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Report Number : ICRR0024243

1. Project Data

Project ID	Program Name	
P163541	Mozambique PHCSP	
Country	**Practice Area(Lead)**	
Mozambique	Health, Nutrition & Population	
L/C/TF Number(s)	**Closing Date (Original)**	**Total Program Cost (USD)**
IDA-D2650,TF-A6152,TF-A9398,TF-B3368,TF-B4481	31-Dec-2022	180,339,082.88
Bank Approval Date	**Closing Date (Actual)**	
20-Dec-2017	31-Dec-2023	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	105,000,000.00	123,200,000.00
Revised Commitment	203,200,000.00	123,200,000.00
Actual	173,985,403.45	103,281,688.23

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Program Context and Development Objectives

a. Objectives

The PDO, as stated in the Grant Agreement and the Project Appraisal Document (PAD), was “to improve the utilization and quality of reproductive, maternal, child and adolescent health and nutrition (RMNCAH-N) services, particularly in underserved areas.” Underserved areas were identified based on their low relative historical provincial and district per capita expenditure, together with other health outcome and service delivery factors detailed in the Program Operations Manual (PAD p.24).

An outcome target was revised downward at a March 2023 restructuring, but the split rating methodology will not be used for this Review as it would not affect any of the ratings.

b. Were the program objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

30-Mar-2023

c. Will a split evaluation be undertaken?

No

d. Components

Program activities addressed three thematic areas of the government's five-year Investment Case (IC) for enhanced delivery of RMNCAH-N services:

1. Enhancing coverage, access, and quality of primary health care services, including high-impact supply and demand-side interventions, with a focus on underserved areas;
2. Strengthening the health system for improved stewardship, financial sustainability, expenditure efficiency and equity, and gender responsiveness of service delivery, together with improved Civil Registration and Vital Statistics (CRVS) systems; and
3. Enabling the Ministry of Health (MISAU) to effectively manage the implementation of the IC, through technical assistance, capacity development, monitoring and evaluation (M&E), and Health Partner coordination activities.

e. Comments on Program Cost, Financing, Borrower Contribution, and Dates

Cost and Financing: The program was originally financed by an IDA grant of US$80 million alongside a Global Financing Facility grant of US$25 million, of which US$77 million and US$22 million respectively were disbursed. In addition, Trust Fund financing from the Netherlands (US$35.5 million) and USAID (US$22.5 million) co-financed the disbursement-linked indicators (DLIs). US$935 million in borrower financing was also committed, although the ICR did not report on the final tally of government expenditures. In the first restructuring, additional financing was committed in the form of US$90 million in Trust Fund financing from the Government of Canada and the United Kingdom's Department for International Development/Foreign, Commonwealth & Development Office (DFID/FCDO). Conversely, the fourth restructuring incorporated withdrawal from prior funding commitments by USAID (US$15.1 million reduction from original commitment) and FCDO (US$11.2 million reduction). In total, US$179 million in World Bank-administered financing, including donor-funded trust funds, was originally committed, later

raised to US$203 million thanks to additional donor commitments, of which US$174 million was disbursed (reflecting non-achievement of some DLIs).

Dates: The program was approved on December 20, 2017, and went into effect on April 18, 2018. Its original closing date was December 31, 2022, which was postponed in restructuring until December 31, 2023, in accordance with additional financing committed. The program was restructured four times:

- March 1, 2019 (25 percent of IDA grant disbursed): Additional financing was secured in the form of grants from the Government of Canada and DFID/FCDO, as noted above. This financing was planned before project launch but only finalized after the project was approved. The results framework was revised accordingly, updating select baselines and targets and scaling up DLIs to reflect the additional financing, and a new DLI was added on availability of essential medicines in primary health care facilities. In addition, the closing date was extended by one year to reflect the additional year of financing provided.
- April 7, 2021 (65 percent of IDA funds disbursed): In accordance with mid-term review recommendations and to accommodate COVID-19-related data collection challenges, several indicators were changed to refine some of the expected outputs/outcomes, improve methodologies used to calculate them, clarify responsibilities for data collection and reporting, and facilitate the monitoring of program activities and interventions. In response to data gathering challenges and pressures on the health and training systems due to the COVID-19 pandemic, some annual targets were modified, and 6th year targets were added. For the most part, endline targets were maintained. In the case of DLI 1, due to "insufficient ownership" by the Ministry of Health and high implementation costs, targets to expand the UpSCALE application among Community Health Workers were removed pending further discussion. Sub-indicators were added to support the institutionalization of the Child Health Workers program (including their official recognition as a public health cadre) (Restructuring Paper, p.8).
- May 4, 2022: This restructuring was required to (a) retroactively include a clause in the Grant Agreement of the executed trust fund (TF0B4481) financed by the UK to enable disbursement against prior results and (b) extend the IDA grant (D265-MZ) from December 31, 2022, to December 31, 2023, to align with the closing date of other funding sources supporting the Program.
- March 30, 2023 (88.6 percent of IDA grant disbursed): The restructuring involved changes to the results framework, in response to a reduced financing envelope and other challenges. The reduction in financing was due to the UK (FCDO) and USAID withdrawing from prior commitments. These reductions, totaling approximately US$36.5 million, constituted 32 percent of the remaining DLI allocation totals for 2021 to 2023. In response, reductions were made in annual DLI and results framework targets, including:
    1. Removing 2023 DLIs (totaling US$16.7 million, enabling sufficient time for DLI verification and Program closing by December 2023);
    2. Eliminating some process indicators; and
    3. Reducing select targets to ensure they would be "both challenging and feasible."

Two intermediate results indicators and one PDO indicator were modified:

- IRI "Number of health facilities providing Basic Emergency Obstetric and Newborn Care" was removed, as it had not been reliably measured to date. The indicator on Comprehensive Emergency Obstetric and Newborn Care was retained;
- IRI "Percentage of pregnant women who receive four doses of intermittent preventive treatment of malaria during their pregnancy" was removed, according to the Restructuring Paper (p.7) "to

streamline and enhance focus" on the PDO indicator "Number of lagging districts (as defined in the IC) that provide four doses of intermittent preventive treatment of malaria to at least 70 percent of pregnant women." The end target of this PDO indicator, which was added in the mid-term restructuring in 2021, was reduced from 70 percent target coverage per district to 60 percent.

