



Immunization Financing

Mozambique:

A Case Study

About WACI Health

WACI Health is an African regional advocacy organization based in Nairobi, Kenya. WACI Health exists to champion the end of life-threatening epidemics and health for all in Africa. It strives to influence political priorities through an effective, evidence-driven Pan-African civil society voice and action.

WACI Health's mission is to ensure equitable access to healthcare for all in Africa. It does this by advocating with Governments and International Agencies to increase their investments in health. WACI Health also works towards the adoption of Regional and National policies and reforms that improve health and equity. Additionally, WACI Health aims to enhance accountability in health governance and delivery and to build health systems that are equitable and responsive to people's needs.

Its work is guided by the core values of Tolerance, Accountability, Leadership, Authenticity, and Learning. WACI Health believes in strengthening Civil Society, promoting justice and equity, fostering Innovation and Learning, nurturing Leadership, and maintaining a functioning organization. WACI Health is a member of numerous national and international networks, working groups, and organizations to leverage synergy in development work.

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Contents

About WACI Health.....	2
Rights & Permissions.....	2
List of Figures	4
INTRODUCTION.....	5
Background	5
Financing Transitions	5
The Addis Declaration on Immunization (ADI)	6
Objective.....	6
Specific Objectives	6
METHODOLOGY.....	6
Study Design and Sampling	6
Data Collection	6
Analytic Framework.....	6
Report Compilation.....	7
Validation	7
Limitations.....	7
FINDINGS	8
Demographic Context	8
Economic Context	8
Health System Context	9
Health Financing Context.....	10
Immunization Coverage	11
Immunization Financing	13
Recommendations towards improving immunization services in Mozambique	15
Recommendations towards improving immunization financing in Mozambique	16
References	17
Appendix 1: Contributors	18

List of Figures

Figure 1: The GAVI Model-Country Contributions to Vaccine Costs (2023).....	5
Figure 2: Proposed Analytic Framework	7
Figure 3: Population Trends in Mozambique.....	8
Figure 4: Development and Productivity Potential in Mozambique	8
Figure 5: Economic performance in Mozambique.....	9
Figure 6: Health System Performance in Mozambique	10
Figure 7: Health Financing Trends in Mozambique	10
Figure 8: Health Financing Sources in Mozambique	11
Figure 9: Immunization Coverage in Mozambique.....	12
Figure 10: Equity Analysis of U5MR and Immunization coverage in Mozambique.....	12
Figure 11: Prioritization of Immunization and Vaccines in Mozambique	13
Figure 12: Government prioritization of Vaccines in Mozambique.....	14
Figure 13: Government Prioritization of Immunization in Mozambique	14
Figure 14: Components of Immunization Spending in Mozambique.....	15

INTRODUCTION

Background

Immunization is a success story for global health and development, saving millions of lives every year[1]. It benefits individuals, communities, countries and the world. It is an investment in the future, in several ways including:

- Saving lives and protecting the health of populations
- Improving countries' productivity and resilience
- Enabling a safer, healthier, more prosperous world

Additionally, Immunization services are a cornerstone of primary health care and, with their already broad reach, can serve as a foundation for other vital services. This means immunization is one of the best uses of limited public funds for health[2].

An underappreciated virtue of immunization is that its benefits impact the poor to a greater extent than most other health interventions. Poor people bear a disproportionate burden of the diseases addressed by immunization.

Despite this, the benefits of immunization are unevenly shared: coverage varies widely among and within countries. Some populations – often the poorest, the most marginalized and the most vulnerable, in fragile, conflict-torn settings – have poor access to immunization services.

Each year, 20 million infants do not receive a full course of even basic vaccines, and many more miss out on newer vaccines. Of these, over 13 million receive no vaccines through immunization programs – the “zero dose” children[1].

Strong immunization program performance depends not only on adequate financing of immunization-specific activities at the national level, including vaccine procurement and supply chains, but also on financing of the primary care facilities and staff that deliver routine immunization as part of a broader program of health services[2].

Financing Transitions

Gavi-eligible countries, especially those that have introduced many vaccines, must plan to assume responsibility for financing these programs as outlined in the GAVI model[3] in **Figure 1**. This is most urgent for countries that have entered the accelerated phase of transition, when they must rapidly scale up domestic financing for vaccines as Gavi support is withdrawn. But countries whose per capita income has not yet exceeded Gavi's eligibility threshold (USD 1730) must also plan to pay for a growing share of vaccine costs in the form of co-financing. Gavi-supported countries must ensure that secure financing will be available not only to purchase vaccines but also to deliver them and to sustain and extend coverage.

