



EDI Working Paper WP20/MID07

Health, development, and institutional factors

The Mozambique case

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October 2020

In partnership with



United Nations University World Institute for Development Economics Research

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This study was prepared under the Mozambique component of the Economic Development and Institutions (EDI) Programme funded with UK aid from the UK government in collaboration with the Inclusive Development in Mozambique (IGM) Programme funded by the Governments of Finland, Norway, and Denmark. The EDI Programme Directorate includes the following institutions that work in partnership: Oxford Policy Management, University of Namur, Paris School of Economics, and Aide à la décision économique.

Abstract: The central aim of this text is to show the impact institutions have on the performance of the health sector in Mozambique. The text shows that of the social determinants of health, institutions play a central role in the performance of the Mozambican health sector—and, through it, economic and social development—particularly for the poorer and more vulnerable, such as children, women, the disabled, and the elderly. It is also argued that the deficiencies and inefficiencies of the operation of the health sector in Mozambique are largely the result of the fact that the institutions with influence on the health sector are controlled by a minority of privileged people who do not give the appropriate priority to the basic health needs of the majority of the population. Finally, it is argued that the most important institutional measures for improving the state of health of Mozambicans are the revision of the Constitution of the Republic, the strengthening of the National Health System (particularly the National Health Service), and the reduction of poverty and economic and social inequality.

Key words: state, traditional medicine, Mozambique, poverty, health

JEL classification: I15, N37, O15

Note: This is a translated version of the original paper in Portuguese, which is available [here](#) (disponível em Português).

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This study is published within the project on [Inclusive growth in Mozambique—scaling-up research and capacity](#).

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Typescript prepared by Adriana Barreiros. Translated from Portuguese by Sofia Roborg-Söndergaard.

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The Institute is funded through income from an endowment fund with additional contributions to its work programme from Finland, Sweden, and the United Kingdom as well as earmarked contributions for specific projects from a variety of donors.

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The views expressed in this paper are those of the author(s), and do not necessarily reflect the views of the Institute or the United Nations University, nor the programme/project donors.

1 Overview

1.1 Introduction

Mozambique is a country with a surface area of around 800,000 km², located in Southeast Africa. It became independent in 1975 after around five centuries of Portuguese colonization. At the time of independence, Mozambique was one of the poorest countries in the world. Between 1976 (less than a year after the proclamation of independence) and 1992, the country was ravaged by a war that caused large-scale destruction of its economic and social infrastructure and affected over 5 million Mozambicans, of whom around 1 million lost their lives and 4 million were forcibly displaced from their homes (Pim and Kristensen 2007).

Thus, in 1992, when the war ended, Mozambique was the poorest country in the world, with a per capita GDP of only USD354 (2011 PPP) (Gradín and Tarp 2019). The economic growth seen in Mozambique from 1995 onwards led to a reduction in poverty levels, with the per capita GDP trebling in only 25 years (Gradín and Tarp 2019). Despite this economic growth, Mozambique is still one of the poorest and least developed countries in the world.

In Mozambique today, over half the population (estimated at around 29,000,000, 66 per cent of whom live in rural areas) lives below the poverty line (less than USD2 per person per day) (Gradín and Tarp 2019). According to data from 2017, Mozambique has a per capita GDP of USD 1,136 and a Human Development Index of 0.442, putting it in 180th place out of 189 countries (UNDP n.d.). According to data from 2019, Mozambique has a Sustainable Development index of 53 points out of 100, putting it in 136th place out of 162 countries (Sachs et al. 2019: 21).

The pattern of economic growth that is leading to a reduction in poverty occurred and occurs at the same time as an increase in economic and social inequalities. These take place in a country with previous inequalities between urban and rural areas and between regions (North, Centre, and South).

1.2 Concept of health and social determinants of health

To look at the topic of health in Mozambique, it is first necessary to understand the concepts of health and social determinants of health. According to the World Health Organization (WHO), 'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 2006). This means that a person might not be sick in the normal opinion of people (i.e. not suffering from fever, diarrhoea, cough, or headaches and going to work every day) and even so not enjoy good health.

There is a general consensus that the living and working conditions of individuals and groups in the population influence their health situation. In other words, the majority of the burden of illness,

as well as health inequalities—which exist in every country—are derived from the conditions under which people are born, live, work and grow old. This is where the concept of social determinants of health comes from. For the World Health Organization, social determinants of health are the social conditions under which people live and work (WHO n.d.).

Some examples of social determinants of health are—apart from the quality and accessibility to health care and services—the quantity and quality of food a person ingests regularly, the quality of the water and sanitation they have access to, the housing and transport conditions, the education level, the working environment, the consumption or not of tobacco, alcohol and other drugs and the state of mental health of each individual and community.

One of the most important social determinants of health are the institutions in a country or a community. Institutions are the rules of the game (formal or informal) that the political, economic, and social players in the country or community are expected to follow. Each society operates with a set of political, economic, and social rules created by the state and the citizens together. In this text, we will be looking specifically at the role of institutions in the state of health of Mozambicans.

1.3 A brief history of the health services in Mozambique before and after 1975

The history of the health services in Mozambique encompasses four different periods:

- a) the period prior to the Independence of Mozambique (1975);
- b) the period immediately after independence (1975–80);
- c) the period from 1980 to 1993;
- d) the period from 1993 to the present day.

Period before independence¹

Although the Portuguese arrived in Mozambique in the late 15th century, the organization of health services by the colonial power in the then districts (now provinces) dates only from the 19th century, with the building of the first health infrastructures and the creation of rules for their operation. Around 1898, the colonial health system was organized in 11 health districts, with each district having a civil hospital and a military hospital.

The health system created by the Portuguese colonial government in Mozambique, which lasted until 1975, was concentrated in the cities and towns where the majority of the colonists lived. It was a fragmented system, based on hospitals and prioritising curative medicine (to the detriment of health promotion and disease prevention). Finally, it had a racist structure.

In rural areas, where 85 per cent of Mozambicans lived before 1975, the majority of the people lived more than 20 km away from the closest health facility. In the event of illness, this situation led to the vast majority of Mozambicans resorting almost exclusively to traditional medicine practitioners.

Period immediately after independence (1975–80)

Immediately after the formation of the Transitional Government, the Committee for the Restructuring and Reorganization of the Health Sector was set up. After 1975—based on the findings and recommendations of the Committee for the Restructuring and Reorganization of the

¹ Gulube 1996.