Additional details on target revisions are provided in Section 4.

3. Relevance

a. Relevance of Objectives

Rationale

The program was in line with Mozambique's commitments to improve its health services, particularly in lagging districts. While Mozambique had demonstrated improvements in access to health facilities and community-based interventions, inequalities persisted, with poor, rural populations, and women and children being the most disadvantaged. 62 percent of deaths in 2015 were due to communicable diseases (especially malaria, and due to inadequate sanitation and potable water) and malnutrition amongst women and neonates (ICR p.6). Mozambique suffered from high rates of stunting (38 percent) and malnutrition as well as one of the highest rates of child marriage and adolescent fertility in the world (CPF 2023, p.60). Mozambique's Human Capital Index was also amongst the lowest in the world at 0.36. To address these challenges, the Government of Mozambique developed a five-year IC, prioritizing high-impact interventions to support access to and quality of Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH-N) services. The IC was supported by multiple donor health partners. This PforR financed the part of the IC implemented through the government's annual Economic and Social Plan (2014-19), supporting three of the IC's thematic areas, as detailed above in Section 2d.

The program was relevant to the most recent Country Partnership Framework (CPF, FY2023-FY2027). It was consistent with High-Level Outcome 3: Improved human capital and women's empowerment, and CPF Objective 7 of Improved Selected Health and Education Outcomes. The CPF, under Objective 7, sets the following goals: "The CPF will continue the current engagements in health and education which, having achieved many foundational reforms, will focus next on outcomes, equitable delivery of frontline services, quality, and adaptability, and resilience to shocks." The "selected" health outcomes identified in the CPF (p.36) include reducing the prevalence of stunting, reducing child mortality, and increasing childhood immunization coverage (CPF p.61). In addition, in line with the emphasis on institutional capacity-building in the CPF, the PforR supported development of health system M&E capacity, increasing numbers of community health workers and health worker and teacher training, and expanding health and nutrition services related to the reduction of stunting (CPF 2023, p.37). The PDO also contributed to Objective 8: "Improved access to services to prevent adolescent pregnancy and promote women's economic participation" through support for sexual and reproductive health services in secondary and technical schools (information and contraceptive methods).

Rating
High

b. Relevance of DLIs

DLI 1

DLI
Number of districts with at least 85 percent coverage of institutional deliveries in lagging districts.

Rationale
Lagging districts were defined in the IC as districts with with lower population density, fewer resources, and less actual production of services and determined by an algorithm detailed in the IC and program manual. Priority Districts included the lagging districts listed in the IC, as well as a list of 55 districts that had high potential for attaining results. The original DLI statement was "Percentage of Institutional Deliveries in 42 priority districts as defined in the IC," but this was revised in 2021. The revision aimed to better capture equity in coverage, as the average coverage masked significant inequities between districts. This DLI aimed at increasing the number of births taking place in hospitals. The percentage of institutional deliveries was defined as the total number of pregnant women who delivered their babies in a health facility in a priority district out of the total number of expected childbirths in the same district in a year. The purpose of this DLI was to improve inadequate service availability to reduce maternal and neonatal mortality. According to data from routine data sources and the 2015 Survey on Vaccination, Malaria and HIV-AIDS Indicators in Mozambique, while there had been marked increases in the coverage of institutional deliveries, there were still substantial inequalities—despite some reduction—in the accessibility and use of maternal and child health (MCH) services (ICR para.6). DLI1 directly corresponded with PDO1, with both measuring achievement of the PDO of enhancing utilization of RMNCH services.

Rating
Substantial

DLI 2

DLI
Percentage of secondary and technical schools offering sexual and reproductive health services (information and contraceptive methods).

Rationale

Mozambique, with one of the highest birth rates in the world, is characterized by high and increasing rates of adolescent fertility. Adolescent pregnancy is associated with increased risk of maternal death. In addition, estimates showed that a reduction of one child in Mozambique’s fertility rate (5.3 in 2016) by 2050 could lead to a 31 percent increase in real GDP per capita and a 3.3 percentage point decrease in poverty headcount rate (PAD p.10). This DLI was intended to contribute to improved engagement of adolescents with family planning services, leading to lower adolescent pregnancy rates. The original wording of the DLI was “Percentage of secondary schools offering sexual and reproductive health services (information and contraceptive methods), *based on visits by health professionals, at least monthly*.” At the 2019 restructuring, the DLI was revised to: "Percentage of secondary and technical schools offering sexual and reproductive health (SRH) services, according to minimum criteria," as monthly visits were determined to be a prohibitively high standard; instead, minimum criteria of quarterly visits (required for consistent access to injectable contraception) were set, as more realistic from an operational and fiscal perspective (ICR p.48). In the 2021 restructuring, the DLI was further amended due to COVID-19-related school closures. The minimum criteria were removed from the DLI statement, and the 2020 target was reduced from 30 to 19 percent, with a focus on technical schools that had remained partially open. Additional process indicators and sub-DLIs were set for 2020 and subsequent years. Sub-indicators confirmed that the recipient had (i) completed an identification of gaps in training materials (Yes/No) (DLI 2.2); (ii) finalized the harmonization of monitoring and evaluation tools (Yes/No) (DLI 2.3); (iii) approved updated training materials (Yes/No); (iv) set adolescent- and youth-friendly services guidelines (Yes/No) (DLI2.4); and (v) trained health providers and focal points on improved monitoring and evaluation tools (Yes/No). Achievement of the DLI was meant to contribute to PDO Indicator 2, which measured contraceptive distribution.

Rating
Substantial

DLI 3

DLI
Couple years of protection (CYPs).

