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PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED GRANT FROM THE
INTERNATIONAL DEVELOPMENT ASSOCIATION SDR 57.00M (US$80.00M EQUIVALENT)

AND A PROPOSED GRANT FROM
THE GLOBAL FINANCING FACILITY (US$25.00M)

TO THE

THE REPUBLIC OF MOZAMBIQUE

FOR A

MOZAMBIQUE PRIMARY HEALTH CARE STRENGTHENING PROGRAM

November 28, 2017

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective {October 31, 2017})

Currency Unit	=	Metical
MZN 60.7	=	US$1
US$ 1.40469	=	SDR 1

FISCAL YEAR
January 1 – December 31

Regional Vice President:	Makhtar Diop
Country Director:	Mark Lundell
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Magnus Lindelow
Task Team Leader(s):	Humberto Cossa; Furqan Saleem

ABBREVIATIONS AND ACRONYMS

APE	*Agentes Polivalentes Elementares*- Community health workers
BEmONC	Basic Emergency Obstetric and Newborn Care
BETF	Bank-Executed Trust Fund
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CPF	Country Partnership Framework
CRVS	Civil Registration and Vital Statistics
TSA	Treasury Single Account
DHIS2-SISMA	Demographic Health Information System- *Sistema de Informação de Saúde para Monitoria e Avaliação* - MISAU's Health Information System for Monitoring and Evaluation
DLIs	Disbursement-Linked Indicators
DNAM	National Directorate of Medical Services
DRH	Directorate of Human Resources
DNSP	National Directorate of Public Health
DPC	Directorate of Planning and Cooperation
DPS	Provincial Directorates of Health
e-SISTAFE	Government's Electronic Financial Management Information System
ESSA	Environmental and Social Systems Assessment
FM	Financial Management
FSA	Fiduciary Systems Assessment
GDP	Gross Domestic Product
GFF	Global Financing Facility
GRS	Grievance Redress Service
HNP	Health, Nutrition, and Population
HP	Health Partners
HPER	Health Public Expenditure Review
IC	Investment Case
IDA	International Development Association
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDTF	Multi-Donor Trust Fund
MEF	Ministry of Economy and Finance
MGCSA	Ministry of Gender, Children and Social Action
MINEDH	Ministry of Education and Human Development
MISAU	Ministry of Health
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organization
NHS	National Health Service
OE	*Orçamento do Estado*- State Budget

PBA	Performance based allocations
PDO	Program Development Objective
PES	Economic and Social Plan
PESS	Government's Health Sector Strategic Plan
PFM	Public Financial Management
PforR	Program-for-Results
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
PMU	Project Management Unit
POM	Program Operational Manual
PPA	Program Preparation Advance
PQG	*Programa Quinquenal do Governo* - Five-Year Program
PROSAUDE	Health Common Fund
RMNCAH-N	Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition
SCD	Systematic Country Diagnostic
SDI	Service Delivery Indicators
SDSGCAS	District Directorates for Health, Gender, Children and Social Action
SDTF	Single-Donor Trust Fund
SISMA	*Sistema de Informação de Saúde para Monitoria e Avaliação* - Health Information System for Monitoring and Evaluation
SMART	Specific, Measurable, Achievable, Relevant and Time-bound
SWAp	Sector Wide Approach
TA	Technical Assistance
UGB	*Unidades Gestoras Beneficiarias* - Budget Beneficiary Management Units
UGE	*Unidades Gestoras Executoras* - Budget Execution Management Units
UHC	Universal Health Coverage
UFSA	*Unidade Funcional de Supervisão das Aquisições* - Functional Unit for Procurement Supervision

BASIC INFORMATION

Is this a regionally tagged project?	Country (ies)	Lending Instrument
No Is this a PforR with an IPF component? [ ] Yes [X] No	Mozambique	Program-for-Results Financing

[ ] Situations of Urgent Need or Assistance/or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	
12-20-2017	12-31-2022	
Bank/IFC Collaboration	**Joint Level**	
No		

Program Development Objective(s)

The Program Development Objective (PDO) is to improve the utilization and quality of reproductive, maternal, child, and adolescent health and nutrition services, particularly in underserved areas.

Organizations

Borrower:	The Republic of Mozambique
Implementing Agency:	Ministry of Health (MISAU)

PROGRAM FINANCING DATA (IN USD MILLION)

[X] Counterpart Funding	[ ] IBRD	[ ] IDA Credit [ ] Crisis Response Window [ ] Regional Projects Window	[X] IDA Grant [ ] Crisis Response Window [ ] Regional Projects Window	[X] Trust Funds	[ ] Parallel Financing

Government program Cost:	Total Program Cost:	Total Financing:	Financing Gap:
963.00	1142	1142	0.00
		Of Which Bank Financing (IBRD/IDA):	
		80.00	

Financing (in USD Million)

Financing Source	Amount
Borrower	963.00
PROSAUDE (Health Common Fund)	16.00
International Development Association (IDA) Grant	80.00
Global Financing Facility (GFF)	25.00
Embassy of the Kingdom of the Netherlands	35.50
United States Agency for International Development (USAID)	22.50
Total	**1142.00**

Expected Disbursements (in USD Million)

Fiscal Year	2018	2019	2020	2021	2022
Annual	26.2	20.0	15.5	15.0	3.3
Cumulative	26.2	46.2	61.7	76.7	80.0

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition and Population Global Practice

Contributing Practice Areas

Governance Global Practice

Climate Change and Disaster Screening

Private Capital Mobilized

Gender Tag

Does the program plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF **YES**

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment **YES**

c. Include Indicators in results framework to monitor outcomes from actions identified in (b) **YES**

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Substantial
8. Stakeholders	Substantial
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the program depart from the CPF in content or in other significant respects?

[ ] Yes [X] No

Does the program require any waivers of Bank policies?

[ ] Yes [X] No

Have these been approved by Bank management?

[ ] Yes [ ] No

Is approval for any policy waiver sought from the Board?

[ ] Yes [X] No

Legal Covenants

(i) The Recipient shall maintain a program management unit within Directorate of Planning and Cooperation (DPC) to provide administrative and logistical support to the Program. The Recipient shall appoint not later than ninety (90) days after the Effective Date, and thereafter maintain, at all times during the implementation of the Program, the following specialists to strengthen the management capacity of the program management unit: (i) a Program manager, (ii) a senior procurement specialist, (iii) a financial management specialist, (iv) two (2) procurement assistants; (v two (2) financial management assistants, and (vi) an administrative assistant ***(Schedule 2, Section I.C (b)).***

(ii) The Recipient shall prepare, in form and substance satisfactory to the Association no later than three (3) months after the Effective Date, an operations manual ***(Schedule 2, Section I.D***).

Conditions

(i) The Additional Condition of Effectiveness consists of the following, namely the GFF Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness have been fulfilled ***(Section 5.01).***

(ii) No withdrawal shall be made: (a) for purposes of Section 2.03 of the General Conditions, for DLRs achieved prior to the Signature Date; and (b) for any DLR, until and unless the Recipient has furnished evidence satisfactory to the Association that said DLR has been achieved and verified, all in accordance with the Verification Protocol **(*Schedule 2, Section IV.B.1).***

TEAM

Bank Staff

Name	Role	Specialization	Unit
Humberto Albino Cossa	Team Leader(ADM Responsible)	Senior Health Specialist	GHN01
Furqan Ahmad Saleem	Team Leader	Lead Public Sector Specialist	GGO18
Amos Martinho Malate	Procurement Specialist(ADM Responsible)	Procurement Specialist	GGO07
Elvis Teodoro Bernado Langa	Team Member	Senior Operations Officer	AFCS2
Carolyn J. Shelton	Team Member	Senior Operations Officer	GHN04
Courtney Price Ivins	Team Member	Consultant	GHN01
Miguel Angel San Joaquin Polo	Team Member	Senior Health Economist	GHNGF
Angela Lopes Delfino	Counsel	Senior Counsel	LEGAM
Mirja Channa Sjoblom	Team Member	Senior Economist	GHNGF
Shomikho Raha	Team Member	Senior Public Sector Specialist	GGO13
Dionísio Nombora	Team Member	Public Sector Specialist	GG013
Paulo Jorge Temba Sithoe	Safeguards Specialist	Environmental Specialist	GEN01
Maria da Cunha	Safeguards Specialist	Senior Social Development Specialist	GSU07
Eden Dava	Team Member	Social Development Specialist	GEN01
Alfredo Zunguze	Team Member	Environmental Specialist	GEN01
Salma Chande	Team Member	Program Assistant	AFCS2
Ziauddin Hyder	Team Member	Senior Nutrition Specialist	GHN01
Brendan Michael Hayes	Team Member	Health Specialist	GHNGF
Jose Janeiro	Finance Officer	Senior Finance Officer	WFALA
Sally Torbert	Team Member	Consultant	GGO13
Sandra Martins	Team Member	Africa Early Years Fellow	GED07
Julie Ruel Bergeron	Team Member	Nutrition Specialist	GHNGF

MOZAMBIQUE
PRIMARY HEALTH CARE STRENGTHENING PROGRAM
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I. Sectoral Context

A. Country and Sector Context

1. **Mozambique has achieved significant improvements in both economic and social indicators since the end of the civil war in 1992, but challenges remain.** From 1993 to 2013, under-five mortality more than halved, and the maternal mortality ratio (MMR) declined by nearly a third. With economic recovery, from 2002-2014, Gross Domestic Product (GDP) growth averaged 7 percent and the nation enjoyed macroeconomic stability. Nonetheless, this growth was not paralleled by expected poverty reduction, especially in rural areas and low-income urban areas. In 2016, Mozambique still ranked 181st out of 188 countries in the Human Development Index. Average life expectancy at birth is just 55 years, and the adult literacy rate is 59 percent (2015).

2. **Prevailing fiscal pressures in Mozambique are likely to continue in the short to medium term, putting advancements in social indicators at risk.** In 2016, low global commodity prices, climate related events (droughts and floods), and the revelation of previously undisclosed debts caused significant deterioration of the country's economy. GDP growth is expected to decrease to an estimated 3.4 percent in 2017. Looking four to five years ahead, planned investments in natural resource extraction are expected to yield increased public revenues. However, these capital-intensive megaprojects could further accentuate Mozambique's pattern of non-inclusive growth. Rapid population growth (2.5 percent) is higher than most countries in the region, straining already weak public service delivery systems. This context reinforces limitations to human capital formation, exacerbated by gender and other socio-economic inequalities.

3. **Over the past two decades, Mozambique has achieved mixed progress in improving health outcomes and expenditure efficiency.** Advancements have resulted in improvements in access to health facilities and community-based interventions, as well as increased demand for care, and improvements in other health determinants. However, results have been uneven, particularly for those in rural areas and the poorest quintiles, and for women and children. This intersection of gender and poverty further reinforces health system inequalities. Sixty-two percent of deaths in 2015 were associated with communicable, maternal, neo-natal and nutritional diseases.[1] Related health outcome indicators that compare poorly in the region and show minimal signs of improvement include: the percentage of women whose needs for modern contraceptives are met; neo-natal death rates; the percentage of births with skilled attendants; and stunting prevalence. Malaria still contributes to 35 percent of child mortality, and lack of access to clean water and sanitation is widespread. Mozambique's level of per capita health expenditure also lags behind sub-regional and regional averages. Country comparisons in the Health Public Expenditure Review (HPER 2015) highlight that Mozambique could achieve more with its current spending. In the context of fiscal pressures, increasing efficiency and protecting pro-poor spending for human development are critical.