Health Sector—the first government of an independent Mozambique defined and began implementing a health policy whose essential principles are enshrined in Decree-Law No. 1/75, of 29 July.

Article 37 of that decree-law states the following:

The essential aim of the Ministry of Health is to put the provisions of Article 16 of the Constitution into practice. It states that it is up to the state to organize a health system that will benefit all Mozambican people.

This campaign will be guided by FRELIMO's policy to place health at the service of the people.

A unified National Health Service will be created to serve all sectors of the population, irrespective of their ethnic group, economic or social level or religion.

Because rural areas were completely neglected in colonial times, efforts must be immediately focused on these areas.

Health is a right of the citizen and a duty of the state [author's underlining]

In the National Health Service, preventive action and curative action must be totally integrated at the base, but it must always be remembered that prevention should take priority over cure. Health education and environmental sanitation will play a major role in the actions of the Ministry.

On 24 July 1975, the government of Mozambique announced the abolition of private medicine practices. The five years after independence were characterized by substantial changes in the health sector. Along with the abolition of all types of private medicine, the process of creating and structuring the public health service, which was called the National Health Service, was begun. Significant steps were taken towards eliminating the fragmented and racist nature of the health services. Hundreds of new health units were built, the vast majority in rural areas. Implementation of a health policy began. This would essentially be enshrined by the WHO three years later under the name of Primary Health Care.

It should be noted that in these early days of independence, debate arose around health as a right versus the financial capacity of the state to assure this right. It was in the context of this debate that, in 1977—when the Free Medicine Act was approved²—the government restricted free health care to disease prevention campaigns, while curative activities had to be paid for, albeit at very low prices.

During this process—and notwithstanding the immense enthusiasm both of the people and the health care workers—the greatest difficulty lay in the extreme lack of a) human resources of all type and at all levels; and b) financial resources.

Apart from the National Health Service, the Military Health Service and the Paramilitary Health Service were also set up, under the Ministry of National Defence (the former) and the Ministry of

² Law No. 2/77, of 27 September 1977.

the Interior (the latter). In prisons, health units were, and still are, managed by the Ministry of Justice.

Period from 1980 to 1993

After 1980, the efforts to build a public health service to serve the entire population were seriously affected by the war. In all the provinces, over one hundred health care workers were killed, hundreds of health units and ambulances were totally or partially destroyed, and tonnes of medicine and medical supplies were destroyed or stolen. Over half of the health network in rural areas collapsed, with dramatic consequences for the health of millions of Mozambicans, especially children, women, and the elderly.

The political and military instability and subsequent economic crisis worsened when, in 1987, the so-called Bretton Woods institutions (the World Bank and the International Monetary Fund) imposed economic policies on the government of Mozambique that led to a drastic reduction in public spending, including the provision of free health care to the majority of the citizens.

At the same time—and due to the joint pressure of the Mozambican political and economic elite (on the one hand) and the imperatives of the policies imposed by the Bretton Woods institutions (on the other)—in 1992, the government of Mozambique reintroduced private for-profit medicine, which had been abolished in 1975 (Law No. 26/91, of 31 December³).

Period from 1993 to the present day

The war ended with the signing of the Rome Peace Accords in October 1992. In 1993, the process of building the health system began again, particularly the National Health Service. Over the last 25 years, hundreds of the health units that had been destroyed were rebuilt and hundreds of new health units were built.

The majority of these health units are health centres and facilities and are mainly located in rural areas. However, the construction of the National Health Institute, of a central hospital (in Zambezia Province), of a provincial hospital (in Maputo Province), and of more than ten district hospitals and infrastructures aimed at providing training to human resources working in health and the logistics of medical supplies must be highlighted.

The National Council for the Fight against HIV/AIDS (CNCS), which is presided over by the Prime Minister, was also set up.

At the same time—and along with a small, but increasing, number of clinics, medical practices, laboratories and private imaging services—dozens of non-governmental organizations (NGOs) appeared, almost all dedicated to vertical programmes in the health area.

However, it must be pointed out that due to the widespread poverty, the private medicine sector covers only 5 per cent of the population.

³ Law authorising the provision of health care by natural or legal persons under private law, for profit or not.

1.4 Description of the health sector

In Mozambique, the health sector is called the National Health System and is structured in the following subsystems:

1. a public subsystem run by the state and called the National Health Service;
2. a private subsystem;
3. a military and paramilitary health subsystem;
4. socio-professional organizations such as the Doctors Association, the Nurses Association and the Medical Association of Mozambique, which are considered part of the National Health System.

The National Health Service is directly dependent on the Ministry of Health and is by far the largest provider of health care to the around 29 million Mozambicans. It includes four central hospitals (each one with over 600 beds), seven provincial hospitals (between 250 and 350 beds), two psychiatric hospitals, a little less than fifty district hospitals, and 1,585 health centres and facilities spread throughout all the districts and communities in the country. It employs over 90 per cent of health workers in Mozambique.

The private subsystem is divided into a) private for-profit; and b) private not-for-profit medicine. The private for-profit sector is concentrated in the cities (mainly in the capital, Maputo) and includes two hospitals (both in Maputo City), a few dozen clinics, medical practices, pharmacies, laboratories, and imaging services. The for-profit private sector is devoted almost exclusively to curative activities.

The private not-for-profit subsystem includes religious organizations and non-governmental organizations (NGOs), mostly foreign and directly funded by the so-called cooperation partners (donors). It also includes health facilities in some large public and private companies and in educational establishments, such as the Eduardo Mondlane University.

The military and paramilitary health subsystem is still in its early stages. Mozambique has no hospital to care specifically for paramilitary forces.

The National Health Institute (aimed at research) and the Traditional Medicine Institute are under the auspices of the Ministry of Health.

1.5 Traditional medicine

Traditional medicine exists alongside the National Health System. According to the WHO, 'traditional medicine is the sum total of knowledge, skills and practices, used in the diagnosis, prevention or elimination of physical, mental and social illnesses, based exclusively on past experiences and observations handed down from generation to generation, orally or in writing' (Ministry of Health 2015).

According to the Ministry of Health, around 70 per cent of the people in Mozambique use traditional medicine to treat physical, as well as mental and social, illnesses. The activity engaged in by traditional medicine practitioners has more coverage of primary health services than the National Health Service, estimated at a ratio of 1 practitioner per 200 inhabitants. This explains why there are still people in Mozambique who are born, grow up and die using only traditional medicine for their health care. This fact is due, on the one hand, to the still poor geographic coverage of the National Health Service and, on the other hand, the intrinsic connection existing between traditional medicine and the defining traits of its users.