Rationale
This DLI estimated the protection provided by family planning services during a one-year period, based upon the volume of all modern contraceptive methods sold or distributed free of charge to users during that period. As with DLI2, this DLI was intended to improve access to sexual and reproductive health services to support a reduction in fertility and improved sexual health. CYP is a standardized indicator developed by USAID. The PAD (p.24) explains the choice of CYP as an indicator for access to family planning: (i) the CYP indicator presents a way to aggregate all family planning methods into a single output measure that can be tracked using the health management information system; (ii) CYP targets can be linked to forecasted coverage changes of various family planning methods, and (iii) unlike the modern contraceptive prevalence rate, CYPs can be measured without a survey methodology at every level within the health system. The DLI corresponded with PDO2.

Rating
High

DLI 4

DLI

The Recipient has increased the percentage of children between 0-24 months of age receiving the Nutrition Intervention Package in the 8 provinces with a prevalence of stunting above 35 percent (percentage).

Rationale

High levels of stunting had remained unchanged over the last 2-3 decades, affecting on average 43 percent of children under five, with higher concentrations in the northern and central regions. Mozambique's stunting rate was the ninth highest in Africa (PAD p.10). This DLI was revised in 2019 from the original indicator of: Percentage of children between 0-24 months of age receiving the Nutrition Intervention Package in the 6 provinces with the highest prevalence of chronic malnutrition. According to the program team, there was no substantive difference between the terminology used in the first phrasing of the DLI "prevalence of stunting" and the change to "prevalence of chronic malnutrition," as both used the same data source. At the same time, (PDO level) end targets were adjusted to reflect reduced availability of nutrition commodities due to supply chain disruptions during COVID and the restriction of public gatherings at all levels, including community nutrition service sites. Sub-indicators for this DLI included: (i) training at least 6 trainers, 100 percent of district nutrition representatives, 30 percent of Community Health Workers, and 30 percent of volunteers in 6 of the 8 targeted provinces, and (ii) finalizing the Monitoring and Evaluation System. The indicator corresponded with PDO 3.

Rating

Substantial

DLI 5

DLI

Domestic health expenditures as a percentage of total domestic government expenditures.

Rationale

This DLI was intended to address low government health spending, which was identified as a key constraint to improving health systems access and quality. According to the PAD (p.10), "while the share of domestic health financing remained relatively constant in 2015-16, it has been jeopardized by Mozambique's growing debt service. The maintenance of domestic expenditures for health must be incentivized to sustain financing for the sector, and to avoid putting undue burden on households. To reach universal health coverage in the longer term, this will require strategies such as increasing allocation of general revenue sources, earmarked taxes, equitably applied user fees, etc." This DLI was supported by a series of reforms to strengthen fiduciary oversight and fiscal decentralization. Achievement of this DLI supported the full PDO, including both quality and utilization objectives.

Rating

High

DLI 6

DLI

Recipient has increased health expenditures from the Sub-Account Resources in Underserved Provinces (Nampula, Zambezia, Tete).

Rationale

DLI6 was an accompanying measure to DLI5. These underserved areas were selected based on their low relative historical provincial and district per capita expenditure, together with other health outcome and service delivery factors detailed in the Program Operations Manual (PAD p.24). Sub-indicators for this DLI included: (i) increasing health expenditures from the Sub-Account Resources in the 28 Underserved Districts in the three Underserved Provinces; (ii) maintaining Domestic Health Expenditures for the three Underserved Provinces (Nampula, Zambezia, Tete) as a share of provincial Domestic Health Expenditures; (iii) maintaining Domestic Health Expenditures for the 28 Underserved Districts in the three Underserved Provinces as a share of district Domestic Health Expenditures; (iv) increasing the number of provinces with Program Contracts; and (v) disbursing grants to 90 percent of primary health care facilities with internment in the three Underserved Provinces. Achievement of this DLI supported the full PDO, including both quality and utilization objectives.

Rating

High

DLI 7

DLI

Number of technical health personnel (Regime Especial) assigned to the primary health care network.

Rationale

Mozambique's critical health system challenges included low health worker density (linked to insufficient per capita health expenditure) and absenteeism (estimated at 23.4 percent). This was exacerbated by inadequate provider capacities, low motivation/effort/accountability for results, and a top-heavy workforce composition inefficiently skewed towards more administrative (non-medical) staff (PAD p.10). The IC named health human resources as a "key bottleneck" in Mozambique's primary health care system and committed to retain and increase the number of health professionals at the primary level to overcome critical shortages. This DLI included all career health professionals belonging to the health "special regime," including the following occupational areas: Nursing, Curative Medicine, Preventive Medicine, Pharmacy, Laboratory, Surgery, Anesthesiology, Instrumentation, Hospital Administration, Nutrition, Radiology, Stomatology, Psychiatry and Mental Health, Physical Medicine of Rehabilitation, Ophthalmology, Health Statistics, and Otorhinolaryngology. In addition, in the 2019 restructuring, a second sub-DLI (7.2) was added aiming at increasing "the number of health care facilities in the primary care network that have at least two active maternal child health nurses." This DLI was intended to contribute to the PDO of increased utilization of RMNCH services.

Rating

High

DLI 8

DLI

Number of district/rural hospitals that received performance-based allocations (PBA) in accordance with a minimum of two scorecard assessments in the previous fiscal year.

Rationale

DLI 8 addressed the challenge of quality of care. This DLI also has a sub-indicator of "increased number of district and rural hospitals that receive allocations based on prioritized action plans that respond to scorecard evaluations. Prior to this PforR, there was no national mechanism established to systematically monitor, compare, and reward health center performance. The PAD (p.17) referenced several surveys that had identified problems in the technical quality of health services. Quality of care was also identified in the IC as a key bottleneck, driving both poor results and insufficient demand for health services. Under the IC, Service Delivery Indicators (SDIs) were to be used to assess health centers and district hospitals using a balanced scorecard (BSC) to hold facilities accountable for results, incentivized through performance-based payments. The DLI target was changed from a percentage figure to a number in restructuring due to measurement challenges, with the target ambition remaining the same. The DLI directly contributed to the PDO of increased quality of services.