[1] Thirty-one percent were associated with non-communicable diseases and seven percent with injuries.

4. **Targeted interventions to accelerate the demographic transition, together with investments in early childhood development, can bring significant returns for Mozambique.** Estimates show that a reduction of one child in Mozambique's fertility rate (5.3 in 2016) by 2050 can lead to a 31 percent increase in real GDP per capita and a 3.3 percentage point decrease in poverty headcount rates.[2] In addition to increasing dependency ratios, the country's high fertility rate is associated with poor pregnancy outcomes. High and increasing rates of adolescent fertility are correlated with increased risk of maternal death and other lasting complications such as fistulae. High levels of stunting have 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 remains at one of the highest levels in the world, and is the ninth highest in Africa. Stunting's costs include poorer education outcomes, lower productivity and incomes, and higher health care expenses. This context has oriented the Government's strategic emphasis on improving primary health care, with a strong focus on Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N) services.

5. **Quality of and demand for care remain a challenge at the primary level.** A recent assessment of the performance of the primary health care (PHC) system in Mozambique,[3] indicated that despite recent improvements in health outcomes, the country is not yet on track to reach the health Sustainable Development Goals. Provider competencies are weak, and adherence to clinical guidelines is low. High levels of dropout for child immunization (e.g. DPT3) show little continuity in care delivery over time. Demand for care is negatively affected by both low perceptions of quality and difficulties in access. 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.

6. **Critical health systems improvements are required to improve primary care and health outcomes.** 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). This is exacerbated by inadequate provider capacities, low motivation/effort/accountability for results,[4] and a top-heavy workforce composition inefficiently skewed towards more administrative (non-medical) staff. Only a dismal 34 percent of facilities meet basic infrastructure requirements, and only 43 percent have priority drugs in stock and not expired.[5] While hospitals perform better than health centers overall, about 40 percent of maternal deaths occur in district hospitals, pointing to the critical need to strengthen the first line of referral for core emergency

[2] Gragnolati and Cossa, 2016
[3] The assessment was conducted by the Primary Health Care Performance Initiative (PHCPI), a partnership between the World Bank Group, the World Health Organization and Bill and Melinda Gates. Main findings of the assessment in Mozambique are presented in Annex 4.
[4] In a 2015 study, only 58.3 percent of health care providers correctly diagnosed five selected tracer cases; 37.4 percent adhered to clinical guidelines; and 29.9 percent followed the protocol for management of maternal and neonatal complications (Service Delivery Indicators – SDI 2015)
[5] SDI 2015

obstetric and newborn services. Addressing cumbersome budget systems, and inequitable, inefficient distribution of resources (overburdening and under-resourcing lower tier facilities) can also improve the value-for-money of financing to the sector.

7. **In addition to strengthening effectiveness and alignment of external funding, it is imperative to mobilize internal resources to sustainably finance the health sector.** Mozambique's per capita health expenditure is low compared to the regional average (US$79 per capita in 2015, as compared to the Sub-Saharan African average of US$200, and the Southern African Development Community average of US$428). As recently as 2013, external sources financed 71 percent of total health spending, much of which was channeled outside the national planning, budget, and treasury single account (TSA) systems to disease-specific programs (mainly for HIV/AIDS). In 2003, the Ministry of Health (MISAU) and Health Partners (HPs) established the common fund, PROSAUDE, taking a Sector Wide Approach (SWAp). Notwithstanding its gains for enabling more flexible responses to arising needs and recurrent costs, challenges with fiduciary oversight, and with linking spending to results, pushed many HPs away from PROSAUDE towards parallel financing, particularly after Mozambique's debt crisis in 2016/17. Starting in 2014, the proportion of external financing for health began to decrease, compensated by increasing internal resources. 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 (UHC) in the longer term, this will require strategies such as increasing allocation of general revenue sources, earmarked taxes, equitably applied user fees, etc.

8. **The Government's five-year Investment Case (the 'program') for enhanced delivery of RMNCAH-N services aims to address these challenges by channeling financing to high impact investments**. While focusing on RMNCAH-N, the Investment Case[6] (IC) defines priorities for strengthening the National Health Service (NHS). The IC focuses on coverage, quality, and access to essential primary health care services (delivered through APEs/mobile teams, health centers, and first line referral hospitals), as well as systems strengthening interventions such as improving data collection and monitoring through Civil Registration and Vital Statistics (CRVS).[7] The IC also promotes increases in the volume, efficiency, and equity of domestic and external health financing. It addresses demand-side constraints as well as gender norms (e.g. family practices, cultural norms, and related inequalities) through a multi-sectoral approach, emphasizing community-based engagement and interventions.

[6] The Investment Case was initiated in 2016 with the aim of prioritizing the national health strategic plan, when Mozambique began to benefit from the Global Financing Facility for every woman and every child.

[7] As a complement to the IC, the Government, with support from various development partners, has also led the development of a health financing strategy that focuses in detail on how to improve the health financing system with the intention to increase the volume and efficiency of health financing.

B. Relationship to the Country Partnership Framework (CPF) and Rationale for Use of Instrument

9. **The proposed operation to support the implementation of the Government's IC is aligned with the World Bank's Country Partnership Framework (CPF) for Mozambique for FY17-21**, specifically, the CPF's objective 5 for "Improving Health Service Delivery," within Pillar 2 of "Investing in Human Capital". The CPF highlights the critical need to focus on early childhood development, accelerate the demographic transition, and mainstream governance to improve service delivery. As reflected in the CPF, the Bank has a well-recognized value-added in supporting the strengthening of health systems, including through broad international experience in health financing and a robust Health, Nutrition, and Population (HNP) portfolio in Mozambique. Opportunities for reforms and results are augmented by both the context of tight fiscal pressures, and the resources available through the Global Financing Facility (GFF), a multi-stakeholder partnership housed at the World Bank supporting country-led efforts to improve RMNCAH-N through smart, scaled and sustainable financing. This partnership has also strengthened the World Bank's accumulated knowledge and experience in advancing the early years agenda.

10. **The Program-for-Results (PforR) is the most suitable World Bank instrument to advance key systems reforms and build institutional capacity.** The proposed PforR draws from recent experience with results-based financing in Mozambique. In particular, the ongoing Public Financial Management for Results Program (P124615) has effectively contributed to strengthening the medicines supply chain. Its design includes components of central coaching and provincial change management facilitation, capacity development (including on results-based financing), and the introduction of subnational performance-based allocation schemes for medicines warehouses. Additionally, the proposed Primary Health Care Strengthening Program will draw from 14 years of implementation experience through the ongoing Education Sector Support Fund, known as FASE, through which the World Bank has channeled financing through disbursement-linked indicators (DLIs), while providing fiduciary oversight and coordination support for a wide range of other partners.

11. **Building on these experiences, the observed advantages of the PforR instrument include**: (i) support for building accountability chains at all levels to develop both provider capacities and executive results management; (ii) flexibility of DLIs to advance reforms at different levels of the causal chain (from policy, to procedures and implementation); (iii) capacity of DLIs to promote equity and performance through budget planning and execution, including through performance-based institutional incentives; (iv) DLIs' promotion of a focus shift from rule to results-based management, stimulating 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 (PFM) systems); and (v) the establishment of a co-financing platform for multiple partners that creates clearer linkages between financing and results, which can help improve spending efficiency to achieve health outcomes as well as to restore HP's confidence and financing to the sector. As opposed to Investment Project Financing,

the PforR also enables the use of country systems (e.g. for financial management and procurement), which include relatively robust regulations, but require critical reinforcement to enhance systematic application.

II. PROGRAM DESCRIPTION

C. Government program

12. **The IC's costed implementation strategy (2017 to 2022) provides a robust guiding framework and prioritizes high-impact interventions.** The IC was developed through an inclusive process led by the Government that included consultations with historically under-served groups like adolescent girls. This process determined key priorities of the Government's Health Sector Strategic Plan (PESS) (2014-2019), which orients all interventions in the sector, and is guided by the Government's Five-Year Program (PQG) and Poverty Reduction Plan. The IC acknowledges that improving RMNCAH-N will require catalytic changes and reforms in both the organization and operation of the NHS to advance the UHC agenda, and in the financing and coordination mechanisms between MISAU and its partners.

13. **To operationalize this approach, the IC seeks to: (i) define priorities to optimize allocation of additional resources to achieve better RMNCAH-N results; and (ii) contribute to strengthening resource management capabilities and the provision of quality care by the NHS**. Drawing from a robust evidence base, the IC identifies bottlenecks hampering progress in RMNCAH-N in terms of both health systems and supply and demand for services, and proposes actions to

Box 1: Addressing Key Bottlenecks in Mozambique's Primary Health Care System

The IC provides a comprehensive and technically sound roadmap to improve RMNCAH-N by identifying the most critical health system bottlenecks and proposing evidence-based interventions to overcome them. The Program will support these interventions, including:

***Service availability and readiness*:** IC interventions will improve the availability of emergency obstetric and neonatal care, essential RMNCAH-N medicines/supplies, and facility access to water and electricity. The IC also orients multi-sectoral engagement for Sexual and Reproductive Health (SRH) services, in particular, through secondary schools to reach adolescents.

***Health Human Resources (HRH)*:** IC interventions will help retain and increase the number of health professionals at the primary level to overcome critical shortages (e.g. through leave management, career progression, and learning, especially for remote postings). Through a country-wide platform for community-based service delivery, there is a national plan to train and assign APEs to provide RMNCAH-N services.

***Quality of care*:** There will be systematic efforts to monitor and improve quality of care at different levels. Service Delivery Indicators (SDIs) will be collected to gauge national progress. Quality of care will be assessed at health centers and district hospitals using a balanced scorecard (BSC) to hold facilities accountable for results, incentivized through performance-based payments. Community consultations will be part of the BSC in health centers to better understand and respond to users' perspectives and concerns.

Health financing and PFM: Actions will protect and increase the currently low share of health in domestic spending. To address inequitable resource allocation, the government will increase health funding for lagging and under-resourced districts. A series of reforms will strengthen fiduciary oversight and fiscal decentralization to facilitate service delivery.

Information for decision-making and accountability: The IC will improve birth and death data in the health information system (DHIS2-SISMA) and strengthen the interface with CRVS, critical to generate routine data for decision making and to guarantee rights.

Change Management Support for the above will include a robust capacity development program for frontline workers and managers, with quality TA and coaches to support incremental changes.

overcome these bottlenecks. Implementation of the IC will require engaging a broad range of stakeholders (e.g. the Ministries of Economy and Finance, Education, and Justice, local government bodies, other health and statistics units of Government, civil society organizations, and the private sector). The IC also categorized Mozambique's 142 districts across 11 provinces according to: (i) needs (including scarcity of resources, and low coverage of services); and (ii) potential for results (including population and existing capacity to produce services). Accordingly, the IC identifies 42 lagging districts in 10 provinces (with 2,642,759 people, approximately 10 percent of the population), characterized by lower population density, fewer resources, and lower production of services. An initial costing of the IC has been completed, and further support will be provided to enhance its details and align it with current Government budget processes.