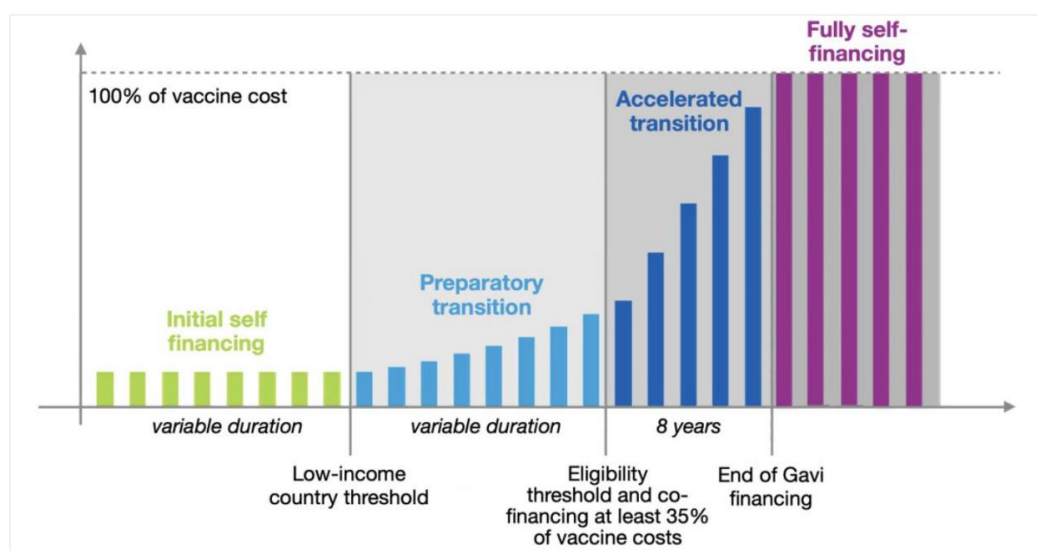


Figure 1: The GAVI Model-Country Contributions to Vaccine Costs (2023)

Some countries also face the withdrawal of donor funding for other health priorities, and all countries must find predictable sources of funding for immunization in an unpredictable global economic environment. The share of health resources devoted to immunization remains small in most countries, however, and with sufficient political will, it should be possible to find the necessary funding to sustain and expand this vital public health service.

The Addis Declaration on Immunization (ADI)

The African continent has made impressive progress in ensuring a better start in life for children. The COVID 19 pandemic, however, caused major disruptions in immunization service delivery leading to a decline in the number of under immunized and zero dose children.

In 2017, African leaders made a historic commitment to immunization by supporting the Addis Declaration on Immunization (ADI)[4]. The goal was to ensure that everyone in Africa, no matter who they are or where they live, receives the full benefits of immunization. In December 2022, African leaders were hosted by the African Union Chairperson in Senegal and had an opportunity to recommit to the implementation of the ADI.

Objective

To review and document the progress made by Mozambique in implementation of goal #2 of the Addis Declaration on Immunization (ADI):

Increase and sustain domestic investments and funding allocations to meet the cost of traditional vaccines, fulfill new vaccine financing requirements; and provide financial support for operational implementation of immunization activities by Expanded Program on Immunization programs.

Specific Objectives

1. To conduct an in-depth analysis of the progress under Goal #2 of the ADI in Mozambique between 2017/18 and 2022/23.
2. To identify the current key bottlenecks hindering adequate financing for immunization in Mozambique
3. To develop a case study with priority actions and recommendations to improve immunization financing in Mozambique.

METHODOLOGY

Study Design and Sampling

This was a retrospective study with literature review on immunization financing in Mozambique. Mozambique was purposively selected given the following considerations: Portuguese Speaking African Country, history of health system disruption through a) natural disasters like tropical cyclones and b) terrorist activities, and being a country of interest for the client, WACI Health. Respondents for the qualitative insights were sampled through nonrandom techniques i.e. Purposive sampling based on their roles in immunization financing and snowballing to get more relevant respondents. These included representatives from the World Health Organization, and Civil Society Organizations in Mozambique. See Appendix 1.

Data Collection

This analysis adopted a mixed methods approach with both quantitative and qualitative data collected. The analysis entailed an in-depth desk review of EPI reports, budgets, annual immunization financing reports, Medium Term Expenditure Frameworks (MTEFs), global immunization and health databases such as the WHO, UNICEF, GAVI, World Bank, Global Health Expenditure Database, the IMF fiscal databases among others.

Qualitative insights to validate quantitative findings and plug any missing points were drawn through virtual interviews with the selected respondents.

Analytic Framework

Analysis of the findings was done in keeping with the framework proposed in **figure 2** below. This framework acknowledged that Immunization services happen with a context that is duly influenced by multiple factors such as population, macro-fiscal and economic, health system and financing among others. The expanded framework is outlined in Annex 1.

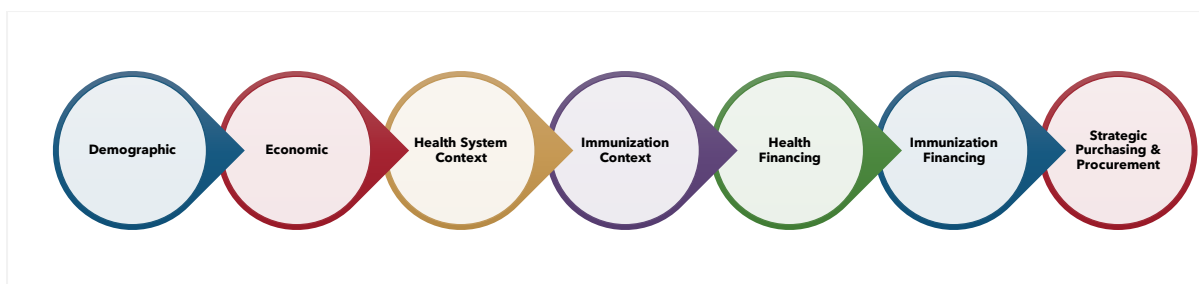


Figure 2: Proposed Analytic Framework

Source: Compilation by Consultant

Report Compilation

The findings from the data collection phase were analyzed using measures of dispersal (quantitative data) and thematically (qualitative data) then summarized in charts, and tables, as appropriate. These were subsequently woven into a draft case study.

Validation

The draft report was internally reviewed with the WACI team for immediate updates. Subsequently, the refined version was presented to key stakeholders selected by the client team.