Rating

High

DLI 9

DLI

Number of health centers in priority districts that received performance-based allocations (PBAs) in accordance with at least one scorecard assessment with community consultations in the previous fiscal year.

Rationale

This DLI provided another incentive for improved quality of care, alongside DLI8. In addition, the DLI introduced social accountability monitoring through use of community consultations. The original DLI, "percentage of rural health centers in priority districts that received PBAs in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year," was modified somewhat in 2021, removing "rural" and switching targets from percentage rates to numbers, while maintaining the ambition of the target. According to the ICR (p.93), these revisions aimed to define the number of health centers instead of percentage because of challenges in their classification and hence variations in the denominator. In addition, removing the classification of rural allowed inclusion of urban and peri-urban health centers. The DLI had one sub-indicator: The Recipient has increased the number of health centers in priority districts that received allocations to implement prioritized action plans responding to scorecards evaluations. The DLI directly contributed to the PDO of increased quality of services.

Rating
High

DLI 10

DLI
The Recipient has increased the number of active Community Health Workers (CHWs).

Rationale
This DLI was revised from the original, ”number of community health workers (APEs) that are trained and active.” The deletion of the training requirement from the DLI was “to account for both the resource envelope and the negative impact of COVID-19 on school health activities and community gatherings for training of community health workers” (ICR p.14). The program team explained in an interview with IEG that CHWs were for the most part existing CHWs that had been inactive, and thus had already previously received training. Consequently, the main purpose of this DLI was to reactivate CHWs who had in many cases ceased functioning, and as such the indicator focused on tracking the activities of these reanimated CHWs. The PAD explained the challenges that this DLI was supposed to address: “Although efforts have been made to expand coverage and continuity through community health workers (Agentes Polivalentes Elementares - APEs), effective mechanisms to finance, train, monitor, and functionally integrate them with health facilities are still lacking…..Mozambique’s health system’s challenges include low health worker density (linked to insufficient per capita health expenditure) and absenteeism (estimated at 23.4 percent).” In the 2021 restructuring, a sub-indicator was added to gauge service quality: “The Recipient has increased the percentage of Community Health Workers that deliver services according to quality standards." Achievement of the DLI was meant to contribute to both the utilization and quality aims of the PDO.

Rating
Substantial

DLI 11

DLI
The Recipient has increased the percentage of deaths in eligible health facilities certified by a qualified clinician with cause of death coded using ICD10/11, and the death record captured in SISMA.

Rationale
This DLI intended to address the key health system challenge of limited information for decision making and accountability and was part of a broader initiative under the IC to improve birth and death data in the health information system (DHIS2-SISMA) and strengthen the interface with the Civil Registration and Vital Statistics platform. This was deemed to be critical to generate routine data for decision making and to guarantee rights (PAD p.22). The DLI contained several sub-indicators introduced at restructuring, including: (i) increasing the percentage of hospitals using the Hospital Data Management Module (MGDH) to generate information on causes of deaths; (ii) increasing the percentage of health centers using the Hospital Data Management Module (MGDH) to generate information on causes of deaths, and (iii) increasing the percentage of deaths

registered, certified, and captured in the civil registration system (SiRCEV) within one year of their occurrence. Achievement of this DLI was associated with both the utilization and quality aims of the PDO.

Rating
High

DLI 12

DLI
The Recipient has introduced reforms to increase the availability of essential maternal and reproductive health medicines at primary health care facilities.

Rationale
This indicator was based on an earlier version added during the first restructuring: Average availability of essential tracer maternal and reproductive health medicines at primary health care facilities. However, the indicator's wording was changed in the 2023 restructuring, as the achievement against targets for 2019 and 2020 had not been measured due to delays and methodological issues with the medicines' availability study, and thus were removed. This DLI included a sub-indicator on implementation of outsourcing of last-mile transportation and distribution of medicines (introduced in the 2023 restructuring). The DLI contributed to the twin goals of quality and access.

Rating
High

OVERALL RELEVANCE RATING

Rationale
The program was fully relevant for the country context and consistent with both government priorities and the CPF. The DLIs, for the most part, captured important elements in the program's theory of change for achieving the PDO. Almost all of the DLIs were modified over the course of the program at least once. In some cases, these modifications reflected changing circumstances, including rising and falling levels of program funding and consequences of COVID-19 on the operating context.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective
To improve the utilization of reproductive, maternal, child and adolescent health and nutrition services, particularly in underserved areas.

Rationale
According to the program's theory of change, the key challenges to greater utilization of RMCNH services were inadequate service availability and readiness, shortage of skilled human resources, lack of a platform for community-based service delivery, and low quality of care. The first three of these challenges were addressed in this objective, through DLIs targeted at increasing the availability of obstetric care, supply of medicines, availability of sexual and reproductive health services in secondary schools, and the number of health professionals in primary healthcare facilities as well as active community health workers.

The PDO indicators measured progress towards this objective, which was primarily to be achieved through boosting funding levels and healthcare staff.

PDO1, Increasing the percentage of institutional deliveries in 42 lagging districts, mirrored DLI1 and was supported by several DLIs aimed at increasing health expenditures and staffing levels in primary health care facilities. In addition, it was associated with several intermediate indicators, including:

- Percentage of women who had at least four antenatal visits during their pregnancy (Fully achieved: Baseline: 42; Target: 66.3; Actual 67.6)
- Number of deliveries attended by skilled health personnel (Fully achieved: Target 4,940,000; Actual: 5,903,136)
- Number of health facilities providing Comprehensive Emergency Obstetric and Newborn Care (Fully achieved: Baseline 33; Target: 60; Actual:61)
- Number of technical staff assigned to type II rural health centers (Fully achieved: Baseline: 11,970; Target: 17,153; Actual: 23,029)
- Number of primary health care facilities that have at least two maternal child health nurses (Fully achieved: Baseline: 638; Target: 768; Actual: 869)
- Number of active community health workers (Substantially achieved: Baseline: 3,380; Target 8,800; Actual: 8,318)