14. **On the demand side,** the IC highlights issues concerning family practices and cultural norms that reinforce gender inequality and require a multi-sectoral approach, identifying diverse channels to promote behavioral change communication among target groups over the medium to long term. This includes, for example, targeting factors that contribute to critical delays in women seeking and accessing maternal care, behaviors and inequalities that result in high and increasing fertility rates and early pregnancy among girls aged 15-19 (up to 65% in some provinces), and limitations in access to knowledge on adequate feeding practices and preventive care. To tackle these factors, the IC prioritizes community-based interventions to address both practical needs and strategic interests of vulnerable groups, considering inequalities of gender, geography, education, income, and other vectors. APEs are also key to increase the demand for services by making them more accessible.

15. **On the supply side,** for sparsely populated districts, the IC prioritizes greater emphasis on APEs and mobile teams to deliver population-based services (e.g. nutrition, family planning, and management of common illnesses) closer to families and individuals, with an emphasis on reaching adolescents, young girls, pregnant women, mothers and their children. For more densely populated districts, the IC prioritizes increasing readiness and effectiveness of care providers, particularly at Type I health centers[8] and district hospitals. This will require improving the training and deployment of balanced teams at district and facility levels, and investing in diagnostic support services (maternal and child health nurses, surgical capacities, neonatal specialists, laboratories, blood banks, etc.), as well as more effective human resource management. In addition, greater investments in infrastructure will be required, especially in underserved areas (i.e. facility rehabilitation, water, energy, and means of transportation and communication) as a remedy for historic under-investment. Investments in CRVS to strengthen and improve the coverage and capturing of vital event registration in both the national health information system (Demographic Health Information System- *Sistema de Informação de Saúde*

[8] Primary care health facilities are classified by size/complexity and location. In rural areas, these include (in ascending order), Type I and II health centers, followed by first line referral district/rural hospitals. In urban areas, these include Type A, B, and C health centers, followed by first line referral general hospitals. More complex tertiary services are offered at provincial and central hospitals.

para Monitoria e Avaliação - DHIS2-SISMA) and CRVS databases will also be critical to improve health systems responses.

D. PforR Program Scope

16. **The Primary Health Care Strengthening Program-for-Results (the 'Program') will only finance the portion of the IC implemented through the sector's annual Economic and Social Plan (PES).** The PES is the planning and budgeting instrument of the Government of Mozambique coordinated by the Ministry of Economy and Finance (MEF) and approved by the Parliament. It provides the political and legal authority to all public sector entities to carry out activities and spend public funds in the pursuit of defined objectives. The PES determines the levels of investment and recurrent spending by different levels of Government (District, Province and central level) and by sector. Any activity or expenditure in the health sector must be included in the PES and budget to be considered eligible for funding by the State Budget (*Orçamento do Estado,* OE).

17. **The IC comprises two parts**: (i) activities that are in the PES– which includes on-budget and on-treasury single account (TSA) health expenditures financed by government-own revenues, and external funds such as PROSAUDE; and (ii) vertical financing by HPs. The vast majority of vertical financing is channeled outside of the TSA (i.e. its execution is not managed or decided by the Government), and a large portion is also channeled off the Government's budget (i.e. not recorded in the Financial Management Information System, e-SISTAFE). By financing the expenditure program of the IC through the PES planning and budgeting process, Program funds may be applied for expenditures covering most of the sector's budget lines nationwide, except for select ineligible categories, namely: (a) non-performance based salary top-ups[9]; (b) large contracts that either exceed 25 percent of the total Program expenditure, or exceed the Operations Procurement Review Committee thresholds for Substantive fiduciary risk (whichever is lower); (c) expenditures on construction of new Level Three and Four health facilities and hospitals (as described in Ministerial Diploma 127/2002, of July 31), or health centers that would be classified as category A or category A+ under Decree 54/2015, of December 31.[10] Continued technical assistance (TA) will support greater alignment of the IC with Government budget categories to facilitate planning and monitoring of expenditures, and to induce progressive budgetary shifts towards IC priorities through engagement of budget-holders at various levels.

18. **Specific activities to be carried out under the Program will focus on three thematic areas of the IC: (i) *enhancing coverage, access, and quality of primary health care services***, including high-impact supply and demand-side interventions, with a focus on underserved areas; **(ii) *strengthening the health system*** for improved stewardship, financial sustainability, expenditure efficiency and equity, and gender responsiveness of service delivery, together with improved

[9] This does not include mobility benefits that are built into salary payments for personnel in hardship districts.
[10] A screening tool to assess land acquisition will be set out in the Program Operations Manual (POM) to enable this determination.

CRVS systems; and **(iii)** ***enabling MISAU to effectively manage the implementation of the IC***, through TA, capacity development, monitoring and evaluation (M&E), and HP coordination activities. The Program will specifically support improvements in RMNCAH-N outcomes, in addition to systemic improvements to equitable distribution of health resources and accountability to results at all levels (including wider, more coordinated mobilization of APEs, and improved M&E capacity through CRVS).

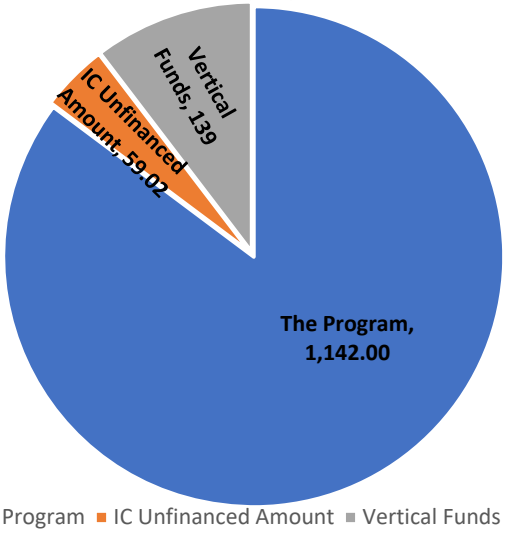
Table 1: Program Expenditures and Financing (US$ Millions)[11]

Program Components/Annual Expenditures	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
Enhancing coverage, access, and quality of primary health care services	179.0	177.1	177.0	177.0	173.0	883.0
Strengthening the health system	47.0	45.0	44.0	44.0	40.0	219.9
Enabling MISAU to effectively manage the implementation of the IC	7.4	7.6	8.2	8.7	7.0	39.1
Total Costs	**233.4**	**229.7**	**229.2**	**229.7**	**220.0**	**1,142.0**
Government	186.0	187.0	192.0	196.0	202.0	963.0
IDA/GFF	32.2	25	21.5	20	6.3	105.0
Multi-Donor Trust Fund (Netherlands)	7.2	7.2	7.7	6.7	6.7	35.5
PROSAUDE	5.5	5.5	3	2	0	16.0
Single-Donor Trust Fund (USAID)	2.5	5	5	5	5	22.5
Total Available Funding	**233.4**	**229.7**	**229.2**	**229.7**	**220.0**	**1,142.0**

[11] Government and PROSAUDE commitments are indicative estimates based on the resource mapping of IC and the medium-term expenditure framework. While PROSAUDE funds are channeled through a different sub-account of the treasury, they are represented here as part of the program to which the PforR is contributing.

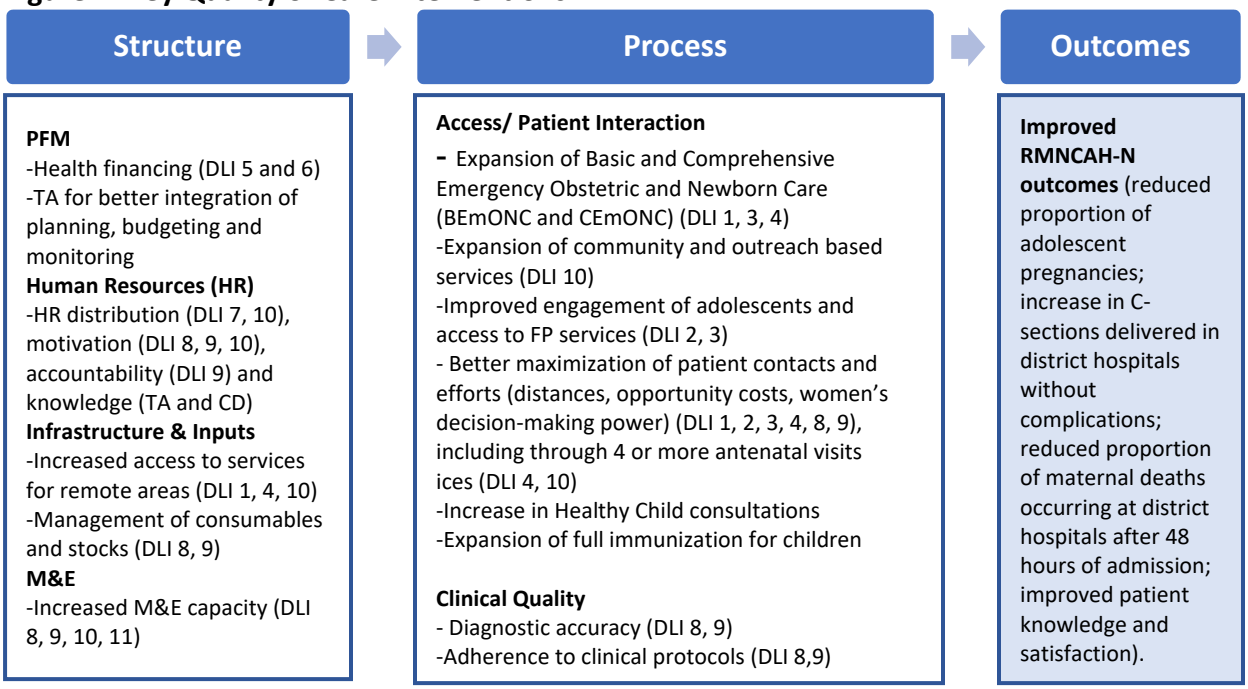
19. **Total cost of the Program is estimated at US$1,142.0 million.** Of this, GFF/IDA will contribute US$105 million and US$1,037.0 million will come from Government and other development partners, including those in PROSAUDE, as shown in Table 1. Figure 1 depicts financing for the IC from two channels: (i) vertical funds (channeled outside the TSA, and largely not accounted for in e-SISTAFE); and (ii) financing implemented through the PES (the 'Program' to which this operation will contribute). The Program can be co-financed by the Government, IDA/GFF, Multi- and Single-Donor Trust Funds, PROSAUDE, and other partners contributing using mechanisms that are implemented through the PES. The cost amounts represent the best estimate derived from the costing of the IC and its resource mapping carried out in 2016. The existing unfinanced amount is in respect to the 'program' (the IC as a whole). As more funding becomes available, the gap will be narrowed through expansion of geographical scope and the addition of other priority interventions, especially those related with health systems and vital statistics.

Figure 1. The Investment Case 2018-2022 (the 'program')



20. **In its interventions to improve quality, the Program will target empirically measurable dimensions in the structure and process of health care delivery.** Several surveys have identified problems in the technical quality of health services, as well as limitations in communications with users (MISAU, 2012, MISAU-MCHIP, 2013, World Bank, 2013), contributing to suboptimal RMNCAH-N services. These quality challenges, from both clinical and user perspectives, reinforce impediments in service regularity and timeliness of responses to obstetric and newborn complications and emergencies. While considering broader quality frameworks, such as the Primary Health Care Performance Initiative (PHCPI) which provides a comprehensive mapping of quality aspects in service delivery (see Annex 5), the Program will focus on key empirically monitorable dimensions of quality of care that link structure and process with outcomes (Donabedian, 1980, 1986, 1988), as highlighted in Figure 2. These include overlapping interventions which focus on improving access and coverage.