Limitations

Extensive analysis across the proposed themes were limited by paucity of data in some of the themes e.g., Equity analysis of immunization coverage, coverage of MCV2, in-depth breakdown of immunization expenditures etc.

FINDINGS

Demographic Context

The population in Mozambique progressively increased from 28M to 32M between 2017 to 2022 as shown in **figure 3**. Infants aged below 12 months and children below the age of 5 years accounted for less than 7% and 17% of the entire population respectively.

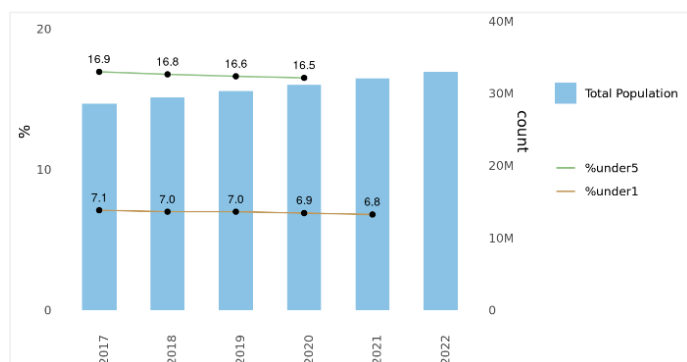


Figure 3: Population Trends in Mozambique

Source: UN and Analysis by Consultant

During the same period, the Human Development Index¹ remained just below 0.5, a below average performance on individual longevity, education and income capabilities (**Figure 4**). The Human Capital Index² was 0.4, which was below average in terms of the expected productivity of future generations owing to deprivations related to health and education. This implied that children born during the period would attain only 40% of their productivity potential. The life expectancy at birth remained between 59 and 61 years.

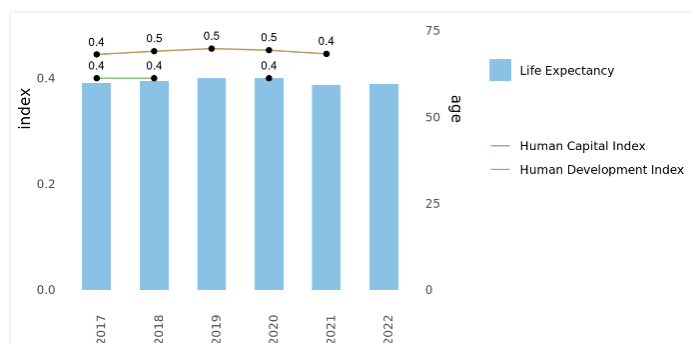


Figure 4: Development and Productivity Potential in Mozambique

Source: World Bank Group, UNDP, Analysis by Consultant

‘The public expenditure structure in Mozambique is skewed against development and infrastructure investments given the predominance of recurrent spending.’ **Public Finance expert in Mozambique**

Economic Context

The Gross National Income Per Capita increased from USD 449 to USD 519 during the period of analysis (**Figure 5**). This matched the initial self-financing phase for GAVI eligibility[3]. The Tax to GDP ratio ranged between 21% and 27%, one of the highest within this cohort of countries. It thus met the regional 15% threshold for adequacy of financing public services.

¹ **The Human Capital Index (HCI)** is an annual measurement prepared by the World Bank. HCI measures which countries are best in mobilizing their human capital, the economic and professional potential of their citizens. The index measures how much capital each country loses through lack of education and health. The final index score ranges from zero to one and measures the productivity as a future worker of a child born today relative to the benchmark of full health and complete education (a maximum index score of 1).

² **The Human Development Index (HDI)** is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and having a decent standard of living. The HDI is the geometric mean of normalized indices for each of the three dimensions.

The Debt to GDP ratio was significantly high spanning between 100% and 120% within the period of interest hence above the Southern African Development Community (SADC) regional threshold of 60% for debt sustainability and adequacy of financing public services beyond debt repayment[5].

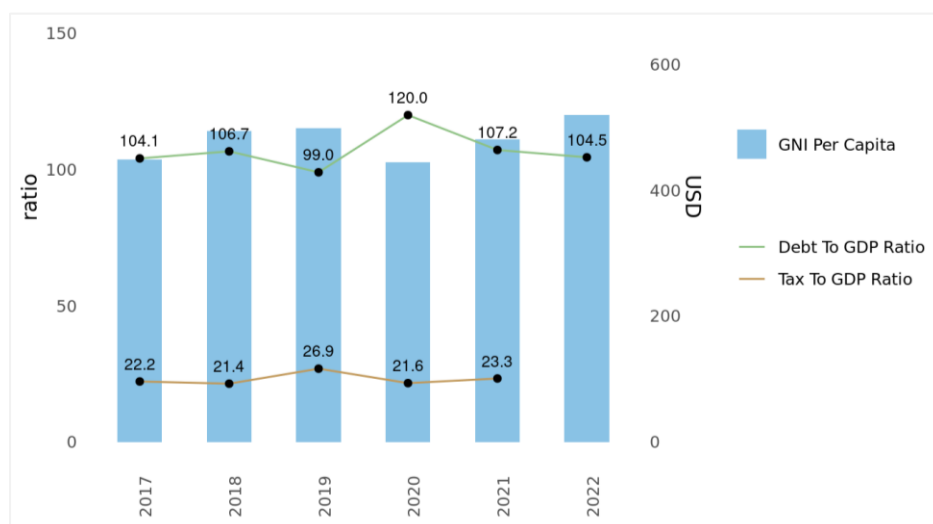


Figure 5: Economic performance in Mozambique.