The PDO indicator was 33 percent institutional deliveries against a baseline of 27 percent and a target of 37 percent. The ICR (p.31) further notes at the 2019 AF and Restructuring the baseline was increased to 71 percent (SISMA 2017) and end-target to 85 percent. 86 percent was achieved at end-2018. The ICR reports "PDO 1 (DLI 1): In 2019, when Additional Financing became available to DLI 1, the end target of percentage of institutional deliveries was increased from 74.9 to 85 percent; and this revised target was achieved in the second year. However, assessment revealed that this achievement masked inequalities between the 42 districts, with 14 of the 42 of the districts below target. To ensure that this inequality was addressed, the 2021 Restructuring revised PDO 1 and DLI 1 statements, setting a target of 37 districts recording at least 85 percent of institutional deliveries. By 31 December 2022, 33 districts (89 percent) had achieved this target."

PDO2, Number of Couple Years of Protection, surpassed its upwardly revised target (Baseline: 1,722,692; Original target: 2,800,000; Revised target: 3,450,000; Actual: 4,336,444.) It was supported by an intermediate indicator of number of provinces meeting annual Couple Years of Protection growth targets (Baseline: 7; Target: 7; Achieved: 7) and number of technical schools offering sexual and reproductive health

services (information and contraceptive methods), which was fully achieved after being downwardly revised due to COVID-19-related school closures (Original target: 60; Revised target: 50; Actual: 51.76).

PDO3, Percentage of children aged 0-24 months receiving a Nutrition Intervention Package in eight priority provinces with the prevalence of stunting of above 35 percent, had an original target of 80 percent that was downwardly revised in 2023 to 40 percent due to "progress and challenges faced to date." Achievement of this indicator was reported as 23 percent (in other words, not achieved) as of December 2022. However, for 2023, MISAU reported coverage of 55 percent. As such, IEG concurs with the Task Team's decision to rate the indicator as fully achieved as, "…we observed that the activity continued to be supported by the Program during December 2023 and beyond. As such we decided to show the result achieved because it was a direct contribution of the Program." This indicator was also associated with several intermediate indicators, including both the staffing and funding indicators cited above, as well as the indicator "Number of women and children who have received basic nutrition services" (Fully achieved: Target: 9,720,000; Actual: 20,377,452).

According to the Bank team, among the significant accomplishments of this PforR was introduction of the Nutrition Intervention Package as a standard offering of the health system, including seven essential interventions for malnutrition prevention, including counselling, supplementary feeding, vitamin A, micronutrients, deworming, and growth monitoring. This represented an important advance from the Mozambique health system's previous almost exclusive focus on treatment of malnutrition, rather than its prevention. Another notable accomplishment was the allocation of more human resources at a primary level, including an increase in the numbers of: (i) technical health personnel assigned to the primary health care network to 23,029 (surpassing the target of 17,153), (ii) primary health care facilities with at least two maternal child health nurses (869, surpassing the target of 768), and (iii) health facilities providing comprehensive emergency obstetric and newborn care to targeted levels. In addition, there was an increase in the number of active community health workers from a baseline of 3,380 to 8,318 (slightly short of the 8,800 target). However, the ICR notes that both the meager size of the monthly stipend for APEs and the timely transfer of the monthly stipend to the APEs remains a challenge, causing high turnover, with APEs leaving for jobs with better remuneration. Despite this, according to the Bank team, payment of the APEs through the Ministry of Health was an important achievement, as previously APEs had only unreliable sources of income through various donor-funded projects.

Rating
Substantial

OBJECTIVE 2

Objective
To improve the quality of reproductive, maternal, child and adolescent health and nutrition services, particularly in underserved areas.

Rationale
According to the program's theory of change, improvements in the quality of RMNCAH-N services was to be achieved through incentivizing quality care through results-based financing and social accountability monitoring, recognition of well-performing districts and facilities, and monitoring quality of care as well as

cause of death reporting for decision making (DLI 8, 9 and 11). In addition, other DLIs incentivized increasing the share of health in the government's spending (DLI 5) and improving health spending in underserved provinces and districts (DLI 6).

The results framework was supposed to monitor outcomes through two indicators: PDO4 (Adherence to clinical diagnostic guidelines for five tracer conditions at health centers and district hospitals) and PDO5 (Adherence to clinical treatment guidelines for maternal and neonatal complications at health centers and district hospitals). Both of these indicators were deleted in the 2021 restructuring. The ICR (p.19) explains that the indicators were meant to be monitored through bi-annual Service Delivery Indicators (SDI) surveys. However, lack of resource availability and the pandemic contributed to the SDI surveys not taking place. There are, however, several intermediate indicators that can be referenced to give some indication of the quality of health care, or, at least, the introduction of measures that, according to the theory of change, were to contribute to better quality of health care:

The intermediate indicator of "Number of district and rural hospitals that received performance-based allocations (PBAs) in accordance with a minimum of one scorecard assessment in the previous fiscal year" was substantially achieved, with 43 hospitals receiving this allocation against a target of 44. It should be noted that this indicator was downwardly revised somewhat during COVID-19, as the original IRI was to be measured with a minimum of two scorecard assessments, rather than only one. In addition, the ICR presents data indicating a steady increase in quality as represented by increasing numbers of hospitals receiving PBAs on the basis of receiving adequate scorecard assessments. Thus, in 2018, 14 percent of the reviewed hospitals received PBAs; in 2019, 34 percent received PBAs; and in 2021, 77 percent received PBAs. However, it is unclear the extent to which this is reflective of quality of service received rather than technical aspects of proper health care management.

<u>PDO6, Number of lagging districts (as defined in the IC) that provide four doses of intermittent preventive treatment of malaria to at least 70 percent of pregnant women</u>, was added in the 2021 restructuring to provide some a measure of quality of care. According to the program team, the ICR's rationale for including this indicator under quality of care was that provision of preventative treatment of malaria as part of regular ante-natal care is an aspect of quality. The indicator was only partially achieved (21 districts as compared to a target of 30 and a baseline of 10), despite the fact that the target had been downwardly revised "for feasibility." No split rating was applied (consistent with the ICR), as neither the original nor the revised target were achieved.