Figure 2. Key Quality of Care Interventions



21. **The Program will include robust elements of TA, capacity development, coordination, and monitoring to support enhanced service delivery.** The implementation approach will seek to strengthen alignment of tracking and monitoring instruments, as well as institutional collaboration to address multi-sectoral challenges, and improve coordination with vertical programs. As highlighted in the IC, achievement of results will also require the alignment of incentives and capacities at central, provincial, district, and facility levels (including the design of institutional performance-based allocations), and improved integration of community-based outreach and expanded population and facility-based service delivery modalities. Strong Government commitment and TA will also be required to strengthen PFM capacities. In particular, this includes capacities to better align annual, bottom-up planning and budgeting with the investment case, to strengthen fiduciary controls and timely funds flow to decentralized budget units (provinces, districts, and heatlh facilities). More robust PFM capacity also requires enabling more timely, granular expenditure monitoring of progressive, prioritized shifts.

22. **These aspects will be supported through both recipient and World Bank-executed TA, and through coordination with other partner support.** To ensure an optimal alignment with the TA provided by PROSAUDE partners, the mapping of TA demanded by the government for the IC will be discussed within an inclusive dialogue framework. Such activities will build on the Bank's ongoing analytical portfolio, including work on hospital scorecards, social audits in health facilities, functional integration of APEs in the health system, human resource management, and improving the responsiveness of health service delivery to intersectional inequality. This includes analysis on gender dimensions of equality, equitable health resource allocation, user fees, and

other support to the Government's Health Financing Strategy. A Program Preparation Advance (PPA) of US$1.2 million has also been prepared to engage significant TA to ensure implementation preparedness when the Program becomes effective.[12]

23. **Gender will be a cross-cutting consideration of the Program, in terms of analysis, target groups, and specific interventions to address social norms and inequalities**. The IC provides an opportunity to align existing and planned government and HP interventions to improve gender equality. This will be guided by MISAU's new Strategy for the Inclusion of Gender in the Health Sector, and through collaboration with the Ministry of Gender, Children and Social Action (MGCSA), the Ministry of Education and Human Development (MINEDH), and HP's providing complementary support. The Program will also draw from prioritized interventions highlighted in the IC and in a complementary gender analysis to address the socioeconomic and gender inequalities. For example, addressing social determinants of maternal and child health (MCH) will be critical for reducing adolescent pregnancy and child marriage, promoting healthier practices for sexual and reproductive health and nutrition, and encouraging health service access and use. Results of these interventions will be captured in the Program results framework (Annex 1), and bolstered through sector partnerships with non-governmental organizations (NGOs) and community organizations, schools, and private health service providers, as well as local and opinion leaders.

E. The Role of Development Partners

24. **HPs, under the leadership of MISAU, have supported the preparation of a joint Disbursement Linked Indicators (DLIs) matrix to operationalize the IC.** HPs are committed to align their financing and support around IC priorities. The Program's DLI matrix provides a platform to support this alignment. Using existing coordination structures, task forces were established around key thematic areas, led by a government chair and an HP vice-chair to produce technical notes for each DLI. The detailed technical notes document 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. These notes are currently undergoing a broader consultative process including governmental and non-governmental stakeholders at different levels. This collaboration has helped ensure that the Program has buy-in from a broad coalition of stakeholders, reflects and reinforces IC priorities, harmonizes external financing, and reduces transactions costs of development assistance, thereby increasing aid effectiveness.

25. **In terms of funds flow, the World Bank and the GFF aimed to develop a mechanism through this Program to maximize the volume of resources aligned with the IC channeled through government systems.** Rounds of consultations were held with HP and government regarding funds flow. In a context where some partners, with large programs in the sector, were not prepared to join or restore commitments to PROSAUDE, the PforR provides an aligned

[12] Financing will be reduced by the amount of the PPA upon effectiveness of the operation.

alternative, establishing a new sub-account of the Treasury to enable HP co-financing of the IC through a: (i) Multi-Donor Trust Fund (MDTF) and/or (ii) Single-Donor Trust Fund (SDTF). These options will remain open to enable HPs to join at any point during the Program's lifespan. Fiduciary oversight of the Program will apply to the entire PES. To the extent that the Program contributes to increase fiduciary capacity and management for results, it can be merged with PROSAUDE in the future.

26. **Preliminary commitments have been made by HPs to cofinance the PforR.** This includes expressed commitment by the Embassy of the Kingdom of the Netherlands and the United States Agency for International Development (USAID) to channel funds through an MDTF and SDTF respectively. The Canadian Department of Foreign Affairs, Trade and Development (DFATD) has also expressed interest in co-financing the MDTF. Other partners have designed programs to provide parallel support to the IC, e.g. the UK Department for International Development (DFID) is now supporting the implementation of part of the IC through UN agencies (in addition to their contribution through the GFF global trust fund).[13]

27. **PHCPI and non-governmental organizations (NGOs) will also support IC implementation for improved quality and monitoring of services.** TA from PHCPI will support the updating of its systematic assessment of PHC performance every two years (see Annex 5), with results made publicly available. PHCPI's support will also be targeted to help MISAU strengthen pathways to improve PHC performance, including TA for the development of a balanced scorecard at facility level. Both national and international NGOs have also commited to taking active roles in implementing the IC, particularly in monitoring at local levels.

28. **The Program will continue to use existing dialogue and partner coordination structures throughout implementation.** The main dialogue structure will be based on the existing Health Compact[14], including all HP signatories, and applying its codes of conduct. This will include continuing to work with one focal partner as a key channel for harmonized communication, and participation in the existing working groups in the SWAp arrangement. Using these mechanisms, regular meetings will be held to track progress on results indicators and implementation of interventions of the Program and the broader IC. Going forward, these mechanisms will be critical to strengthen coordination and maximize synergies in support of the IC, especially with the

[13] DFID's investment will finance health worker training, mainly for maternal and child health nurses, which is a critical input to improve coverage and quality of RMNCAH-N services. DFID will also support the acquisition of equipment for health facilities and other commodities to improve health facilities' performance.

[14] The main objective of the Health Compact promoted under the International Health Partnership (IHP) sponsored by the UK government in several countries, was to establish rules and a code of conduct to further improve external aid. In Mozambique, in the context of a well-advanced Sector Wide approach, health partner signatories of the Compact agreed to abide to: (i) One Plan and one single country validation process; (ii) One single results framework and monitoring process; (iii) One Budget; (iv) Scaled Financing; and (v) One single fiduciary framework. The compact was signed on September 16, 2008 by most PROSAUDE partners, GAVi, and Global Fund. The World Bank also signed after making specific statements on certain clauses.

remaining partners' financing the sector through PROSAUDE[15] and vertically (outside of country systems). The main difference between the PROSAUDE common fund and the Primary Health Care Strengthening PforR is that PROSAUDE provides sector budget support to the entire PES, while the PforR will finance, *through DLIs*, the majority of the PES that is directed to implement the IC. The majority of PROSAUDE and PforR expenditure categories will be complementary, and fiduciary and dialogue mechanisms will be aligned. The Program will also work through the Health Partners' Group (HPG) to strengthen engagement with NGOs supporting IC implementation.

F. Program Development Objective(s) (PDO) and PDO Level Results Indicators

29. The Program Development Objective (PDO) is to improve the utilization and quality of reproductive, maternal, child and adolescent health and nutrition services, particularly in underserved areas.

The PDO level results indicators are as follows:

- Percentage of institutional deliveries in 42 lagging districts as defined in the IC
- Couple Years of Protection (CYPs)
- 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 (Cabo Delgado, Manica, Nampula, Niassa, Tete and Zambézia)
- Adherence to clinical diagnostic guidelines for five tracer conditions at health centers and district hospitals
- Adherence to clinical treatment guidelines for maternal and neonatal complications at health centers and district hospitals

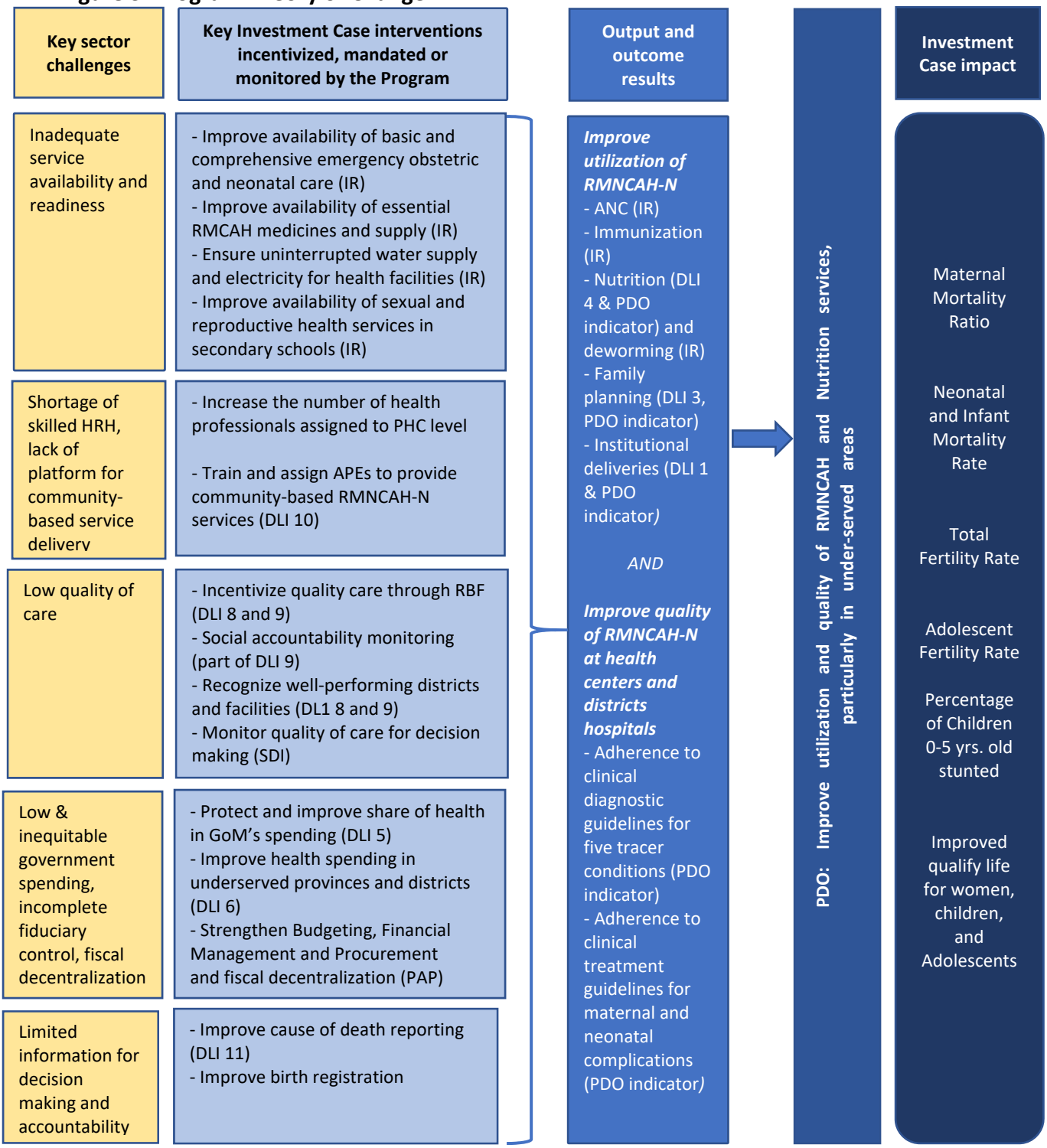
G. Disbursement Linked Indicators and Verification Protocols

30. **The proposed PforR operation will disburse based on achievement of pre-agreed targets for a set of 11 DLIs established jointly with MISAU and HPs** (see Table 2 below). The cross-cutting themes of the DLI design focus on underserved populations, institutional performance, and improving quality of services. Certain DLIs also prioritize select geographic areas according to outcome indicators and analyses done through the IC of underserved areas.[16] To ensure predictable financing for enhanced service delivery and essential TA/capacity development, many DLI disbursements will be scalable based on the extent of target achievement. The detailed DLI matrix is provided in Annex 2. Figure 3 illustrates how the Program's focus areas and financing will contribute to the broader theory of change of the Investment Case, advancing the achievement of its intended outcomes and impacts.