Source: WHO, IMF, Analysis by Consultant

Highlight

The significantly high debt levels in Mozambique beyond the regional threshold highlights potential risk of debt repayments crowding out expenditures on other essential public services including health and immunization.

The relatively high Tax to GDP ratio in Mozambique points to a fairly reliable tax administration system that ought to be strengthened to ensure fair, predictable and improved revenue mobilization to finance public services including health and immunization.

Health System Context

The top 3 causes of death in Mozambique were HIV/AIDS, neonatal conditions and Stroke. Malaria, HIV, Diarrhea and Pneumonia were the main causes of under 5 mortalities.

There was a steady decline in the Infant and Under Five Mortality Rates over the period of analysis. The Infant Mortality Rate (IMR) declined from 57 to 51 deaths per 1000 live births, while the Under Five Mortality Rate declined from 78 to 70 deaths per 1000 live births as shown in **figure 6**.

The UHC Service Coverage Index³ in 2021 was 44% implying that less than half (44%) of the population in Mozambique had access to quality essential services including reproductive, maternal, newborn and child health, infectious diseases, and non-communicable disease services.

³ **Coverage index** for essential health services (based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access). It is presented on a scale of 0 to 100.

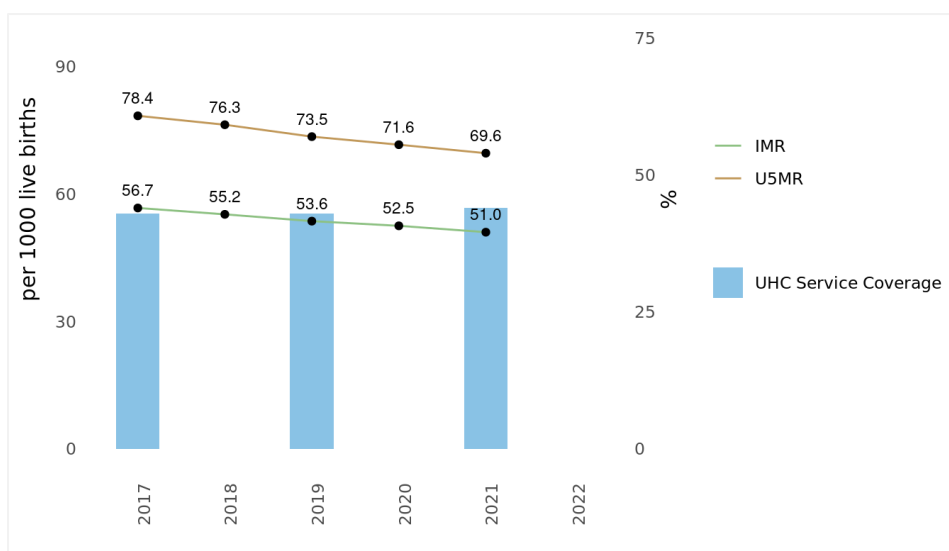


Figure 6: Health System Performance in Mozambique

Source: World Bank, WHO, Analysis by Consultant

Health Financing Context

Government spending on health was at 2% of the GDP which was markedly below the minimum of 5% recommended for progression towards UHC [6]. The per capita spending on health was between USD 34 and USD 41 across the years, which was below the recommended per capita target of USD 86 [6]. Further, the government expenditure on health relative to other sectors was between 6% and 7%, which was below the 15% Abuja target (**Figure 7**).

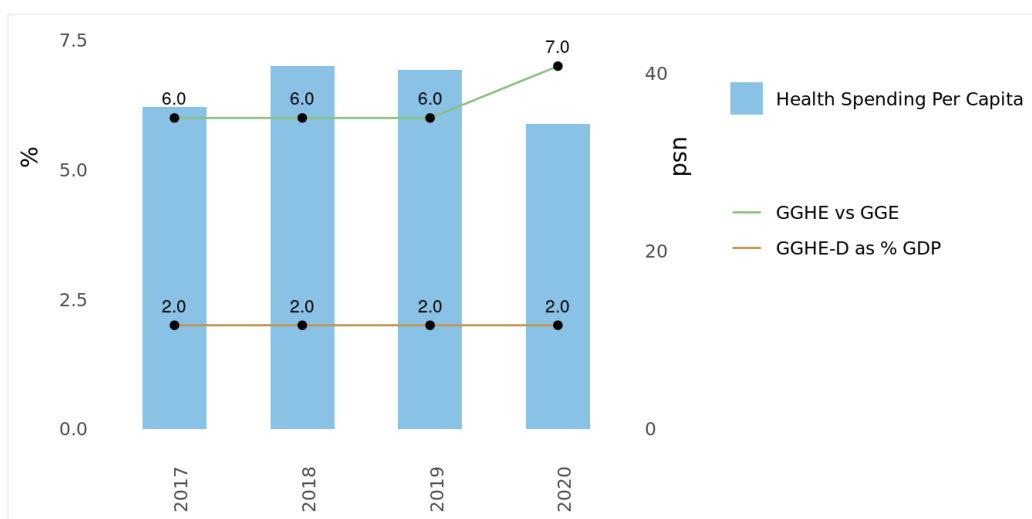


Figure 7: Health Financing Trends in Mozambique

Source: WHO Global Health Expenditure Database, Analysis by Consultant

Though declining, donor financing was the most significant source of funding for health in Mozambique. Donor funding accounted for between 52% and 62% of all health funding during the period of analysis, while government funding accounted for 22% to 32%, and Out of Pocket expenditures accounted for about 10%. (**Figure 8**)