During colonial times, traditional medicine was looked on as a lack of knowledge or superficial knowledge, superstitious and based on folklore. Immediately after the proclamation of independence, the government of Mozambique recognized the importance of traditional medicine. In fact, Article 38(7) of the first decree-law of the government (Decree-Law No. 1/75, of 29 July), states: 'Boost medical and pharmacological research and, particularly, studies on traditional medicine'. Since then, traditional medicine has been gaining ground and consideration in government policies. In 1977, the Office of Traditional Medicine Studies was set up under the Ministry of Health. In 2010, the Office of Traditional Medicine Studies was closed and gave way to the Traditional Medicine Institute, also set up under the Ministry of Health.⁴

Despite these advances, the reality is that little is yet known about Mozambican traditional medicine.

Table 1: What is known about the practice of traditional medicine

Type	Coverage	Payment	Registration	Representativeness
Herbal medicine practitioners: those practitioners that treat patients with chemicals prepared from plants.	There are practitioners of traditional medicine all over the country, both in rural and in urban areas.	The provision of services by practitioners of traditional medicine is not free.	Patients often have recourse both to traditional medicine and so-called conventional medicine.	The Association of Traditional Healers of Mozambique (AMETRAMO) and the other associations of practitioners of traditional medicine do not represent all the practitioners.
Traditional midwives				
Healers who practice divination.				

Table 2: What is **not** known about the practice of traditional medicine

Statistics	Training	Relationships	Type of activities	Integration
The exact number of practitioners of traditional medicine per province, district and place (total number and by type of practitioner).	The type, content and duration of training for each one of the three types of practitioners of traditional medicine.	The relationship between practitioners of traditional medicine and their patients (and their families), including the means of payment for the work done.	If practitioners of traditional medicine limit themselves to curative activities or if they engage in other activities, whether in the health area or in other areas.	The best strategy for integrating traditional medicine into the Mozambican Health System. Specifically, should traditional medicine be considered as a subsystem or should it be integrated into the National Health Service?
		The relationship between practitioners of traditional medicine and the other traditional authorities.		

Source: author's elaboration.

1.6 Characterization of the state of health of Mozambicans in 2019

The state of health of the majority of Mozambicans is precarious. The burden of disease is high. Endemic infectious diseases predominate, such as malaria, tuberculosis, AIDS, respiratory

⁴ Ministerial Order No. 52/2010, of the Ministry of Health, of 23 March 2010.

infections, diarrhoeal diseases (including cholera) and intestinal and bladder parasitosis, with the last three being very closely linked to access to drinking water and environmental sanitation.

Mozambique is one of the five countries in the world with the highest prevalence of tuberculosis (551 cases/100,000 inhabitants, compared to a world average of 140 cases/100,000 inhabitants) and among the 10 countries in the world with the highest prevalence of AIDS. Data for 2015 indicate that the prevalence of AIDS in people aged from 15 to 49 was 13.2 per cent, with 15.4 per cent being women versus 10.1 per cent being men, and 16.8 per cent in urban areas versus 11.0 per cent in rural areas (Ministry of Health et al. 2013; Ministry of Health et al. 2018). Cholera is endemic, with outbreaks practically every year, varying only in the part of the country it appears. A study carried out between 2005 and 2007 and encompassing over 80,000 school-age children revealed a generalized occurrence of bladder infection caused by *Schistosoma haematobium* (national prevalence of 47 per cent) and intestinal helminths (national prevalence of 53.5 per cent) (Augusto et al. 2009). These diseases, related to lack of access to drinking water and basic environmental sanitation, are responsible for a higher number of deaths than malaria and AIDS combined. Mozambique is one of the few countries in the world where leprosy still exists.

At the same time—and as is the case in other African countries—an epidemiological transition is underway in Mozambique. Thus, the incidence and prevalence of non-communicable diseases, particularly high blood pressure and other cardiovascular diseases, diabetes, chronic respiratory diseases, cancer, and trauma (especially road traffic accidents) is increasing inexorably. A study on cardiovascular risk factors carried out in 2005 shows a high prevalence of high blood pressure (34.9 per cent).

Data from the UNICEF Annual Report 2019 entitled *The State of the World's Children 2019: Children, food and nutrition* (UNICEF 2019) indicate that Mozambique has one of the highest rates of child malnutrition in the world (43 per cent of children under five suffer from chronic malnutrition and 8 per cent from acute malnutrition). Chronic malnutrition increases the morbidity and mortality rate in children aged under five and reduces their cognitive abilities. The same report reveals that, for the first time in many years, Mozambique reported cases of pellagra, a disease linked to niacin (vitamin B3) deficiency.

Other indicators reflecting the deficient nutritional situation of Mozambicans are the following (Ministry of Health et al. 2013; Ministry of Health et al. 2018):

- 14 per cent of babies whose birth weight was registered weigh less than 2.5 kg at birth (underweight);
- 64 per cent of children aged under five and 54 per cent of pregnant women suffer from anaemia;
- in 2011, only 45 per cent of the families questioned used iodized salt;
- in 2015, the exclusive breastfeeding rate was only 55 per cent.

Mozambique is among the countries in the world with the highest birth rates (five children per woman) and gross mortality (11.8/1000 inhabitants) and a low life expectancy (53.7 years). Maternal mortality (452/100,000 live births) and infant mortality (68/1,000 live births) are also very high (INE 2019).

2 Institutional factors with an impact on the health sector

As previously mentioned, institutions are the rules of the game (formal or informal) that political, economic, and social players are expected to follow.

The institutional factors impacting the performance of the health sector can be structured in five groups, as follows.

2.1 Rule of law and judicial independence

Despite it being enshrined in the Constitution, Mozambique is still far from being a state under the rule of law.

With regard to the health sector, there are several factors—mainly related to non-compliance with the laws in force—which contribute to this:

- The process of contracting companies to carry out public works (such as building health centres, hospitals, human resource training centres and institutes, warehouses, housing for health care staff, etc.), as well as for the acquisition of medicine, medical supplies, hospital equipment and the like (such as ambulances), is very often done on the fringes of the law. There is frequent, abusive and illegal recourse to what is called *private treaties* to the detriment of public tenders. This all leads to the construction of poor quality buildings, the acquisition of medical supplies and equipment of inferior quality and the unlawful siphoning of money to dishonest businesspeople.
- In clear breach of the law, the processes of selecting people for jobs are frequently carried out without being offered for public tender. This gives rise to this selection being based on party political affiliation, nepotism, friendships, ethnic identity and even the provision of sexual favours.
- With regard to promotions and career progression, it is common for the time periods provided for by law not to be complied with, allegedly due to budgetary restrictions.
- These practices are also contributed to by the fact that both trade union organizations (such as the Medical Association of Mozambique) and socio-professional organizations (such as the Doctors Association and the Nurses Association) are weak and not very proactive.