[15] The PROSAUDE common fund is used by several partners to provide general health sector support through Government systems. It is currently being used by the Governments of Switzerland, Ireland, Spain, Italy, and Flanders, as well as the UN Population Fund (UNFPA) and the UN Children's Fund (UNICEF). While the MDTF through which the PforR financing will be channeled entails a separate sub-account of the treasury and distinct arrangements (i.e. disbursement through DLIs and additional fiduciary requirements), both funds will be implemented through the PES providing support to the IC, and their dialogue structures will be aligned.

[16] Calculations of "classifications" were determined using a sum of ratios (in relation to the national average) of a series of indicators representing each weighted criteria).

Figure 3: Program Theory of Change



31. **The DLIs are structured through an appropriate mix of high level and intermediate results, balancing ambition and feasibility.** Based on the S.M.A.R.T. principle[17], select indicators draw from the IC's current five-year monitoring framework, as well as other Government targets (e.g. the health sector's Performance Evaluation Framework). The DLIs aim to address the bottlenecks along the results chain, including a reasonably even distribution of disbursements. An advance (not exceeding 25 percent of the total grant amount) will be recommended at the time of this operation's effectiveness to support activities required to achieve results. For some DLIs, higher weight is also given to process indicators to initiate results, with subsequent shifts in emphasis to output and outcome indicators.

32. **The pricing of the DLIs was based on the following principles**:

- ***Front-loading:*** DLIs have higher prices in the first half of the Program cycle (especially in Year 1 and Year 2) with the aim of jumpstarting the system and helping overcome inertia;
- ***Effort intensity***: DLIs which are deemed to be more difficult and require more effort to achieve have higher total allocations;
- **Scalable**: From Year 2 onward, DLIs are formulated as "scalable" whenever possible (rather than "all-or-nothing") to reward partial achievement proportionally;
- **Roll-over**: Wherever applicable, undisbursed amounts of financing for a DLI in a given year will be rolled-over for use in the next year (with a cap).

The distribution of financing across HPs for each DLI took into account various factors: (i) HP's interests in particular DLIs; (ii) available financing from each HP; and (iii) a reasonable disbursement schedule for each HP.

33. **Complementary supporting interventions will include: TA and capacity development, performance-based allocation schemes, communications interventions, coaching and facilitation, and support to reinforce M&E and verification protocols.** These needs are outlined in the technical notes for each DLI, and where relevant, will be included in the Program Operations Manual (POM). As highlighted in Annexes 2 and 3 below, M&E and verification protocols seek to reinforce routine data collection systems, while relying on independent verification agents (e.g. surveys by qualified third parties or the Government's supreme audit institution) as the basis for disbursement. Coordination structures will also seek to ensure supporting interventions financed by other HPs outside the Program, and complementary TA and analytical work, are harmonized in support of the IC.

[17] The SMART principle ensures that all indicators are Specific, Measurable, Attributable, Realistic, and Timebound.

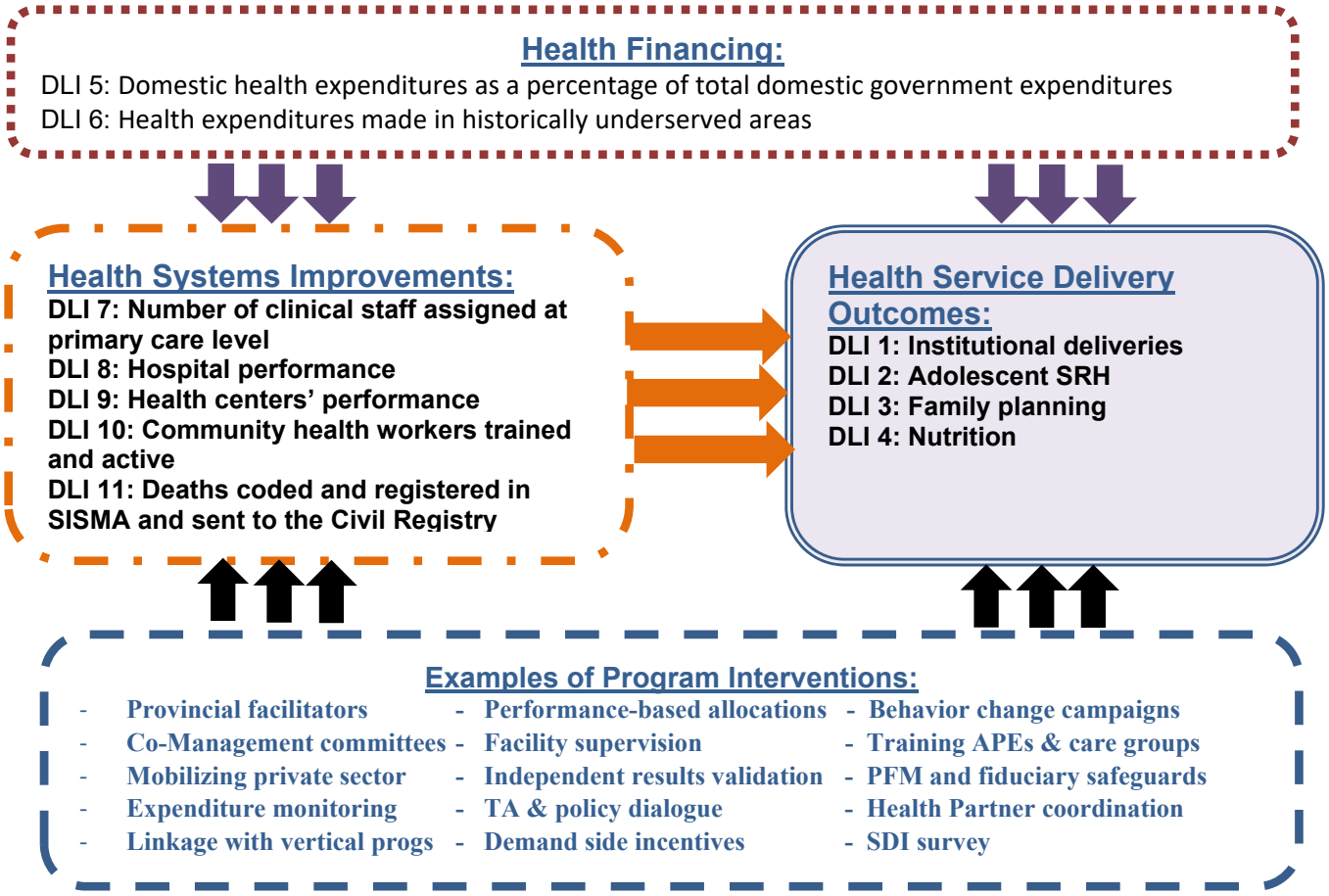
Table 2: Disbursement-Linked Indicators (DLIs)

DLI 1: Percentage of Institutional Deliveries in 42 priority districts as defined in the IC
DLI 2: Percentage of secondary schools offering sexual and reproductive health (SRH) services (information and contraceptive methods), based on visits by health professionals (at least monthly)[18]
DLI 3: Couple Years of Protection (CYPs) [19]
DLI 4: 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 (Cabo Delgado, Manica, Nampula, Niassa, Tete and Zambézia)
DLI 5: Domestic health expenditures as a percentage of total domestic government expenditures
DLI 6: Health expenditures made in historically underserved areas (3 provinces and 28 districts identified)[20]
DLI 7: Number of technical health personnel (*Regime Especial*) assigned to the primary health care network
DLI 8:[21] Percentage of district/rural hospitals that received performance-based allocations (PBA) in accordance with a minimum of two scorecard assessments in the previous fiscal year
DLI 9: Percentage of rural health centers in priority districts that received PBA in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year
DLI 10: Number of community health workers (APEs) that are trained and active
DLI 11: Percentage of deaths certified in health facilities with data on cause coded per the International Classification of Diseases version 10 (ICD 10), reported in the Health Information System for Monitoring and Evaluation (SISMA), and sent to the Civil Registry

[18] This is a multi-sectoral intervention together with the Ministry of Education and Human Development (MINEDH). Out-of-school adolescents will also be targeted through community health workers (DLI 10).
[19] Couple Years of Protection (CYP) is a core FP2020 indicator and was selected as a DLI for this program for the following reasons: 1) CYP presents a way to aggregate all family planning methods into a single output measure that can be tracked using the health management information system (DHIS2/SISMA); 2) CYP targets can be linked to forecasted coverage changes of various family planning methods and; 3) unlike modern contraceptive prevalence rate, CYPs can be measured without a survey methodology at every level within the health system.
[20] These 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.
[21] District and rural hospitals provide the first line of reference for the delivery of core emergency obstetric and neonatal services, particularly for rural and underserved populations, making them a key focus of systems strengthening for the IC. See Footnote 8 above.

Figure 4 presents a schematic view of how DLIs focusing on health financing, health systems improvement, and health service delivery outcomes fit within the Program's theory of change, supported by various Program interventions.

Figure 4: Conceptual Framework - Disbursement-Linked Indicators and Program Interventions



III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

34. **MISAU leads the implementation of the PES, the expenditure program of the sector encompassing all activities, including those that will be supported by the Program at different levels.** The Provincial Directorates of Health (DPS) are responsible for operationalizing the PES in each of Mozambique's 11 provinces. DPS are deconcentrated entities that report to the Provincial Governor with technical oversight and central guidance from MISAU. Under each DPS, the District Directorates for Health, Gender, Children and Social Action (SDSGCAS), accountable to District Administrators, are responsible for implementing PES activities in their respective territories. The SDSGCAS also manage health centers - type I and II (rural) and type A, B and C (urban) - and in some cases, district/rural hospitals and/or general hospitals. Sub-district administrative divisions include administrative posts and localities, respectively. Type II Health

Center Managers are accountable to the head of the Administrative Posts and Localities, and participate in the Administrative Posts' local advisory boards (*Conselho Consultivos do Posto Administrativo*).Type I and II health centers are the first point of entry of patients including mothers, pregnant women, children and most other users, particularly in rural areas, making them a central focus of the Program for expanding coverage. APEs provide a range of health promotion and prevention interventions at community and family levels and are attached to the nearest health center, from which they receive working kits with basic materials and medicines.