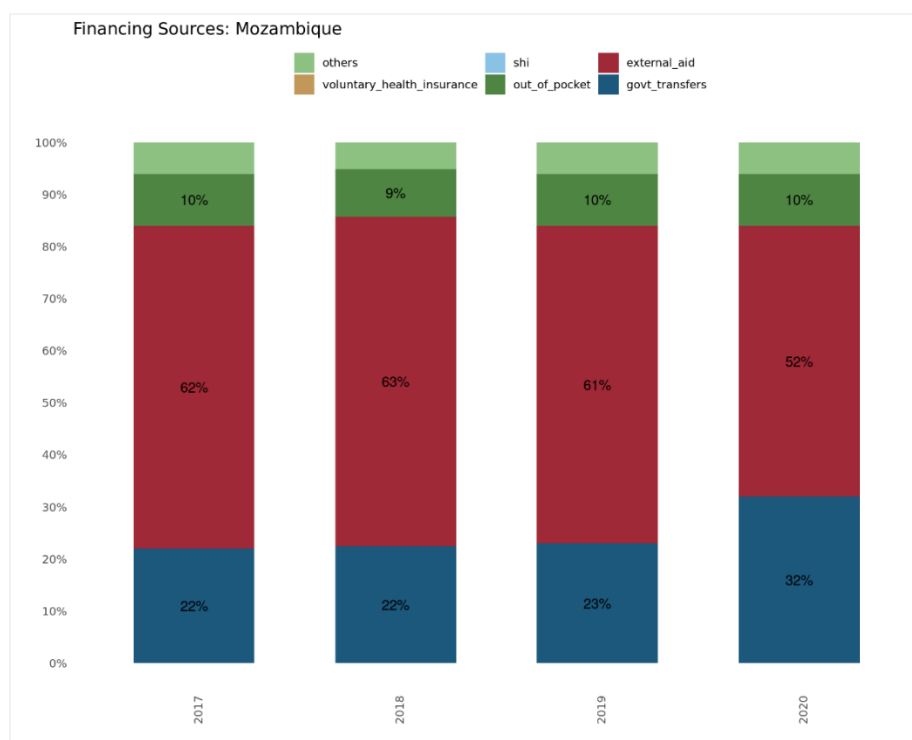


Figure 8: Health Financing Sources in Mozambique

Source: WHO Global Health Expenditure Database, Analysis by Consultant

Highlight

The low UHC service coverage index highlights the need for system wide improvements to facilitate access to quality essential healthcare in Mozambique.

Though improving, there was still a high dependence on donors in financing health in Mozambique. Increased government allocations are essential to guarantee sustainability of health services, including immunization services.

Immunization Coverage

Immunization coverage for all the selected vaccines declined between 2019 and 2022 as shown in **figure 9**. The least affected vaccine was Measles 1. It is estimated that the tally of Zero Dose children rose from 97,000 in 2019 to 750,000 in 2023 [7]. This indicated challenges in access and utilization of immunization services possibly due to COVID-related restrictions, the aftermath of Cyclones, and supply chain disruptions for the vaccine products.

'The low coverage during and just after pandemic would partly be accounted for by the disrupted utilization in the conflict-ridden northern Mozambique which hosts about 7 to 8% of coverage in Mozambique.' **Immunization CSO Executive**

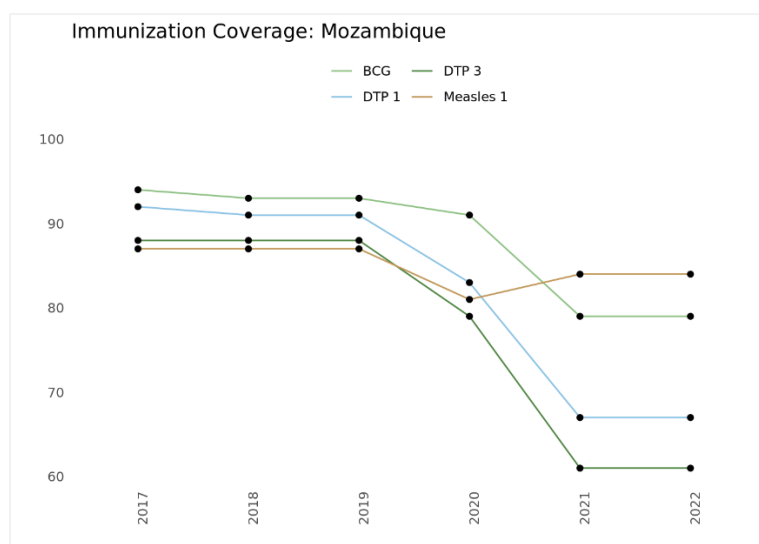


Figure 9: Immunization Coverage in Mozambique

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

'The joint planning for Immunization services coordinated by the government but involving all the stakeholders has great potential in ensuring synergy of interventions, efficient coordination and equitable geographical coverage.' **Public Policy Researcher, Mozambique**

Overall, lower income groups had higher under five mortality rates, and higher immunization coverage (**Figure 10**). There was a gap of more than 30 deaths per 1000 live births among the under-fives between the wealthiest and poorest income groups. The coverage gap for DTP3 and MCV2 was approximately 10 percentage points in favor of the poorest income groups. Paucity of data limited equity analysis of Zero Doses by income level.