The fact that these irregular situations persist—despite being frequently reported in the media and the repeated criticism in the annual report from the Administrative Court (Court of Auditors) to the National Assembly—gives citizens the feeling that the culprits can get away with anything because of the state's lack of political will, calling the legitimacy of that very state into question in the eyes of its citizens.

2.2 Voice, participation, and accountability

- Although it is provided for and heralded in the Constitution of the Republic⁵ (Articles 89 and 116) and in the Charter of Patient Rights and Responsibilities,⁶ the right of citizens to health care is not clarified or sufficiently protected.

In the National Health Service—and in clear breach of Article 116(4) of the Constitution—citizens are discriminated against by the state on a socioeconomic basis. All but one of the central and provincial hospitals have special clinics, special consultations, and private rooms that are off limits to anybody who cannot pay the prices stipulated. It should be noted that there is no legal basis for the existence and operation of these special clinics, special consultations, and private rooms. All attempts made to close these special clinics, special consultations, and other special services have been thwarted due to resistance linked to the combined interests of the doctors, on the one hand, and the political and economic elite on the other.

Even in the services considered to be free by law, citizens are frequently subject to unlawful charges.

- The involvement of citizens and communities in the management and monitoring of health sector activities is very poor. Despite there being regulatory documents on the connection between the health sector and the communities, it is the norm for there to be no accountability to citizens regarding health activities. The citizens know little or nothing about the annual budget for the health sector, from its preparation to resource allocation priorities and how these resources are spent. This is one of the reasons explaining why the Ministry of Health budget favours allocations to:
 - a) central and provincial bodies to the detriment of district bodies, where primary health care takes place;
 - b) spending mainly on curative actions to the detriment of health promotion and disease prevention actions; and
 - c) money spent on needless bureaucracy (travelling abroad with the corresponding travelling expenses, expensive meetings at hotels and tourist resorts, acquisition of cars for leaders) to the detriment of the acquisition of medicine and medical supplies and equipment and ambulances that would improve the quality of health care.
- Particularly in rural areas—and because of fear of reprisal—citizens are afraid to report any abuses by health workers, such as absenteeism, non-compliance with schedules, ill-treatment and unlawful charges.

⁵ Constitution of the Republic of Mozambique, 2018.

⁶ Approved by Resolution No. 73/2007 of the Council of Ministers, of 18 December 2007.

2.3 Political instability, violence, and the legitimacy of the state

Over 40 years after the proclamation of independence, the National Health Service still does not cover the entire country or respond to the basic needs of all citizens, both in cities and towns and in rural areas. As previously mentioned, there are three causes:

- a) the colonial legacy;
- b) the destruction of hundreds of health units during the war that ravaged the country between 1976 and 1992; and
- c) the difficulty in moving forward more quickly, both in the replacement of the infrastructures destroyed and in the building of new infrastructures, due to the lack of human resources and financial constraints.

After a 20-year period of calm, political and military instability re-emerged in the centre of the country in 2013. To further aggravate the situation, in October 2017 a military conflict broke out in Cabo Delgado Province, the cause of which is still not clear, and which is tending to spread. These focuses of political and military instability:

- have negative repercussions on the lives of the people in towns and rural areas (where physical safety has been threatened and economic activities paralysed);
- negatively affect activities in the health sector and lead to stagnation or to setbacks in many health indicators. Two concrete examples of this negative impact are the temporary cessation of health promotion and disease prevention activities;
- ultimately, they call the legitimacy of the state into question, either because the state cannot protect its citizens or it does not assure the provision of basic health services, drinking water, basic sanitation, education, etc. in adequate quantity and quality.

2.4 State capacity and independence from private interests

Since 1975, the Government of Mozambique has generally outlined good policies for the health sector. The main problem lies in the weak capacity of the state to assure the implementation of these policies. There are many examples of this deficient implementation and the following are of particular importance:

Lack of human resources and low motivation of the majority of human resources

The lack of human resources of all types—from doctors to orderlies, as well as nurses, pharmacists, laboratory and imaging professionals, management specialists, maintenance specialists, hospital administrators, etc.—is, alongside chronic underfinancing, the greatest weakness of the National Health Service.

No health facility (from the most modest health centre to the largest central hospital) has enough human resources. The doctor/inhabitant (1/15,000) and nurse/inhabitant (1/2,000) ratios do not allow for health care with even a minimum of quality.

The majority of the scarce human resources existing and particularly those working in health units are unmotivated and demoralized, as they earn low salaries, lack basic working conditions (equipment, medicine, food, uniforms, etc.) and they have to deal with a large (and always increasing) number of patients.

Chronic underfinancing and poor financial management

Since 1975, the health sector has been faced with the problem of not having enough money to meet either operational expenses (salaries, fuel for transport, acquisition of medicine and other consumables, etc.) or investment expenses (building new health units, acquisition of equipment, etc.). In 2001, the WHO published the document *Macroeconomics and Health: Investing in Health for Economic Development*, in which it showed that the minimum required in any country for the health sector to be able to ensure the provision of basic services stood at between USD30 and 40 per person per year. This means that in 2019, Mozambique should have spent around one billion US dollars in order to ensure that the health sector could operate with a minimum of quality. The reality is that, since 1975, the amount allocated to the National Health Service (which is responsible for health care for at least 90 per cent of Mozambicans) has never even reached a sum of USD25 per inhabitant per year. Thus, it is clear that Mozambique is facing a problem of chronic underfinancing of the health sector.

This chronic underfinancing calls into question the right of Mozambicans to health, as provided for in the Constitution, and has caused the government—under pressure from the World Bank—to opt for solutions to make up this financial deficit, such as user fees and other forms of immediate co-payment that penalize the vast majority of Mozambicans. What has just been written is clearly described in the WHO document (2010) entitled *Health Systems Financing: the Path to Universal Coverage*, which emphasises that universal health coverage will only become a reality when, and where, the citizens have access to quality health services (promotion, prevention, treatment, rehabilitation, and palliative care) without the fear of being irretrievably drawn into poverty.