The IRI "Number of health centers in priority districts that received performance-based allocations in accordance with at least one scorecard assessment with community consultations in the previous FY" was surpassed, with 425 receiving PBAs against a target of 391, with the numbers of health centers receiving PBAs increasing steadily throughout the program period. In this case as well, the indicator was revised due to COVID-19 restrictions from two scorecards to one. There is no evidence of improved quality of CHW services. The baseline study concluded in December 2020 on the quality of services provided by the CHWs showed a low percentage meeting quality standards (28 percent, based on a composite calculation of having basic medicines/contraceptives and diagnostic capacity). At the 2023 restructuring, the 2022 target on the proportion of APEs meeting quality standards was reduced from 80 percent to 50 percent, considering the low level achieved in January 2020. The rationale for this was that reaching the original end target (80 percent) would require significant reform and investments. Despite this, achievement of quality targets was not measured, as MISAU did not conduct the requisite quality study on the performance of the APEs.

Rating
Modest

OVERALL EFFICACY

Rationale
Objective 1 was rated Substantial, and Objective 2 was rated Modest. Overall efficacy is therefore rated Substantial, but with caveats related to shortcomings in achievement of the second objective.

Rating	**Primary Reason**
Substantial	Insufficient evidence

5. Outcome

Outcome is rated Moderately Satisfactory, with Relevance High and Efficacy Substantial (based on Substantial achievement of one objective and Modest achievement of the other objective).

Outcome Rating
Moderately Satisfactory

6. Risk to Development Outcome

The ICR (p.27) assessed the risk to development outcome as low, citing several reasons. First, there is continuing commitment of both the Ministry of Health and other donor health partners to supporting RMNCAH-N outcomes in Mozambique. According to the ICR, the IC helped prioritize and identify financing needs that seem to have been internalized by MISAU. Second, a new Bank operation has been approved to help sustain and further improve health outcomes for women and children in the country. The new operation is a combination of PforR for incentivizing results, and an IPF component to enable institutional capacity building and better access to services for the population in the conflict-affected northern areas, with the support of a contracted third party/non-government organization.

7. Assessment of Bank Performance

a. Quality-at-Entry

The choice of PforR instrument was suitable for the context, building on past experience with similar instruments in Mozambique, and directed toward building incentive structures and accountability. Among the reasons cited in the PAD (p.12) for this modality were: (i) to support accountability chains at all levels to develop both provider capacities and executive results management; (ii) flexibility to advance reforms at different levels of the causal chain (from policy, to procedures and implementation); (iii) to promote equity and performance through budget planning and execution, including through performance-based institutional incentives; (iv) to stimulate executive innovation and motivation to supersede structural and procedural deficiencies and promote institutional and multi-sectoral collaboration (critical for areas like nutrition and family planning, and for strengthening domestic sector financing and public financial management systems); and (v) to establish a co-financing platform for multiple partners that creates clearer linkages between financing and results, to improve spending efficiency to achieve health outcomes as well as to restore health partners' confidence and financing to the sector after Mozambique's debt crisis in 2016/17. The decision to opt for a PforR was partly based on the success of the ongoing Education Sector Support Fund, known as FASE, through which the World Bank, over a 14-year period, had channeled financing through DLIs while providing fiduciary oversight and coordination support for a wide range of other partners. In addition, MISAU was familiar with the format due to the ongoing Public Financial Management for Results Program (P124615), which contributed to strengthening the medicines supply chain.

The theory of change was robust, identifying specific key constraints and addressing both structural and process changes needed to overcome these constraints. The theory of change identified five key bottlenecks to improving outcomes and then clearly traced how incentives provided by DLIs, alongside complementary support, could overcome these constraints in order to improve utilization and quality of RMNCAH-N in the country. For each DLI, a technical note assessed what complementary support would be needed, including TA and capacity development, performance-based allocation schemes, communications interventions, coaching and facilitation, and support to reinforce M&E and verification protocols (PAD p.23).

Substantial efforts were made during program preparation to ensure the relevance and evaluability of indicators, although in some cases problems with DLIs were not identified in planning phases. According to the ICR (p.16), during program preparation, task groups (including both government and development partners) were formed to detail out each DLI as a technical note, including a clear protocol and methodology for its monitoring, verification, and reporting, which was described in the Program Operations Manual. The detailed technical notes documented the indicator definitions, proposed activities to reach the DLIs, baselines and targets, implementation and data collection responsibilities, validation protocols, underlying performance-based allocations to select institutions, and other supporting interventions required for results achievement (ICR p.21). As a result, the M&E framework was for the most part well planned and corresponded to the theory of change, although as documented in Section 3, some of the DLIs needed to be revised during implementation.

The program was prepared in close collaboration with the government and health partners. The Mozambique health sector was supported by several partners through different mechanisms, including PROSAUDE, a common fund with a Sector-Wide Approach. Health partners, under the leadership of MISAU, supported the preparation of a joint DLIs matrix for the IC, with

partners committing to aligning their financing and support around IC priorities. However, according to the Bank team, some of the co-financers committed to the program without a full understanding of the PforR mechanism, which allows for phased allocation of funds with the possibility of non-disbursal. In consequence, there were fluctuations in funding throughout the program, with some donors committing to but later withdrawing promised funding. In retrospect, the Bank team acknowledged to IEG that “establishing clearly the rules of the PforR with cofinancers is really important so that they understand the mechanism. We should have spent a lot more time educating them on this instrument.”

The PAD recognized and worked to mitigate financial management, procurement, environmental and social risk. Financial and procurement risks, as well as environmental and social risks, were rated as substantial, and the PAD included specific mitigation measures to address these risks. (A more in-depth presentation of these risks and mitigation strategies can be found in Section 9.)