35. **At a central level, MISAU is also responsible for coordinating with other ministries in PES planning and execution, which must be strengthened through the IC.** The proposed Program will include activities striving for: (i) improved coordination with the MEF to advance the health financing and domestic resource mobilization (DRM) agendas; (ii) strengthened collaboration with the Ministry of Gender, Children and Social Action (MGCSA), the Ministry of Youth and Sports (MINJUD), and the Ministry of Education and Human Development (MINEDH) on activities to enhance access to information on nutrition and comprehensive sexuality education, and to empower women and adolescent girls to increase their service utilization and decision making power (e.g. through programs for youth and adolescent girls known in Portuguese as *Geração Biz* and *Rapariga Biz*); and (iii) partnership with the Ministries of Justice and the Interior on CRVS system strengthening.

36. **The Program will strengthen the Provincial Directorates of Health and SDSGCAS to improve their capacity to support the delivery of priority services.** This will be done through capacity development activities and coaching to management/administrative district and provincial level staff responsible for planning and budgeting, procurement, fiduciary oversight, monitoring and evaluation, and programmatic areas related to key indicators/results.

37. **At the central level, the Directorate of Planning and Cooperation (DPC) in MISAU will provide the overall coordination for the Program**. This includes ensuring that the key activities to meet the DLIs are incorporated in national, provincial, and district plans. The DPC also oversees the M&E of the PES, and will manage the process of measurement of the DLIs as outlined in the technical notes for each DLI. The National Directorate of Public Health (DNSP) will provide the key strategic and technical guidance to Program implementers, and will ensure implementation oversight at all levels. In addition, through the main health programs (malaria, reproductive health, nutrition, HIV and AIDS), the DNSP will ensure quality of frontline interventions and carry out operational research for learning and service delivery improvement. DNSP oversees and promotes the primary health care approach in the sector including advocacy and the promotion of health in other sectors. The National Directorate of Medical Services (DNAM) will be responsible for ensuring service delivery in health facilities, especially the district/rural and general hospitals targeted through the Program as first lines of reference for primary care users. DNAM will work to ensure optimal implementation of clinical protocols and defined standards of care and improve other key hospital functions such as financial and asset management, patient records, logistics, health care waste, etc. The Directorate of Human Resources (DRH) is responsible for human resource policies, training of health professionals, and overall management of personnel, including recruitment, retention, career progression and promotion.

Finally, the Directorate of Administration and Finance (DAF) will support budget execution, internal controls, logistics, and other financial management (FM) and fiduciary responsibilities, including at decentralized and facility levels, and the provision of follow-up on audit recommendations. Procurement is the responsibility of UGEA (MISAU's procurement unit), which reports to the Permanent Secretary. The Central Medicines Warehouse (CMAM), responsible for the supply and distribution of medicines and medical supplies, also has a procurement unit.

38. **To address the limited institutional capacity and additional tasks required for successful Program implementation, technical support through coaches and facilitators will be made available to the key MISAU Directorates involved in implementing Program activities (as outlined in Figure 5).** At the central level, the coaches will work closely with health program managers and Heads of Departments to promote institutional collaboration, communication, and problem-solving, thereby improving overall management and leadership of implementation. Technical specialists in reproductive, maternal and adolescent health, health systems, health financing, public health, M&E, health information systems, planning and budgeting, and behavioral change communications will also be recruited. An environmental safeguards specialist will be engaged as required, in addition to a social development specialist to focus on gender and culturally appropriate outreach and service delivery, non-discrimination, and education for better social integration of patients with potentially stigmatizing conditions. These specialists will work with counterparts in each of the respective units at central level and will provide hands-on training to MISAU staff at central and provincial levels. The global PHCPI will also provide TA to strengthen the development and applications of primary care facility scorecards (DLIs 8 and 9). At the provincial level, it is anticipated that each DPS will have two facilitators. Facilitators will work closely with the Provincial Health Directors and Chief-Medical Officers, responsible for the implementation of health programs at the Provincial level. The facilitators will also develop capacity building activities and TA for SDSGCAS to improve district-level health program management. This proposed coaching model builds on the successful experience under the ongoing PFM for Results PforR. The PPA being provided to the Government will help lay the groundwork for these extensive coaching and TA component to increase implementation readiness at the time of effectiveness.

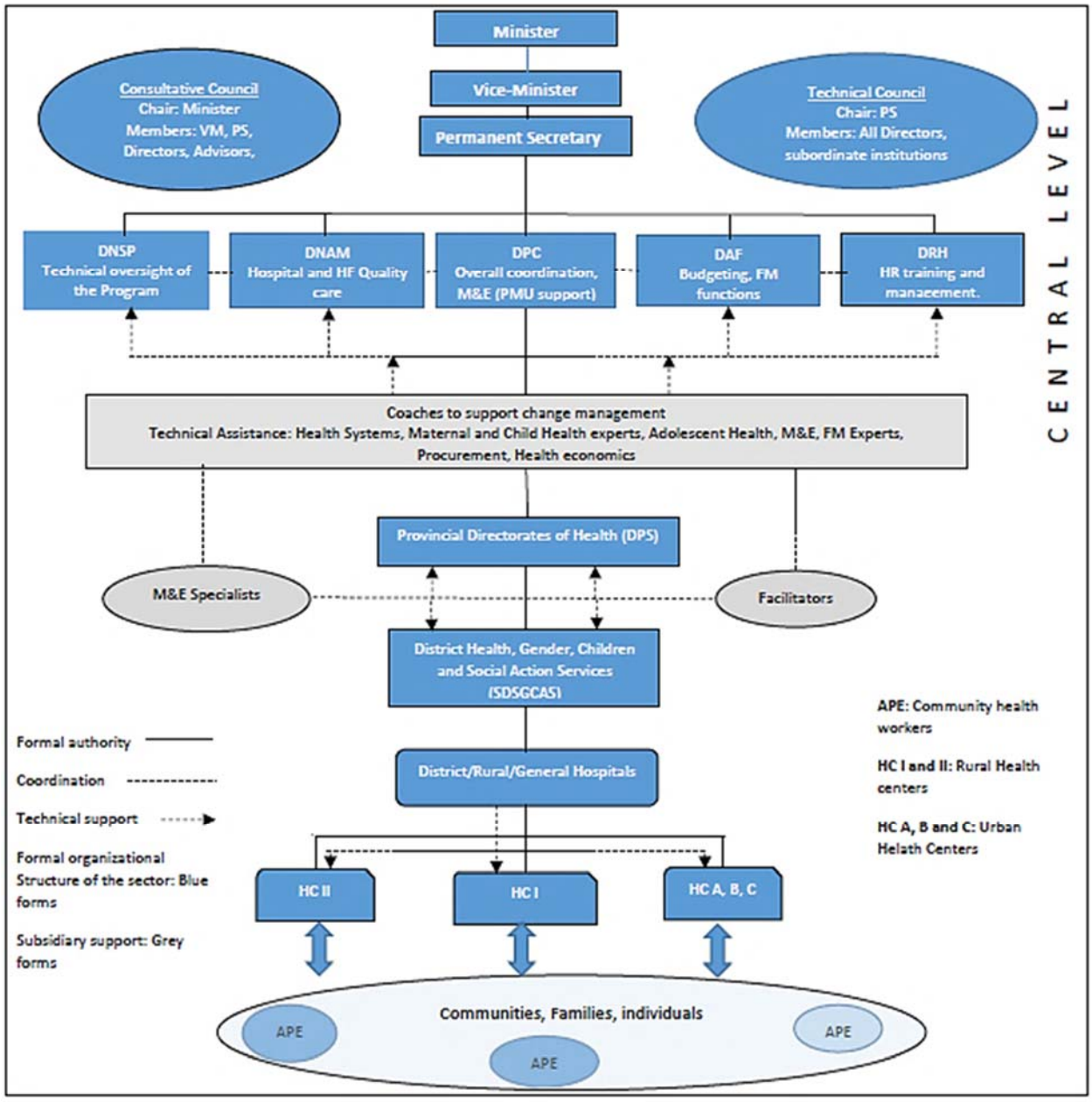
39. **A complementary World Bank-Executed Trust Fund (BETF)[22] will be an important and effective way of augmenting the results of the Program**. While implementation of most IC program activities will be executed by the Government, BETF activities will be an aid to accelerate the efforts of the Government in achieving the program objectives. The BETF will ensure the provision of timely and quality TA and advice as required and include the engagement of expertise to support the government in niche areas (such as gender strategy implementation, scorecards, social audits/community consultations, facilitating alignment of annual budgets with the IC, etc.) as well as several monitoring activities which require a higher level of independence and predictability (such as DLI validation, procurement audit, etc.). These and other complementary activities will rely on the Bank's comparative advantage to: (a) rapidly mobilize suitable international expertise; (b) facilitate knowledge exchanges and twinning between

[22] Amount to be determined.

Mozambican authorities and counterparts in other countries considered exemplary; and (c) foster dialogue and effective coordination among several country institutions for the implementation of health systems reforms and delivery of nutrition services, especially where collective action is needed to achieve key objectives. These features of BETF initiatives will help overcome several reform challenges experienced in the past while building on the successful implementation of the BETF model in several other countries.

40. **An existing Program Management Unit (PMU) reporting to DPC will be reinforced to provide administrative and logistical support to the Program.** The PMU in DPC currently manages Bank-funded operations. This includes the ongoing Health Service Delivery Project (P099930), the Public Financial Management for Results Program (P124615) in the pharmaceuticals subsector, and the Regional Tuberculosis and Health Systems Strengthening Project. The existing PMU has been reinforced and expanded as part of Program Preparation, and this will continue during the first three months of effectiveness. Although the PMU has accumulated experience in managing Bank-funded operations in the health sector, its capacity to manage both the Regional TB Project and this Program is severely limited. The following specialists will be recruited to strengthen the management capacity of the PMU: (i) Program Manager; (ii) Senior Procurement Specialist; (iii) Financial Management (FM) Specialist; (iv) two Procurement Assistants; (v) two FM assistants; and (vi) Administrative Assistant. As described in the previous paragraph, the TA to strengthen institutional capacities at MISAU and decentralized levels will be embedded within the relevant directorates and administrative bodies, to contribute to sustainably strengthen country systems. The role of the PMU in DPC will be limited to providing robust administrative, logistical, and operational support to central level Directorates and the team of coaches and facilitators throughout implementation. In addition, the PMU will ensure that the fiduciary requirements of the Program are complied with by all implementing agencies.

Figure 5. Implementation Arrangements



41. **A Program Operational Manual (POM) will be developed to help guide implementation.** The POM will include the technical notes for each DLI, verification protocols, and details pertaining to overall M&E, reporting, and disbursement procedures, implementation arrangements (including the role of coaches, facilitators, the PMU, local governments, and other actors), details on legal covenant compliance, environmental and social screening tools and compensation requirements for minor economic/livelihood impacts, etc. The POM will refer to national procurement and FM procedures, which will be applied by the Program.

B. Results Monitoring and Evaluation

42. **The overall Program Monitoring and Evaluation framework is aligned with the IC, from which indicators were selected as DLIs.** The PDO indicators for the Program are in line with the results framework of the IC and with the M&E frameworks of the PESS and the Government's Five-Year Program (PQG). Most PDO indicators and DLIs will be measured based on data from the routine health information system (SISMA), and from select surveys that will be carried out periodically. In addition, data from the Government's electronic FM information system (e-SISTAFE) will be used to monitor specific DLIs related to sector financing, allocations, and expenditures. Independent verification will be carried out by the Administrative Tribunal, the Health Inspector General (IGS), professional/academic organizations, and studies, depending on the nature of each DLI. Detailed descriptions of verification protocols are presented in the respective Technical Notes for each DLI. In addition, national surveys like the Mozambique Demographic and Health Survey will be conducted at regular intervals of 4-5 years, with the next expected to take place during 2018, when the implementation of the Program starts. At least one Service Delivery Indicator survey (SDI) through Bank-executed TA linked with the Program will provide additional confirmation on the progress of several Program indicators. A detailed Results Framework is presented in Annex 1.