Even more tragic is the fact that the management of the scarce financial resources is deficient. It is very common for the financial resources allocated to a certain period not to be fully used, whether through incompetence or negligence of the managers. The most obvious example is the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Insufficient geographical coverage

One of the weaknesses of the Mozambican health system, and of its most important subsystem (the National Health Service) in particular, is insufficient geographical coverage, mainly in rural areas, where around 2/3 of Mozambicans live. Although the government has built over 1,000 health centres since 1975, mainly in rural areas, these are still insufficient for the demand. This explains why, to this day, there are Mozambicans who have to travel ten or more kilometres on foot to get to the nearest health facility.

In over 70 per cent of the 154 districts, there is no hospital with an x-ray machine and/or a laboratory and/or an operating theatre. At the same time, over 40 per cent of the districts do not have a pharmacy, either public or private.

This insufficient coverage explains, for example, the difficulty in a) reducing the mother and child mortality rate; and b) increasing the vaccination coverage rates.

Deficient implementation of the primary health care policy

The primary health care policy prioritises health promotion and disease prevention over curative medicine. However, in Mozambique, health care is still predominantly curative and consists of medical interventions in hospitals and health centres.

Other aspects neglected by the primary health care policy are community involvement and inter-sector cooperation. It is well-known that the greater the involvement of citizens and communities in the planning and monitoring of activities in the health sector, as well as current management of the activities of health units, the greater the satisfaction of these communities and the more careful and responsible the health workers. In Mozambique, the examples of community involvement are few and far between and consist essentially of sporadic meetings to listen to the views of patients at a minority of health units.

On the other hand—and as already mentioned—the state of health of a community depends on factors such as the quantity and quality of food available, a supply of drinking water, environmental sanitation, quality housing, access to quality education and reliable transport at accessible prices, factors which are the responsibility of sectors other than the health sector. This is why improving the state of health of a community depends largely on cooperation between different government sectors at all levels and between the central government and local governance authorities. This is what is called inter-sector cooperation. In Mozambique—and despite regular meetings of the Council of Ministers—the ministries work in isolation from each other, like silos. The same situation is seen at provincial, district and municipal levels. And it is this practically non-existent inter-sector coordination that explains the fledgling state of initiatives such as school health, employee health and the water and food hygiene area.

Health inequities

Health inequities are health inequalities between population groups which, apart from being systematic and relevant, are also unjust and avoidable. One of the main obstacles to improving the quality of health care in Mozambique has to do with the existence of health inequities.

Here are some examples of these inequities (Equity Observatory [Ministry of Health 2010]):

- the rates of infant mortality, maternal mortality and malnutrition in children aged under five are higher in rural areas than in urban areas (urban-rural ratio of 1.6);
- children in the lowest wealth quintile are 1.8 times more likely to die before the age of five than children in the highest wealth quintile;
- a child in Cabo Delgado Province is around three times more likely to die before the age of five than a child in Maputo City;
- the rate of institutional births is slightly more than 40 per cent in Zambezia Province compared to over 90 per cent in Maputo City and Province;
- around 55 per cent of children in rural areas are vaccinated compared to 74 per cent in urban areas;
- Maputo City (with a population of around 1.1 million) has twice the number of doctors as Zambezia Province (with a population of over 5.5 million).

Inefficient planning and management

One of the weaknesses of the health system in Mozambique and particularly the National Health Service lies in the inefficient planning and management methods at all levels and in all sectors. Planning is carried out using rudimentary methodologies and the plans are rarely complied with in full. The quality of management of human resources, of financial resources, of medicine and medical supplies, of transport, etc., is low, which generates a large number of inefficiencies. The same thing happens with maintenance of infrastructures and equipment.

Hospitals and other health units have very inefficient management and administration methods. Hospital administration practices are essentially the same as those that were in force at the time of independence. Although computers have been introduced in hospitals, they are mainly for the use of the executives and some employees. Not one single hospital has been completely computerized with the different sectors networked. The management of the clinical files of patients, outpatient consultations, the pharmacy, laboratories, kitchen, laundry, transport, etc., is all paper-based. The same thing happens with the maintenance of any hospital equipment. This archaic form of management and administration not only contributes to the poor quality of health care, but also to the corrupt practices engaged in by health workers.

Poor regulation capacity in the other service providers

The Mozambican State has poor capacity to regulate the activities of the other providers of health services. Here are some examples:

- there are private clinics and practices that are set up and operate without authorization from the competent authorities;
- several mandatory regulations issued by the Ministry of Health are not complied with by some service providers;
- control over the sale of medicine whether by state-licensed pharmacies or operators in the informal market is very deficient. It is common to see medicine acquired by the Ministry of Health on sale at markets and even on the streets. Mozambique is one of the few African countries and the only country in the Southern African Development Community (SADC) that does not have an operational regulatory authority for medicine;
- particularly at provincial level, priorities are frequently defined by the NGOs because they are the ones that fund the majority of health activities.

Corruption

Corruption is the misuse of the power entrusted to someone for private gain (Transparency International, n.d.[b]). Mozambique is among the countries considered the most corrupt in the world. According to the *Corruption Perceptions Index*⁷ (which assesses the people's perception of corruption in the public sector), published by Transparency International, in 2019, Mozambique was in 146th place out of 180 countries, with an index of 26 (with 100 = *very clean* and 0 = *highly corrupt*). It should be noted that in 2013, Mozambique had an index of 30, which means the perceptions of corruption are increasing (Transparency International n.d.[a]). In Mozambique today, corruption is no longer seen as deviant behaviour, but rather has become something 'normal'.

The health sector is among those considered most corrupt, along with public works, education, the police, justice bodies and others. In health, corruption is seen at all levels—from the central bodies of the Ministry of Health to health centres and maternity hospitals—and all over the country.

⁷ (Transparency International 2020).

Corruption in the health sector takes a variety of forms, such as:

- unlawful charges both at the health units and in the Ministry of Health's management bodies;
- salary payments to 'ghost' employees;
- theft of medicine and medical supplies at all levels (from large warehouses to hospital pharmacies and wards);
- fraud in the tenders for the construction or renovation of infrastructures (such as hospitals, health centres, warehouses, etc.) and for the acquisition of equipment, medicine and medical supplies;
- bribery to gain admission to the Ministry of Health's training centres;
- leaving work in the public sector to engage in private activities elsewhere;
- deliberate creation of difficulties in what is called normal service (free or almost free) to oblige patients to resort to what is called special service (much more expensive).