Quality-at-Entry Rating

Moderately Satisfactory

b. Quality of supervision

The Bank closely monitored the program and responded in a timely manner to the many implementation challenges faced. Among the key challenges faced were fluctuations in donor funding contributions, including a US$32 million shortfall in funds due to the withdrawal of commitments by two lead co-financers for reasons not connected with the program. In addition, a significant change in government regulations led to lengthy procurement delays. Finally, the COVID-19 pandemic significantly impacted the program due to: (i) supply chain disruptions leading to great difficulties procuring needed health and nutrition consumables; (ii) suspension of training and planned school- and community based in-person activities; (iii) disruption to planned data-gathering activities for monitoring and evaluation of program performance; and (iv) the overwhelming burden on the health system due to the pandemic. The many program restructurings and changes to the results framework reflect the Bank’s work to constantly adapt the program to changing circumstances and a changing funding envelope. For the most part, these adaptations were found to be both timely and appropriate; however, measures of quality of services were limited, especially after the removal of PDOs 4 and 5.

The task team engaged in regular monitoring and evaluation, doing so virtually when pandemic restrictions made travel impossible. In addition, the Bank team continued to engage in inter-partner dialogue, and coordination continued through the existing Health Compact, including all health program signatories. Using this mechanism, regular meetings were held to track progress on results indicators and implementation of interventions of the program and the broader IC (PAD p.19).

Most of the Bank team (except for the GFF focal person and Governance colleague) and co-financiers were based in Maputo, and there was little turnover, which facilitated smooth implementation. Monitoring was conducted on a regular basis, with virtual meetings and missions being held when travel was not possible in 2020-21. All agreements and revisions were clearly documented, and

Implementation Status and Results Reports were candid. Supervision of fiduciary, environment, and social aspects was part of all missions.

Quality of Supervision Rating

Moderately Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

8. M&E Design, Implementation, & Utilization

a. M&E Design

Design of both DLIs and the results framework corresponded closely with the program's theory of change and were based on significant preparatory work. However, at times capacities were overestimated. A detailed M&E plan and DLI Verification Protocol was articulated, including different sources and means for data collection. The results framework, DLI matrix, and DLI verification protocol spelled out the sources of data collection and validation of results by an independently contracted agency, the Civil Registry, and the Administrative Tribunal. The M&E and DLI frameworks were discussed and jointly formulated by MISAU, co-financing partners including GFF, and the IDA team (ICR p.23). The ICR, however, points out several shortcomings in M&E planning. First, program design underestimated the extent to which capacity constraints would affect implementation, monitoring, and verification. To quote the ICR (p.23), “An independent agency for verification of specific DLIs was contracted. However... it had grossly underestimated the cost and effort that would be needed for verification of results; and the protracted time and processes needed for certain contracts – verification agency, micronutrients, community-based NGO.” Second, the ICR acknowledges that, “The deletion of the original PDO 4 and 5, and its replacement with a proxy indicator, could have been avoided with better assessment during Program preparation, including data sources and collection” (p.23). Finally, the ICR acknowledges the setting of unrealistic targets due to overestimation of governmental capacity. “In hindsight, design of these DLIs (2, 4, 11 and 12) may have been ambitious, given the existing weak institutional capacity; and the need for multiple actors/sectors to be involved” (p.16).

b. M&E Implementation

There was a well-formulated protocol for M&E. There was a dedicated officer in the PMU responsible for data compilation (relevant for DLIs 1-4 and 8-12) from the routine Health Management Information System of MISAU. Sources of data for the results framework and DLIs were multiple: routine data collection systems of MISAU (SISMA), HRH Information System (SIP), the Ministry of Economy and Finance through e-SISTAFE Budget Execution, CR system, SDI surveys, community surveys, and Supervision Committees. Data validation and verification was designed to be done by different means: surveys done by independent verification agency (DLIs# 1-4, and 8-10), the Administrative Tribunal (DLIs

5-7 and 12), and data from the Civil Registry under the Legal and Justice Department for DLI#11 (ICR p. 24).

Failure to implement the SDI survey as planned had significant implications for program M&E. At the design stage, regular SDI surveys were meant to provide data to measure quality and service readiness of RMNCAH-N services through PDOs 4 and 5, and Intermediate Results Indicators (IRI) 2.1 (BEmONC services), 2.2 (uninterrupted water supply and electricity), and 2.3 (availability of essential reproductive and maternal health medicines in district and rural hospitals). However, during implementation, due to a paucity of resources for SDI surveys because of withdrawn donor commitments, PDOs 4 and 5 were replaced with a "proxy" indicator. In addition, because of non-implementation of an endline SDI, and the IRIs referred to above were deleted.

The use of an outside verification agency led to unanticipated delays due to capacity constraints. The contracted verification agency had a learning curve, and the time this would take had not been anticipated by the task team. However, once fully on board, and within the constraints of traveling and social distancing during the pandemic, the verification was done satisfactorily (ICR p. 24).

c. M&E Utilization

M&E Utilization performance was mixed. According to the ICR (p.24), the scorecards developed and used for performance evaluation and incentivization with PBA were significantly used by the facility-level personnel (including the community) for identifying gaps and small incremental improvements in quality, particularly of existing infrastructure, and for greater patient and provider satisfaction. Data reports (for the results framework and DLIs) were also discussed with MISAU and HPs during implementation support missions of the Bank. However, discussion of reports at District and Provincial levels was not done routinely, and discussions revealed that the MISAU considers this as a weakness and is keen to focus on institutionalization of data discussion for informed decision-making, with the support of the recently approved Program for the health sector.