C. Disbursement and Funds Flow Arrangements

43. **The Program will disburse funds based on achievement of DLIs on a proportionate basis.** The first disbursement will be an advance, which could be up to 25 percent of the total Program financing to provide sufficient resources during the first year of implementation. For each DLI, a yearly target is set against which an amount ('price') has been determined. This amount will be disbursed in proportion to the achievement of the annual target, with partial disbursements made available for select "scalable" DLIs. Full achievement of the first year's target will demonstrate a significant advancement against a DLI; hence the minimum threshold (engagement floor) for disbursement against that DLI. This should not affect the funding requirements of the Program given there is a 25 percent initial advance. In all other cases, disbursement may occur in accordance with the established formula as described in the technical notes anytime the target is achieved in full or partially. The DLI prices are designed to reflect strategic importance and difficulty of achievement of given targets, but they are not direct reflections or related costs or expenditures.

44. **Other HP funds will be channeled to finance parts of the Program**. PforR financing from IDA, the GFF Trust Fund, a Multi-Donor Trust Fund (MDTF), and a Single Donor Trust Fund will be channeled through a sub-account of the Treasury. Funding will be accessed the same way that state budget funding is accessed, but mechanisms will be put in place to ensure a more efficient, regular flow of funds to decentralized levels. The GFF Trust Fund amount (totalling US$25 million) includes lagged financing of US$10 million that will become available no later than June 30, 2020. The applicable grant agreement will be amended to increase the financing. The World Bank Board will be notified when the lagged GFF financing of US$10 million becomes available.

45. **MISAU will manage the budget appropriations from the Program's treasury sub-account.** The Program will disburse funds from IDA, the GFF, and other partners in the Multi-Donor Trust Fund (MDTF) to a USD segregated account to be opened within the Banco de Moçambique to receive funds. These funds will then be transferred into a sub-account of the Government's TSA, designated for this operation. Like the health sector component in the PFM for Results Program, the budget appropriations from the Program's treasury sub-account will be initiated by MISAU for approval by MEF via the government financial management information system (e-SISTAFE). The appropriations will be made as per resource requirements for several budget-holders at central, provincial, and district levels as determined by MISAU (DPC). Unspent appropriations will be available for carry-forward through budget re-inscription in the following fiscal year, especially those pertaining to funds distribution under DLI 6. Budget holders receiving funds allocation will utilize these in accordance with the government's own procurement and financial management procedures through e-SISTAFE.

D. Capacity Building

46. **Capacity building activities are foreseen under thematic area 3 of the Program - *Enabling MISAU to effectively manage the implementation of the IC*** (see Paragraph 17). It is anticipated that a significant number of training activities will be implemented during the life of the Program to increase availability of skilled resources for service delivery (MCH Nurses, surgical staff, etc.) and to improve management skills at district and provincial levels. In addition, the focus of some DLIs on health systems strengthening will further contribute to capacity development. In particular, there will need to be a focus on training health workers in adolescent responsive service delivery approaches and to ensure integration of issues like sexual and gender-based violence for clinical and non-clinical staff. The Program will also invest in coaches and facilitators whose key role is to strengthen planning and problem identification/solving, working closely with managers at central and provincial levels. As shown in the ongoing PFM for Results PforR, this approach has helped improve local management skills and change management practices.

IV. ASSESSMENT SUMMARY

A. Technical (including program economic evaluation)

Strategic Relevance and Technical Soundness

47. **The Investment Case provides a robust evidence base and operational framework to advance key Government Health Sector Plan (PESS) priorities for improving RMNCAH-N and strengthening health systems.** The IC was formulated as part of the Government's response to a proposal for inclusion in the GFF. The IC was produced through a consultative process led by MISAU, involving its National Directorates and Departments, other governmental entities (including MINEDH and the Ministry of Justice), civil society, the private sector, beneficiaries (such as adolescents), professional associations, and HPs. Based on extensive documentation and statistical data, the IC was informed by a prioritization process to enable feasible investments

and apply an integrated approach across different areas of RMNCAH-N. Within the framework of the PESS, the IC is also designed to increase the effectiveness of services provided by the national health system, strengthening its pillars and advancing the UHC agenda, while improving coordination mechanisms between MISAU and HPs. Complementing MISAU's Health Financing Strategy – currently under development – the IC will also support measures to increase sustainability and cost effectiveness of health spending, through the promotion of DRM reforms, private sector engagement, and TA to support all the above.

48. **Within the bounds of the IC, the Program focuses on key challenges at each level of the health system and aims to scale-up already tested interventions.** As shown in Figure 4 (in Section G), these include interventions to support improvements in both process, financing, and outcomes. Many of these interventions have been piloted and proven successful with a promise for a progressive scale-up. These include social audits/community consultations, and linkages between APEs and Care Groups for the extended outreach and distribution of nutrition and family planning commodities. Since these are proven interventions with a high-level of stakeholder ownership, the technical risk is considered low.

Program expenditure framework

49. **The estimated costing of the IC, developed with the National Directorates of Human Resources and Planning and Cooperation of MISAU, followed an incremental cost approach** (i.e. the increase over the current costs of the pool of resources spent on MCH programs). The costs are based on coverage targets set in the IC's Monitoring and Evaluation framework. The annual cost evolution took into account the gradual growth in the volume of activities and the time to prepare investments in fixed resources (e.g. training, infrastructure).

50. **The proposed operation will be implemented over five years** (see Table 1 in Section D above). MISAU will manage the new sub-account through which the funds will be channeled, to support IC implementation through the PES. All primary health care and health systems expenditures will be eligible for financing, with the exception of: (i) non-performance based salary top-ups; (ii) large contracts that either exceed 25 percent of the total Program expenditure, or exceed the Operations Procurement Review Committee thresholds for Substantive fiduciary risk (whichever is lower); (iii) expenditures on construction of new Level Three and Four health facilities and hospitals (as described in Ministerial Diploma 127/2002, of July 31), or health centers that would be classified as category A or category A+ under Decree 54/2015, of December 31. The Government also may not report as part of their contribution any expenditures that have been financed through World Bank Investment Project Financing or vertically by other health partners.

Program's results framework and M&E capacity

51. **Indicators in the DLI Matrix and Results Framework will pull largely from existing data sources (e.g. SISMA, e-SISTAFE), while some will rely on periodic surveys**. A process of broad consultations and quality assurance has been undertaken to assess existing M&E systems and

agree on appropriate arrangements/institutions for ensuring credible and timely data on program results including necessary gender and age disaggregation. DLI technical notes elaborate measures to verify the quality and integrity of data on which disbursements will be based, including through the engagement of independent validation agents. The operation will also support the required updating of the Service Delivery Indicators, as well as MISAU targets set in the IC for CRVS- improving vital event registration formats in health facilities to expedite their transfer to the civil registration network, and the quality of information they contain through the training of health professionals. The PHCPI framework can be used as a basis to support the definition of the balanced scorecard at facility level (see Annex 5 for full framework). Other key components of TA for M&E are highlighted in Section III. – Program Implementation.

Economic justification of the Program

52. **The Program has the potential to make large contributions to Mozambique's economic development by reducing maternal and child mortality, decreasing malnutrition, and kicking off the demographic transition, while promoting DRM reforms**. Program support will contribute to: (i) reduced rates of unmet needs for family planning; (ii) decreased maternal, newborn, and child deaths and related morbidity, as well as malnutrition; and (iii) strengthened capacities and systems to deliver services more efficiently. While it is challenging to establish causality between the benefits of the Program and economic development, in the long term, the Program will contribute to reduce extreme poverty through: (i) expected reductions in fertility rates and dependency ratios; and (ii) reductions in the costs of child and maternal morbidity and mortality. Mozambique lags behind regional peers in kicking off a demographic transition. A one child difference in Mozambique's fertility rates by 2050 can lead to a 31 percent increase in real GDP per capita and a two-percentage point decrease in poverty headcount rates. These gains are substantive and could be even more significant if the fertility reduction is accompanied by shifts in gender norms and corresponding improvements in education and employment opportunities.

53. **Mozambique pays a significant price for high malnutrition and maternal and child deaths and related morbidity.** For instance, estimates show that Mozambique loses US$116 million to vitamin and mineral deficiencies alone annually (World Bank, 2010). Estimates of expected productivity losses from child deaths using the cost-of-illness method show that the expected non-health GDP losses from under-five deaths in 2013 reached US$2.164 billion (Joses M. Kirigia et al., 2015), and losses from maternal deaths were in excess of US$50 million in 2010 (Joses Muthuri Kirigia et al., 2014). The non-health GDP losses from under-five deaths represents 16.5 percent of Mozambique's current GDP. The Program will reduce these costs. While it is difficult to quantify the benefit of the health system strengthening component of the Program, it is likely to be large given that it will improve the performance of the entire sector, which according to recent analysis (see e.g. PER 2015), could achieve better outcomes with the current level of health spending.

54. **The technical risk of PforR is rated as "Moderate" considering the aforementioned context.** The expectation is that the Government is likely to continue supporting the approved

plans, the Program design provides the institutional framework and incentives for continued focus and prioritization of primary health care, there is a strong technical consistency of the Program with the IC and Health Sector Strategic Plan (PESS), the design and disbursement conditions are controllable, and the Government has been closely supported by the Word Bank and HP.

B. Fiduciary

55. **A Fiduciary Systems Assessment (FSA), consistent with PforR financing policies and procedures, was carried out to evaluate related capacities of MISAU to provide reasonable assurance that the financing proceeds will be used for their intended purposes**, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. The FSA covers all FM, procurement, and fraud and corruption (F&C) aspects of the health sector PES (the sector's annual work plan), from the lowest point of spending, to provincial and central units. For FM, aspects assessed include planning, budgeting, accounting, internal controls, funds flow, financial reporting and auditing systems. For procurement, they include planning, bidding processes, contract awards, and contract management arrangements, with a focus on the procurement units of MISAU (UGEA) and the Central Medicines Warehouse (CMAM), as well as those of DPS and SDSGCAS.

56. **The Program's Financial Management and Procurement risk rating is Substantial**. The analysis took into consideration the recent Public Expenditure and Financial Accountability Assessment (PEFA 2015), evidence on the macroeconomic and political stability of the country, sector reports, the World Bank's knowledge of the sector and experience from World Bank-financed operations, and a review of the audit reports, including those of PROSAUDE. The assessment also builds on the lessons from the implementation of the ongoing Public Financial Management for Results PforR. Several FM risks were identified during the review, and these include but are not limited to: (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 include: (i) procurement delays due to coordination challenges; (ii) inadequate quality of technical inputs (terms of references, 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.

57. **The F&C risks identified are embedded as part of the broader fiduciary risks and mitigation measures.** The F&C assessment also involved a review of the complaint handling mechanisms in the sector and how they can be strengthened to be used in the PforR. The Government has committed to implementing the Program within the Bank's Anti-Corruption Guidelines, as is currently taking place under the ongoing PforR. The Bank's right to investigate will also apply.