Corruption in the health sector has a particularly negative impact on poor patients and their families and contributes substantially to the increase in the dissatisfaction of the people with the health services. Unless corruption in the health sector is effectively, efficiently and continuously combated, the goal of humanized and equal health care for all Mozambicans will never be achieved.

In conclusion, it should be noted that the failure in the fight against corruption is largely due to the fact that in Mozambique, the judicial power is completely dependent on and subject to the executive power. This comes as a result of the Constitution, according to which the members of the Supreme Court, the Constitutional Council, the Administrative Court and the Office of the Attorney General are all appointed by the President of the Republic, and can be removed by the president at any time and without prior consultation with any state body.

2.5 Sovereignty and independence

Now more than ever, it is clear that Mozambique needs help from the international community to improve the provision of quality health care to its citizens, especially the poorer ones. But it is equally clear that this help must be given correctly in order to ensure that it does not have the opposite effect to what is intended.

Unfortunately, facts show that in the last 30 years, the Government of Mozambique has not defined the public health policy independently. This applies both to the definition of priorities and particularly to the preparation of the budget for the health sector. The health policy is defined more by the international community (the cooperation partners or donors) than by the Government of Mozambique.

This is the case because the international community a) makes the largest financial contribution to the health budget; and b) it orders and funds the 'consultations' where the diagnosis of the health sector is made and where health policy proposals are presented. It is based on these 'consultations' ordered and paid for by the international community that the Government of Mozambique is pressured into prioritising selected strategies, programmes and activities 'proposed' by the donors, not always coinciding with the strategies, programmes and activities that are really a priority for improving the state of health of Mozambicans. We will cite examples of the negative role the cooperation partners play in the health sector in Mozambique.

First, human resources. A sufficient number of well-trained human resources are of vital importance for the correct operation of any health system. The shortage of human resources

undermines the capacity of the health system to meet the health needs of the population. In Mozambique, the shortage of human resources is the biggest weakness of the National Health Service. Unfortunately, this shortage is aggravated by health workers (especially those more qualified and/or more experienced) leaving the National Health Service to go to work at embassies, NGOs, cooperation partner agents based in Maputo and the private for-profit sector.

The main reason for this, but not the only one, is that these organizations pay higher salaries than the government. This is called an internal brain drain, as opposed to the brain drain out of Mozambique. In Mozambique, the internal brain drain is at least three times higher than the brain drain out of the country. In other words, recruitment practices by the donor community in Mozambique undermine and weaken the National Health Service that this community claims it wants to strengthen.

At the same time, the macroeconomic policies imposed on Mozambique by the World Bank and by the International Monetary Fund imply restrictions to the contracting of human resources for the health and education sectors by the government. This is why, over the last 15 years, the government has been unable even to hire and employ all of the doctors, nurses and other health workers trained in Mozambique.

Secondly, almost all of the cooperation partners decided to channel the largest slice of their financial resources not into the National Health Service (which provides health care to over 90 per cent of the population), but rather to NGOs and other partners dedicated to the so-called vertical programmes for fighting diseases.

These vertical programmes, dedicated at the most to three diseases or a specific segment of the population (such as mother and child health), and with bottom-up dynamics, contribute to the weakening of the public health sector due to the duplication of efforts, the distortion of national health plans, the ‘theft’ of scarce human resources and the chronic underfinancing of the National Health Service.

In addition to the above—and because the ultimate causes of diseases are not properly taken into account—these vertical programmes for combating diseases have a limited impact on improving the health conditions of poorer citizens and communities, despite the hundreds of millions of US dollars invested each year by the international community in health in Mozambique.

Thirdly, it is important to mention another nefarious aspect of the World Bank’s policy. From the 1980s, the World Bank began demanding that all developing countries should introduce user fees as an option for funding health services. It is now agreed that user fees punish the poor and constitute an obstacle to access to health care by citizens. According to the WHO, user fees are ‘the most unequal way of funding health services’ (WHO 2008: 28 *apud* OXFAM 2013: 11). Worldwide, around 150 million people incur financial catastrophe due to direct payments for health care, while 100 million are being pushed into poverty, the equivalent of 3 people per second (OXFAM 2013). Although the WHO has already taken a clear stance against user fees and the World Bank has issued a *mea culpa* (see the speech of the then president of the World Bank, Jim Yong Kim, at the World Health Assembly in 2013), the reality is that user fees persist in Mozambique.

To finish off, it should be pointed out that the majority of the reforms and strategies proposed for the health sector by the so-called cooperation partners are unrealistic given the poor economic capacity of the country and because the cooperation partners are not willing to fund the policies they themselves advocate as the most correct for Mozambique.

There are many examples, the most important of which is the much acclaimed **universal health coverage**, which is a constant in speeches by the World Bank, the WHO, UNICEF, and others in the United Nations and in other international forums, but which funding was never directed to in Mozambique. This is how a situation is created where a poor country like Mozambique is eternally 'plagued' by serious problems in terms of the credibility of the health sector arising from the poor quality of the health care provided.

The question that naturally arises is: why do things like these happen?

The starting point is that it is the political process that determines the type of institutions existing and that it is the institutions (mainly political) that determine how this process operates. It is the political institutions of a nation that determine the capacity of its citizens to control the politicians and influence their behaviour. In turn, this determines whether the politicians are representatives and defenders of the rights of the citizens who elected them or if they have the ability to abuse the power entrusted to them to achieve their own ends, even if this is to the detriment of the majority of the citizens.

Mozambican society is a profoundly unequal society, divided between a privileged minority that holds the reins of political and economic power and 'the others', i.e. a vast majority of poor, disadvantaged and marginalized citizens, who have little capacity of controlling the actions of the political leaders and very little influence on the determination of the fate of the country.

The final cause explaining the weakness of the institutional factors with an impact on the health sector and, very particularly, the poor capacity of the Mozambican state to prioritize the public health sector (which as we have seen is responsible for the health care provided to over 90 per cent of Mozambicans) lies in the lack of political will of the political leaders to put the satisfaction of health care needs in the poorer segments in first place. These leaders are part of, or have close connections with, the privileged minority groups in society, who relegated the public health sector to second place, largely because their own health care needs are met by going to organizations (such as hospitals, clinics, rehabilitation centres, etc.) abroad or, when this is not possible, the national private sector.

