity in 2013 and the Nacala-Porto District Hospital did not exist prior to 2013. All funds for the Fight against HIV/AIDS are considered at the Central level.

### Glossary of Budget Terms:

**Initial Allocation (Dotação Inicial):** The first allocation of funds, approved by Parliament

**Revised Initial Allocation (Dotação Rectificativa):** A revised allocation of funds, approved by Parliament

**Updated Allocation (Dotação Actualizada):** The total funds that arrive at the disposal of a given health institution

**Expenditure (Despesa Realizada):** Allocated funds spent on health investment, services, and products

**Budget Execution (Execução do Orçamento):** Percentage of allocated funds spent out of the total allocation

### Acronyms

CGE General State Account (Final Budget Report)  
 CMAM Centre of Medicines and Medical Articles  
 CNCS National Council for the Fight against HIV/AIDS  
 DPS Provincial Health Directorate  
 GBS General Budget Support  
 GDP Gross Domestic Product  
 G19 Group of 19 General Budget Support donating countries  
 HCM Maputo Central Hospital  
 LOE State Budget Law  
 MISAU Ministry of Health  
 MT Mozambican Metical (Local Currency)

NPCS Provincial Nuclei for the Fight against HIV/AIDS  
 PPP Purchasing Power Parity  
 REO State Budget Execution Report (Budget Update Report)  
 SADC Southern African Development Community  
 SDSMAS District Service for Health, Women, and Social Action  
 UGB Beneficiary Management Unit used to designate an autonomous funds-receiving institution in State Budget