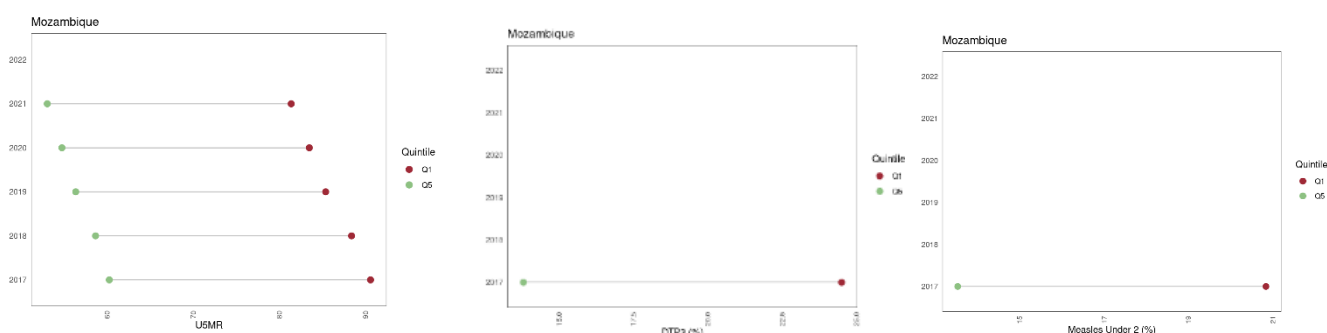


Figure 10: Equity Analysis of U5MR and Immunization coverage in Mozambique.

Source: WHO Equity Database

Highlight

Periodic targeted immunization campaigns are necessary to ensure catch up to pre-2019 coverage levels, to reach the zero dose and under immunized children and to sustain coverage of essential vaccines above 90%.[7]

'The disparities based on income are partly driven by poor transport network with limited last mile coverage in the vast country, low maternal literacy levels, gender-based violence, and limited service integration in the rural areas.' **Immunization CSO Executive**

Immunization Financing

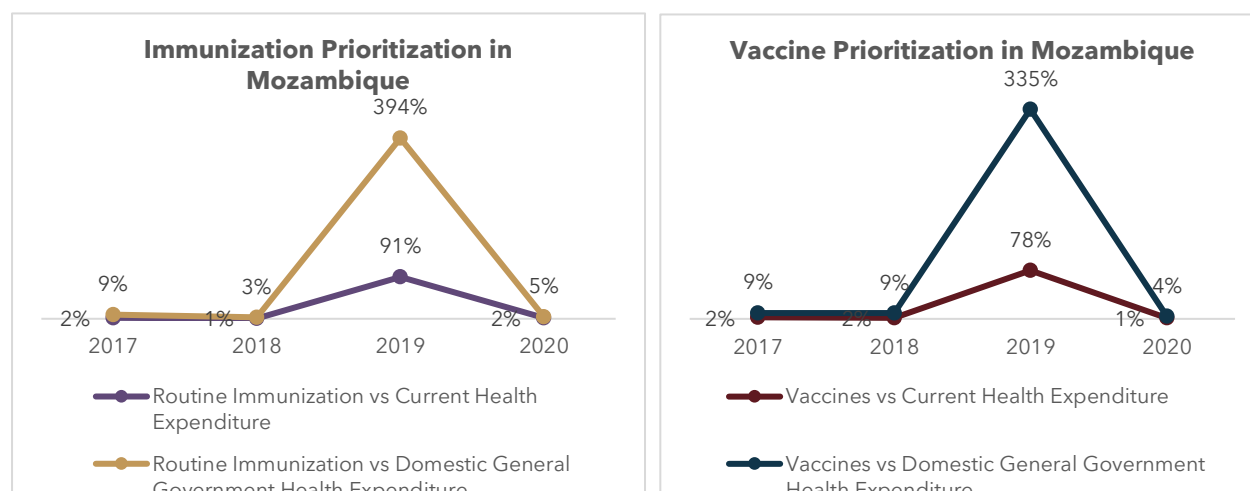


Figure 11: Prioritization of Immunization and Vaccines in Mozambique

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

Expenditures on Routine Immunization in Mozambique were unpredictable during the period of analysis. Routine immunization accounted for between 1% (2018) and 91% (2019) of the Current Health Expenditure; and between 3% and 400% of the Domestic General Government Health Expenditures between 2017 and 2020. Vaccine related expenditures also had a similar trend accounting for between 2% and 78% of the CHE, and between 9% to 335% of the Domestic General Government Expenditures (**Figure 11**).

The high donor contributions and relatively low government spend on health in 2019 may be attributed to the impact of humanitarian emergencies such as Tropical Cyclone Idai and Cyclone Kenneth.

Highlight

There is significant donor dependence in financing of health and immunization services in Mozambique. This significantly peaked in 2019 due to the humanitarian emergencies occasioned by Cyclone Idai and Kenneth. This donor dependence is also compounded by the unpredictable nature of the financing available for immunization services.