Another no less important aspect lies in the fact that in Mozambique there is limited and deficient understanding of the problems in the health sectors among political leaders, citizens, and the so-called civil society. There is confusion between the limited concept of curative medicine and the broader concept of health and public health at all levels of Mozambican society. This results in the health care being predominantly curative and revolving around procedures in health centres and hospitals, with the consequent subordination of the promotion of health, the prevention of illness, community participation and inter-sector cooperation. This is called medicalization of health care. At meetings between the people and politicians, requests from the citizens revolve around the construction of more hospitals and maternity hospitals or at least requests for ambulances. This lack of knowledge results in there not being more interest or political merit in the promotion of public health on the part of political leaders.

At the same time, both the opposition leaders and the majority of civil society organizations (including the media) do not give due priority to or show any ability to present concrete solutions for the most pressing health problems for the majority of Mozambicans.

To give an example, a Mozambican opposition force has never presented a duly prepared document on the deficient implementation of the primary health care policy, or on the chronic underfinancing of the health sector, or on the inequities in health, or on the discrimination that poorer Mozambicans are subject to, even in the public health sector, or on the problem of leprosy

(whose elimination in Mozambique was proven by the WHO in 2009, only to resurge due to the negligence of the government), or, finally, on a coherent policy for the relationship of the government with the foreign donor community for the health sector.

The disputes and ‘contradictions’ between the party in power on the one hand and the opposition forces on the other revolve mainly around the sharing of resources by the different factions of the privileged elite.

It is interesting to note that these ‘contradictions’ always disappear when, for example, parliament is discussing increases in salaries and the allocation of more privileges to different party representatives. On these occasions (as once again happened this year), unanimity is the rule that has never been broken.

Finally, in Mozambique, the executive power controls and dominates both the legislative power and the judicial power. Under these conditions, there are no checks and balances, which would perhaps make the elite in power take interests other than their own into account.

All these findings ultimately explain the poor positive impact of institutional factors on the performance of the health sector, particularly in the quality of the health care provided to the majority of poor, disadvantaged and marginalized citizens.

3 The future: action proposals

In the short- and medium term, the main challenges for the health sector can be looked at from two points of view:

The nosological point of view

Over at least the next two decades, the burden of disease will continue to be very high in Mozambique. Although there is a trend towards a reduction in their incidence and prevalence, the infectious diseases referred to above (diarrhoeal diseases, respiratory illnesses, intestinal diarrhoeal diseases, schistosomiasis, tuberculosis, malaria, HIV-AIDS) and child malnutrition will continue to predominate, all linked to the poverty that affects the majority of Mozambicans. At the same time, with the growth of the so-called middle class and the adoption of new and harmful lifestyles by an increasing number of Mozambicans (such as sedentarism, smoking, exaggerated and uncontrolled consumption of food high in fat, of alcohol, of soft drinks and sugary drinks, etc.) will continue to increase the incidence of non-communicable diseases.

If there is political will and better organization, it will be possible to eliminate and then eradicate leprosy and then substantially reduce the prevalence of other diseases that are now neglected, such as trachoma, lymphatic filariasis, scabies and rabies.

The institutional point of view

As previously mentioned, the Mozambican state is characterized by the weakness of its institutions, particularly political ones, which:

- on the one hand, make them vulnerable to the private interests of the privileged minority and the pressure from foreign organizations, whether international (the World Bank, the International Monetary Fund, etc.) or governmental, which organizations, as we have seen, are commonly called cooperation partners;

- and, on the other hand, they limit their capacity to respond adequately to the material and spiritual needs and desires of the majority of Mozambicans.

Ultimately, the aim is for there to be strong institutions in Mozambique, capable of outlining a health policy that puts the needs of the majority of its citizens in first place, provided with effective regulatory capacity, capacity to suppress all forms of crime, capacity to negotiate with the cooperation partners and make the interests of Mozambicans prevail, and that contribute towards balanced political, economic and social development in the country.

With regard to the health sector, the ultimate aim is the provision of quality, **free** health care to all Mozambicans, without any economic, social, racial, ethnic, sexual, religious or geographic discrimination.

Even in a country as poor as Mozambique, it is possible to advance progressively towards quality, free health care at all levels, and not just basic health care. Obviously, this is a long-term process, but it all depends on political will, **a clear definition of what the priorities are and what can be achieved in health sector at each stage** and the sustained implementation of an economic and social policy that will reduce poverty levels, as well as economic and social inequalities.

The crucial question is: how can this goal, which is as noble as it is ambitious, be achieved?

Our proposal focuses on six priorities:

1 – Enshrining clearly in the Constitution that: a) all Mozambicans have the right to quality, free public health care at all levels of care, without any economic, social, racial, sexual, religious or geographic discrimination; and b) it is the responsibility of the government to progressively assure universal health coverage in Mozambique.

2 – Based on the experience of other countries that made advances in political and administrative decentralization, introducing changes to the structure and operation of the public health sector. One example that is a good source of inspiration is the Unified Health System (SUS) in Brazil, a country with social and anthropological characteristics similar to Mozambique.

Here, it is important at least to:

- Legislate the separation between the Ministry of Health (regulatory body) and the National Health Service (implementing body) with different budgets.
- Legislate the links between the National Health Service and the health services in municipalities and other local authorities.

All the aspects mentioned above should be contained in a law that defines a National Health Policy suitable for the next five decades, to be approved by the National Assembly (Parliament).

3 – Clearly defining how to progressively increase funding for the public health sector so that—as recommended by the WHO—the goal of at least USD60 per inhabitant per year for health sector expenses is achieved by 2050. To do this, the government must:

- Implement the Abuja Commitment (Nigeria) of allocating 15 per cent of the state budget to health.
- Institute a **specific health tax** (for example, through an increase in current taxes on tobacco, alcoholic drinks, soft drinks, luxury products like jewellery, cosmetic, perfume and cars and charge a percentage fee on each airline ticket sold in the country).

- Change the priorities in the health budget so that at least 50 per cent of the government's health expenditure is allocated to districts and 25 per cent to primary health care.
- Eliminate user fees and other forms of direct payment for the health care provided by the public sector.
- Harmonize the different mechanisms for funding health under a universal coverage framework.
- Be guided by austerity and strenuously fight against needless expenditure.
- Significantly improve budget management at all levels.

It is important to clarify here that a national health insurance system set up and run either by the state or by private entities is not a viable option for Mozambique. And the reason is simple: with over half the population of Mozambique living on less than USD2 per person per day, who would pay that insurance?