M&E Quality Rating

Modest

9. Other Issues

a. Safeguards

The Environmental and Social risk was rated as Substantial, as there was a poor track record of safeguards implementation in existing projects, including proper management of health care waste and health and safety of workers, and management of construction impacts (PAD p.35), but no major issues arose during implementation. These shortcomings were assessed to be associated with the limited technical capacity within MISAU to implement safeguards regulations. The Program Action Plan articulated actions that would need to be implemented and monitored to address environment and social weakness and risks identified. The Plan also included several actions for improving gender and socio-

cultural responsiveness (ICR p.22). During the course of the program, no significant safeguard-related issues arose.

b. Fiduciary Compliance

Fiduciary risk was rated as substantial throughout the project. A Fiduciary Systems Assessment was carried out as part of program preparation to evaluate related capacities of MISAU. The program's Financial Management (FM) and Procurement risk was rated as Substantial based on the 2015 Public Expenditure and Financial Accountability Assessment and macroeconomic and political stability as described in country sector reports. Specific risks were identified, including: (i) shortages of human resources and limited capacities for key FM functions; (ii) weak internal controls and auditing, particularly at decentralized levels, and limited follow-up on audit issues; (iii) low budget execution rates for external funds; (iv) limited planning capacities; (v) delayed availability of funds for spending; and (vi) lack of resources allocated to implement policies for decentralizing sector expenditures. Procurement risks identified included: (i) procurement delays due to coordination challenges; (ii) inadequate quality of technical inputs (terms of reference, specifications, and technical evaluations); (iii) limited availability and experience of the members of evaluation committees; (iv) limited exposure to complex processes; (v) deficiencies of procurement record keeping; and (vi) poor contract management. These risks were addressed in the Program Action Plan, including specific capacity building measures to be carried out and compensatory oversight mechanisms (PAD p.33). According to the ICR (p.26), these mitigation measures were completed, but with delays. For example, capacity building of PFM staff, particularly at the health facility level, was challenging due to frequent transfers of personnel, with the resultant need of training the new recruits. The timely transfer of allocated funds to districts, including the monthly stipend to the community health workers, remained a challenge throughout the PforR.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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10. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Satisfactory	
Bank Performance	Satisfactory	Moderately Satisfactory	Moderate shortcomings in design and implementation.
Quality of M&E	Substantial	Modest	Shortcomings in M&E design and implementation.

Quality of ICR	---	Substantial

11. Lessons

Lessons from the ICR (p.27):

1. **When PforRs are co-financed by other donors, failure to adequately communicate to donors the terms of their commitment can lead to problems during implementation.** PforRs are a relatively new instrument, which differs from traditional donor financing in that payment is dependent on performance. Thus, while donors make funding commitments earlier in the process, the actual disbursal of funds takes place over years, and full disbursal is not guaranteed. Over the course of program implementation, priorities and resources of partners may change, especially when there are external shocks such as inflation, conflict and war, health emergencies, and natural disasters. This clearly played out during implementation of this program, where key donors withdrew financing as circumstances changed. To mitigate risk, when partners indicate an interest and commitment to join as co-financiers, it may be useful to include the Bank's and partners' fiduciary, governance, and legal teams in the deliberation. Such collaborative discussions would enable a better understanding of the donor landscape in the country, enabling/disabling factors within each partner's internal environment, and the funding and disbursement cycles of each partner (which may not necessarily match with those of the Bank).
2. **In PforRs, in order to better enable the WB task team to influence the recruitment of technical assistance to support strategic functions or to provide critical support in key areas to the client, at times blended financing may be preferable.** In a PforR, all TA is recruited by the government and follows national rules. While this is the right approach in terms of ownership of the Programs by the government/Ministry of Health, it can lead to bottlenecks such as lengthy processes of developing and approving terms of reference, lengthy advertisement and complex evaluation processes, and several and redundant steps required to clear the evaluation reports. One option to overcome this problem could be for the Bank to retain some capacity to directly provide TA (procurement and funding) to the client through a Bank-executed trust fund or to exert priori review of the recruitment process on an exceptional basis. The inclusion of an IPF component could help achieve the latter.
3. **A narrow geographic focus as well as a results framework that exposes disparities between targeted geographies can drive more cost-effective impact.** While health sector outcomes are measured and reported for the whole country, it is often realistic for a project to narrow the geographic focus (different demographic and vulnerability criteria can be used to prioritize) to enable a more cost-effective impact. Often, the geographically underserved areas are those that have poor access to quality health services and have worse health outcomes. When the choice is made to narrow focus to lagging regions, it is important that the results framework be structured in a way to detect disparities between treatment areas, to ensure that more challenging contexts are identified and supported during implementation. This learning underlay the decision in this PforR to revise the phrasing of DLI 1 and its associated PDO indicator from "Percentage of Institutional Deliveries in 42 priority districts as defined in the IC" to "Number of districts with at least 85 percent coverage of institutional deliveries in lagging districts," in order to better capture disparities between targeted districts.

4. **Even when outside parties are contracted to do M&E, it is important to build governmental capacity for this function.** While independent verification gives the assurance that results have/have not been achieved, it can be challenging. Under this PforR, independent verification was done by a national private firm with reasonable capacity. The process, however, was slowed down by prolonged contracting time, delays in obtaining consolidated data and reporting from MISAU, and the constraints of movement during the pandemic. Hence capacity building of the M&E system of the relevant government body needs to be an integral part of an operation. Collaboration with partners such as the Global Fund can support data quality efforts in the health sector. The availability of adequate and timely resources for important surveys, such as the SDI, should be facilitated by the Bank and other health partners. The availability of reliable and adequate funding to plan for and implement good M&E is a crucial constraint for a program/project. Task teams need the support and facilitation of Bank management and leadership to enable effective M&E.

12. Assessment Recommended?

No

13. Comments on Quality of ICR

The ICR was a candid review of a complex program. It clearly identified the program's shortcomings and success, drawing upon available evidence, and provided relevant lessons for future health PforRs. At times, however, a more in-depth presentation would have been useful. For example, while the ICR, like the ICR Review, parses the objective statement into "utilization" and "quality" components, the ICR's analysis of quality did not provide sufficient evidence to judge whether this aspect of the PDO was materially achieved. Similarly, more systematic information on the many revisions to the DLIs and results framework over the course of the program would have been useful.

a. Quality of ICR Rating

Substantial