'Collaborative transition planning over the medium and long term by government and partners is very essential for continuity of immunization services given the reality of declining donor financing.' **Multilateral Partner Representative**

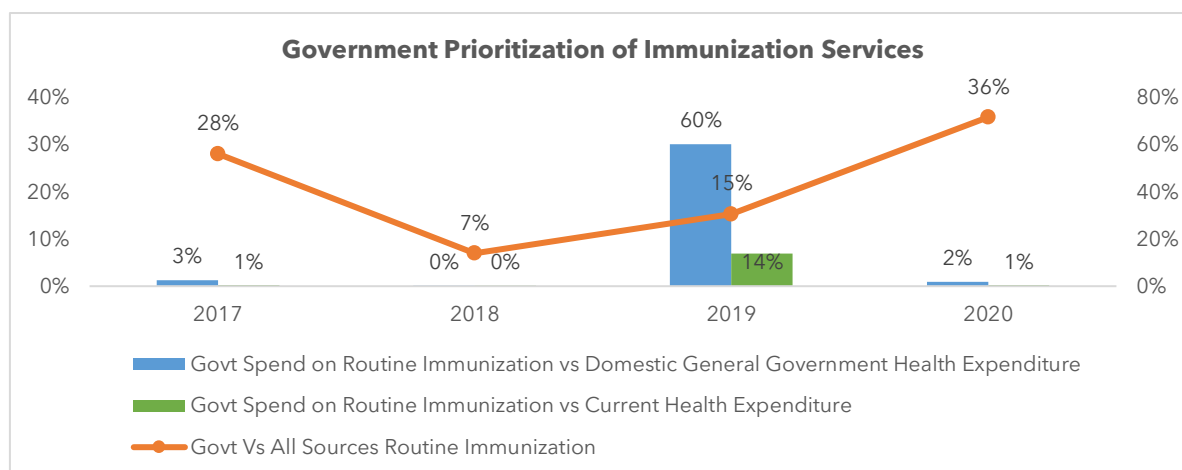


Figure 13: Government Prioritization of Immunization in Mozambique

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

Government funding as a source of immunization financing fluctuated between 7% to 36% between 2017 and 2020. This accounted for between less than 1% (2017) and 14% (2019) of Current Health Expenditures and below 1% (2018) and 60% (2019) of the Domestic General Government Health Expenditure. The highest allocations were at the peak of Cyclone Idai and Kenneth in 2019 (**Figure 13**).

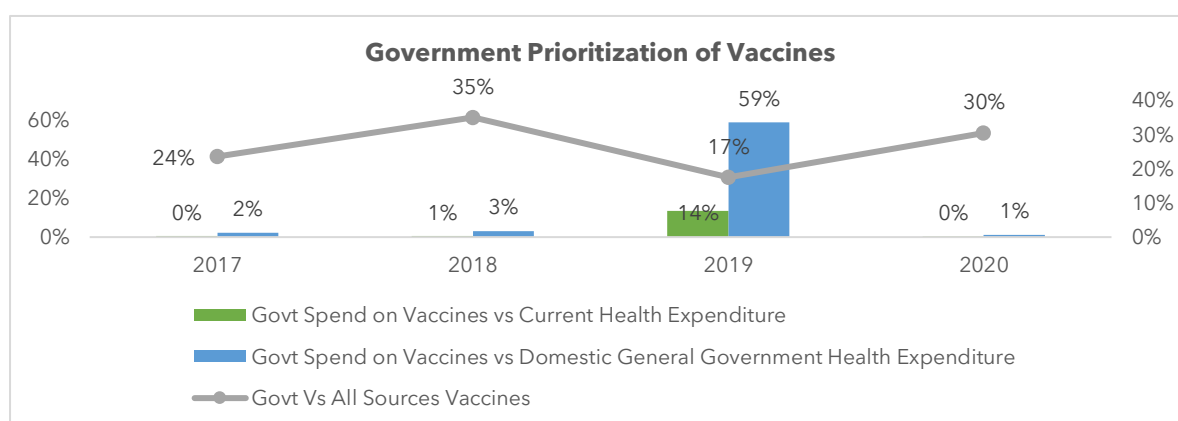


Figure 12: Government prioritization of Vaccines in Mozambique

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

During the period of analysis, Government financing as a source of vaccination financing varied between 17% (2019) to 35% (2018). This accounted for less than 1% of Current Health Expenditures except for 2019 (14%) and less than 3% of the Domestic General Government Health Expenditure except for 2019 (59%). **See figure 12.**

'Perhaps it is high time funding partners were flexible to support health system interventions beyond vertical disease areas if we are to see stronger health systems that can outlast the tenure of donor financing.' **Multilateral Partner Representative**

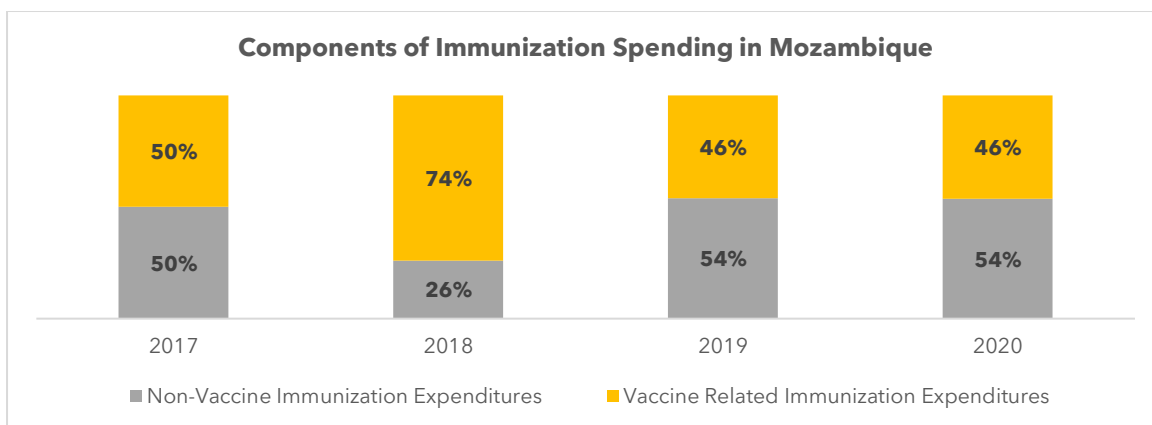


Figure 14: Components of Immunization Spending in Mozambique

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

Except for 2018 when the vaccines accounted for 74% of all immunization spending, vaccine related expenditures accounted for between 46% and 50% of immunization spending during the period of analysis (Figure 14).