On the other hand, we see no reason why private health insurance should not exist for the citizens who wish to have their health care provided by private health organizations.

4 – Implementing the primary health care policy nationwide, comprehensively and at all levels of health care. To do this, the government must:

- Progressively strengthen the National Health Service, which is the main subsystem of the National Health System.
- Give due priority to health promotion and disease prevention activities, rehabilitation and palliative care, as well as curative activities.
- Implement effective coordination between the Ministry of Health and other sectors (Ministries, local authorities such as municipalities, NGOs, religious persuasions, unions, etc.) whose activities have an impact on the state of health of Mozambicans. As explained above, the health sector alone cannot assure an improvement in the state of health of Mozambicans. Many other sectors of governance and society play a crucial role in the improvement of living conditions—and, through this, the improvement of health conditions—of the people, through the provision of diversified food in quantity, drinking water, environmental sanitation, housing, transport, quality education, etc. The implementation of this inter-sector coordination should be inspired by the experiences in other countries.
- For inter-sector coordination to be effective and efficient, it must be institutionalized. It is under this framework that an Inter-Sector Health Coordination Council (CCIS) should be set up, a body whose mission will be to ensure inter-sector coordination, with the aim of taking concerted action on the social determinants of health at the different levels. It is important to specify the mission, the tasks and the composition of the CCIS.
- Give priority to community participation.
Community participation has two main aspects: a) the right and duty of each citizen to participate individually and collectively in the planning and implementation of the health care aimed at them; and b) the need for the entities responsible for the provision of health care to be accountable to the citizens (or their representatives) for their actions.
In this framework—and based on the experience of other countries, such as Brazil (Cornwall and Shankland 2008) and Thailand (Rasanathan et al. 2011)—community participation must be institutionalized through the set-up of bodies at all levels responsible

for ensuring increasing involvement by the citizens and communities in health sector activities.

5 – Boosting the activities of the Traditional Medicine Institute.

Given the importance and the potential of traditional medicine in the provision of health care to Mozambicans, the government must further bolster the activities of the Traditional Medicine Institute, providing it with financial resources and qualified human resources at all levels. The Traditional Medicine Institute, working closely with the National Health Institute, must base itself on the experience of other African countries, as well as the experience in Asian countries (like China, Vietnam, North and South Korea, etc.) to define the best ways to stimulate research into traditional Mozambican medicine, seeking ultimately to make the most of its enormous potential.

6 – Engaging the international community in the efforts with the aim of improving the quality of health care in Mozambique.

Such engagement implies, first of all, progressively reducing interference from cooperation partners in the formulation of health policies and the implementation of sovereign decisions made by Mozambicans.

On the other hand, if the international community does in fact want to help improve the quality of health care in Mozambique—so that the much-heralded universal health coverage that enshrines the values of universality, equity and solidarity can be achieved—it should undertake the following actions:

- Allocate a larger proportion of aid in the form of direct support for the National Health Service budget. Government-to-government aid through direct support for the state budget or the Ministry of Health budget is the best way of helping the Government of Mozambique to achieve the aim of universal health coverage.
- Cease the promotion of inappropriate approaches in the name of universal health coverage, especially vertical programmes.
- Help the Government of Mozambique to make equity and universality explicit priorities from the outset. It is fundamental that poor people (i.e. the majority of Mozambicans) benefit at least in the same way as better-off citizens, at all stages.
- Help the Government of Mozambique to measure and assess the progress and results of the actions aimed at universal health coverage, especially equity.
- Take steps to combat the tax evasion that prevents Mozambique from having access to the financial resources that are so necessary in order to ensure quality health care for all Mozambicans.
- Honour their commitment to allocate at least 0.7 per cent of their Gross Domestic Product to official aid for the development and improvement of the effectiveness of aid to the health sector.

4 Final considerations

Mozambique is still one of the poorest and least developed countries in the world. Here are some of the facets of poverty that directly influence the health of Mozambicans (INE 2019):

- Over 2/3 of Mozambicans do not have two balanced daily meals from the point of view of protein and calorie intake;
- Over half of Mozambicans do not have access to drinking water (only 5 per cent have running water in their homes and almost 60 per cent use water from wells, rivers or lakes);
- Over 2/3 of Mozambicans do not have access to adequate basic sanitation (24 per cent do not have latrines and defecate outdoors and only 10 per cent have a toilet connected to a septic tank);
- Over 2/3 of Mozambicans do not live in decent housing (over 47 per cent live in grass-covered huts);
- Less than 25 per cent of Mozambicans have access to electricity in their homes;
- In 2017, the illiteracy rate (percentage of people aged 15 or over that cannot read or write) was 39.0 per cent and the number of years of schooling for the people was 3.5 years. These figures conceal important gender inequities (the illiteracy rate is 27.2 per cent for men and 49.4 per cent for women and the number of years of schooling is 2.5 for women and 4.6 for men) and geographic inequities (the illiteracy rate in Cabo Delgado is almost twice that of Maputo City);
- The unemployment rate is high (24.9 per cent) (Sachs et al. 2019: 317).

Poverty blocks access to the benefits arising from economic growth. The differences between social groups, based on the place of residence, education level and other social differentials, make the advantages arising from economic opportunities more accessible to certain groups.

Finally, economic inequality is frequently associated with worse results in the health area, not only for poor people, but also for the population in general (Wilkinson and Marmot 2003; Wilkinson and Pickett 2009). This is why the fight against poverty and economic and social inequality must be made a priority, so that economic growth in Mozambique can be seen through the achievement of the improvements recommended in the Sustainable Development Goals.

5 Conclusion

All of the above makes it possible to conclude that the institutions—understood as the rules of the game (formal or informal) created jointly by the state and by citizens and that are expected to be followed by the political, economic and social players—play an important role in the performance of the health sector and, through this, the economic and social development of Mozambique.

Of the institutional factors, the (in)capacity of the state and its (lack of) independence from private interests stand out negatively.

This (in)capacity and (lack of) independence of the state from private interests comes largely as a result of the state being under the control of a privileged minority who do not give due priority to the basic health needs of the vast majority of the population.

If there is really a desire to improve the provision of health care to **all** Mozambicans, changes absolutely must be made in the institutions with influence on the health sector.

The most important institutional measures are the revision of the Constitution of the Republic, the strengthening of the National Health System (particularly the National Health Service) and the reduction of poverty and economic and social inequality.

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