'Reduction of intermediaries within the vaccine supply chain in Mozambique can help save public resources as most of these actors escalate the costs significantly.' **Public Finance Expert, Mozambique.**

Highlight

There is still significant donor dependence for immunization financing in Mozambique. This threatens sustainability of immunization services. Progressive increments in government financing of health and immunization will help mitigate against donor dependence and financial hardship among households as they seek for immunization services.

Recommendations towards improving immunization services in Mozambique.

- **Access to healthcare services:** Establish more healthcare facilities and mobile vaccination clinics in underserved areas.
- **Geographic barriers:** Invest in strengthening transportation infrastructure and consider innovative vaccine delivery methods such as drones.
- **Vaccine supply chain challenges:** Upgrade the cold chain infrastructure, implement robust supply chain management systems and expedite customs clearance for vaccines.
- **Vaccine hesitancy and cultural factors:** Launch public awareness campaigns and engage community leaders and trusted figures. Target outreach efforts to address specific challenges, promote female education, and facilitate dialogue with community and religious leaders.

'A low hanging opportunity for partners and government lies in training local trusted community representatives to support awareness creation for immunization within communities' **Mozambique CSO M&E Lead**

- **Socioeconomic barriers:** Implement subsidies or free transportation and strengthen social safety nets.
- **Health worker shortages:** Invest in training and education programs and offer incentives for healthcare workers to work in underserved regions.

- **Infectious disease outbreaks and diversions:** Develop and implement contingency plans and allocate resources for both routine immunization and outbreak response.
- **Vaccine funding and health system weaknesses:** Advocate for consistent and increased government funding and explore sustainable funding models in partnerships with international organizations and donors.
- **Cultural and linguistic diversity:** Tailor immunization communication and engage community leaders and cultural influencers.
- **Civil unrest and conflict:** Collaborate with security and humanitarian agencies and implement strategies to maintain healthcare services during conflicts.
- **Data management and monitoring:** Improve data collection and reporting systems and implement real-time monitoring.
- **Climate-related challenges:** Develop disaster response plans and invest in climate-resilient healthcare facilities.

Recommendations towards improving immunization financing in Mozambique.

1. Government Funding:

- Advocate for increased budget allocation for health and immunization with the executive and legislative teams including through earmarked taxation such as Sin Taxes and taxes on extractive industries (gas, petroleum etc.)
- Advocate for enhanced collaboration and cross talk between the Ministry of Finance and Ministry of Health in planning and budgeting for health and immunization.
- Emphasize immunization's cost-effectiveness in disease prevention.
- Advocacy for economic stability and strong Public Finance Systems to boost public funding capacity and efficiency.

'The government has recently passed laws that earmark sin taxes to healthcare. While this is commendable, its operationalization and implementation remain a major cause of concern.' **Public Policy Researcher, Mozambique**

2. External Donor Dependency:

- Advocacy for donor transition planning by the government to ensure sustainability of previously donor funded interventions, including immunization.
- Build domestic resource mobilization capacity through strengthened Public Finance Management (PFM) systems.
- Advocacy for flexibility among donors to invest in health systems strengthening rather than vertical disease programmes.
- Advocacy for on-budget channeling of donor financing to improve visibility and accountability for donor funding; and strengthen country PFM systems.

3. Vaccine Costs and Supply Chain:

- Negotiate favorable vaccine prices.
- Increase investments in cold chain infrastructure.
- Implement cost-effective vaccine transportation.

'While domestic vaccine manufacturing is an active, desirable conversation, it may not be the priority presently given the resource requirements and the need to build capacity for the same. Perhaps smaller, resource constrained countries should consider establishing regional remote R&D hubs to carry out contextual operational research as they work towards manufacturing.' **Immunization CSO Executive**

4. Human Resource and Health System Costs:

- Streamline healthcare worker training and capacity-building.
- Strengthen healthcare infrastructure.
- Improve financial management and transparency within the health sector to optimize efficiency gains.

5. **Access and Disparities:**

- Target underserved regions with immunization campaigns.
- Enhance healthcare infrastructure in economically disadvantaged areas.

6. **Advocacy and Awareness:**

- Capacity building among Civil Society on Immunization financing for effective and targeted immunization advocacy.
- Conduct public awareness campaigns on the importance of immunization.
- Civil Society to continually engage political leaders for immunization funding prioritization.
- Civil Society to continue with active engagement in the joint immunization planning platforms.

'CSOs can achieve more through synergy if only they were proactive and coalesced advocacy initiatives targeted at immunization financing.' **Mozambique CSO M&E Lead**

7. **Data, Monitoring, and Accountability:**

- Allocate resources for data collection and monitoring.
- Strengthen inter-agency coordination and accountability mechanisms amongst stakeholders in immunization services.

8. **Vaccine Demand and Coordination:**

- Enhance forecasting and resource allocation strategies through continuous capacity development.
- Educate healthcare workers and communities on vaccine importance.
- Improve efficiency in resource utilization through collaboration.

9. **Health Insurance Coverage:**

- Expand health insurance for immunization.
- Provide subsidies or free vaccines for the uninsured.

10. **External Factors and Shocks:**

- Develop contingency plans to protect immunization programs during crises.
- Coordinate with disaster management agencies for effective resource use.

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Appendix 1: Contributors

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