58. **The Program Action Plan (Annex 4) summarized fiduciary risk mitigation measures required under the Program to address these shortcomings.** These include: (i) design and implementation of a medium-term (4 year) targeted capacity development and staffing plan for fiduciary staff at all levels (including for planning and budgeting, accounting and financial reporting, treasury management, internal controls/auditing, external auditing, and procurement); (ii) support to strengthen sector capacities, mechanisms, and resources required to improve funds flow to health facilities (including for performance-based allocations through the Program); (iii) support to align IC costing with the Government's planning, budgeting, execution, and monitoring processes; and (iv) support to improve the quality of procurement (including record keeping systems, planning, technical inputs, and updated Standard Bidding Documents).

59. **Key risk mitigation actions to be supported by the Program in the Program Action Plan (PAP - Annex 4) will include:**

- Annual accounts of the health PES audited within 12 months after the end of the fiscal year by the Administrative Tribunal;
- Annual procurement audits conducted within 12 months after the end of the fiscal year by an independent auditing firm, including compliance, performance, and value-for-money components;
- Resulting Action Plans for the financial and procurement audits produced, implemented, and reported on annually;
- Clear remedies against ineligible expenditures and mis-procurement;
- Assurance that adequately trained accounting technicians are appointed in SDSGCAS, and at district hospitals as they become Budget Execution Management Units (UGEs);
- Appointment of a qualified Procurement Specialist in the Program Management Unit;
- Additional measures to support capacity for implementing fiduciary controls and strengthening fiscal decentralization and funds flow to decentralized budget units, as described in the Program Action Plan.

60. Overall, the FSA concludes that, subject to the adoption of the mitigation measures for the weaknesses identified, the Program fiduciary systems provide reasonable assurance that the financing proceeds under the Program will be used for intended purposes.

C. Environmental and Social

61. **The Environmental and Social risk is considered Substantial,** as there is clear indication of a poor track record of safeguards implementation in existing projects, including proper management of health care waste, health and safety of workers and management of construction impacts. These shortcomings are associated with the limited technical capacity within MISAU to implement safeguards regulations. The Program activities seek to improve the utilization and quality of reproductive, maternal, child and adolescent health and nutrition

services. While Program activities are mostly expected to generate positive environmental impacts, potential adverse impacts can also occur. The scale of anticipated civil works related to the construction and rehabilitation of health facilities is unlikely to generate high environmental and social risks. Additionally, the Program is not likely to have significant impacts on natural habitats, or create environmental pollution, apart from temporary and localized impacts during construction phase and issues related with health care waste management as discussed below. The Program is also not likely to cause negative changes in land use patterns and/or resource use. Projects with the potential to require physical resettlement will be excluded through local processes that classify them as category A and through the environmental screening tools and process included in the Program Operation Manual.

62. **Health care waste management and issues associated with physical interventions are considered important challenges on which the Program should focus**. The challenge in health care waste management is related to ensuring that the methods, procedures and requirements for disposal employed by Program-supported facilities are consistent with international and sectoral best practices and Mozambican regulations governing the disposal of biomedical waste. Despite the requirements in the regulations for the development of a bio-medical waste management plan, which must include appropriate methods for separation, storage, transport and disposal of different categories of bio-medical waste, compliance is limited and the risks associated with poor management of biomedical waste prevail in most health units nationwide.

63. **Although the scale of anticipated civil works to be supported by the Program may not result in high environmental and social risks, past experience in projects involving civil works demonstrated challenges.** These include poor construction waste management; inadequate sanitation conditions for workers, poor workers' health and safety records and difficult relationships between contractors and construction workers have consistently been a challenge in the course of project implementation. These issues should be adequately considered during Program implementation, to mitigate associated negative environmental and social impacts. Land acquisition, where necessary, must be well documented to ensure that construction is carried out only at sites with previous clear ownership by the Government (MISAU or the concerned District) and no conflicting uses, and that compensation for any minor economic impacts on land occupants or users is addressed through mitigating measures included in the Environmental and Social Management Plans (ESMP).

64. **National environmental and social laws and regulations** (mainly the EIA Decree 54/2015) are in general considered robust and adequate for most of the activities financed under this Program. The regulatory framework is also consistent with international standards, including World Bank Group Safeguards Policies, with some minor differences. Enforcement of the regulations is constrained by inadequate institutional capacity, insufficient human resources and poor cross-sectoral coordination at various levels, including coordination within the Ministry of Health (MISAU), where environmental aspects receive less attention.

65. **Overall the social impacts for the Program are expected to be positive**. Construction of large health facilities will be ineligible for financing by the Program. Rehabilitation and/or new construction will be limited to community health centers and small rural/district hospitals (not in densely populated areas and not requiring large land areas), therefore the risk of resettlement (physical relocation) is negligible and will be excluded through categorizations under local law or application of the screening form to be applied in accordance with the Program Operations Manual. Minor economic impacts will be either screened out or addressed under the project ESMP.[23] Local laws and regulations (particularly Decree 31/2012), in combination with provisions of the POM in line with World Bank Safeguard Policy OP 4.12 provide the basis for screening and definition of compensation measures to be included in ESMPs where applicable. Measures to address gender and vulnerability (language, geography, cultural barriers, stigma) will be built into the Program Action Plan (PAP) and integrated in specific DLIs as appropriate. The Program will seek to reinforce existing mechanisms for handling complaints and redressing grievances through national systems, as analyzed in the Environmental and Social Systems Assessment (ESSA).

66. **Communities and individuals who believe they are adversely affected as a result of the Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS).** The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit *www.inspectionpanel.org*

The ESSA highlights how relevant challenges and risks will be addressed during the Program, with priority actions highlighted in the PAP (Annex 4).

D. Risk Assessment

67. **The overall risk rating for the proposed operation is Substantial.** First, the Program includes fiduciary weaknesses in both the health sector and the broader context of macrofiscal management. The World Bank is working closely with the Government and HPs to ensure fiduciary systems in the sector are strengthened (e.g. internal and external controls, and reinforced linkages between spending and results). Second, full financing of the Program from other development partners is not yet secured, and some partners have withheld their contribution or opted for vertical funding as a result of fiduciary concerns. The World Bank team

[23] If construction works result in economic impacts, (for example, small scale losses of crops or trees, non-dwelling structures), the POM will provide for compensation in kind or at full replacement with the corresponding measures included in the ESMP.

is working closely with HPs to improve harmonization around Program priorities, and HPs have been closely involved in the preparation of the IC. Continued progress on broader policy responses (e.g. debt restructuring, tightening of monetary policy, and the independent audit of undisclosed loans) is expected to help normalize relations between the Government and partners. Third, the PforR approach significantly relies on existing implementation agencies whose capacities are known to be limited. The government's commitment and capacity to recruit and apply adequate resources for TA and M&E will be critical for successful implementation, and for achievement of the DLIs. Through the preparation stage, the team has worked with the Government to identify the required TA and to incorporate these needs into the budget framework, the DLI technical notes, the PAP (see Annex 4) and in legal covenants where deemed necessary. The Bank team is also coordinating with other HPs to mobilize financing for TA, including other HPs committed to supporting the IC who may prefer to finance through vertical channels.

ANNEX 1. RESULTS FRAMEWORK MATRIX

MOZAMBIQUE:
Primary Health Care Strengthening Program-for-Results

Program Development Objectives

The Program Development Objective (PDO) is to improve the utilization and quality of reproductive, maternal, child, and adolescent health and nutrition services, particularly in underserved areas.

Program Development Objective Indicators

			DLI #	Unit of Meas.	Baseline (2017)	End Target (2022)	Frequency of measurement	Data Source
PDO/Outcome Indicators		**PDO Indicator 1** Percentage of institutional deliveries in 42 lagging districts as defined in the IC[24]	**1**	Percentage	66.1% (SISMA 2016)	74.9%	Annual	SISMA
		PDO Indicator 2 Number of Couple Years of Protection (CYPs)	**3**	Number	1,722,692	2,800,000	Annual	SISMA and modeling
		PDO Indicator 3 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 (Cabo Delgado, Manica, Nampula, Niassa, Tete and Zambézia)	**4**	Percentage	0% of children benefiting from Nutrition Intervention Package 0% of nutrition sites meet the minimum standard of quality	70% of children benefiting from Nutrition Intervention Package 90% of nutrition sites meet the minimum standard of quality	Bi-annual	Survey (conducted by competitively selected firm/ organization)

[24] While PDO Indicator 1 is focused on 42 lagging districts identified in the IC, the intermediate indicators remain national in scope, to ensure intermediate steps contribute to both maintain and expand institutional deliveries.

			DLI #	Unit of Meas.	Baseline (2017)	End Target (2022)	Frequency of measurement	Data Source
		PDO Indicator 4 Adherence to clinical diagnostic guidelines for five tracer conditions at health centers and district hospitals		Percentage	37.4 (SDI, 2014)	75	Bi-Annual	SDI survey
		PDO Indicator 5 Adherence to clinical treatment guidelines for maternal and neonatal complications at health centers and district hospitals		Percentage	29.9 (SDI, 2014)	80	Bi-annual	SDI survey
Intermediate Results Indicators	**1. Service delivery outputs**	1.1 Percentage of pregnant women who had 4 or more antenatal visits		Percentage	54.6	66.3	Annual	SISMA
		1.2 Number of children immunized (millions) (Corporate Results Indicator - CRI) [25]		Number	0	5.10	Annual	SISMA
		1.3 Number of deliveries attended by skilled health personnel (millions) (CRI)		Number	0	4.94	Annual	SISMA
		1.4 Number of women and children who received basic nutrition services (million) (CRI)		Number	0	9.72	Annual	SISMA
		1.5 Percentage of children between 0-24 receiving deworming tablets		Percentage	65.8	72.6	Annual	SISMA
	1. Service readiness and availability	2.1 Number of health facilities providing Basic (BEmONC) and Comprehensive (CEmONC) Emergency Obstetric and Newborn Care		Number	BEmONC: 68 CEmONC: 33	BEmONC: 300 CEmONC: 60	Annual	Reports DNSP/DNAM
		2.2 Percentage of district hospitals with uninterrupted water supply and electricity		Percentage	Water: 87 Electricity: 54	Water: 95 Electricity: 85	Bi-annual	SDI Survey
		2.3 Availability of essential		Percentage	66(SDI, 2014)	90	Bi-annual	Survey (SDI)

[25] These represent Corporate Core Results Indicators for World Bank financed operations. The expectation is that before the operation starts, there are no beneficiaries of the present World Bank financing, and for this reason the baseline is by default set to '0'.

			DLI #	Unit of Meas.	Baseline (2017)	End Target (2022)	Frequency of measurement	Data Source
		reproductive and maternal health medicines in district and rural hospitals						
		2.4 Percentage of secondary schools offering sexual and reproductive health (SRH) services (information and contraceptive methods)	**2**	Percentage	47 (December 2016)	80	Annual	SISMA
	2. Health Human Resources (HRH)	3.1 Number of community health workers (APEs) that are trained and active	**10**	Number	3,380	7,623	Annual	SISMA/ UPSCALE + Independent Validation Agent
		3.2 (i) Number of technical health personnel (*Regime Especial*) assigned to the primary health care network, and (ii) to Type II Rural Health Centers in particular	**7**	Number	(i) 11,970 (ii) 3,787	(i) 15,277 (ii) 5,311	Annual	HRH Information system (SIP)
	3. Quality	4.1 Percentage of district/rural hospitals that received performance-based allocations (PBA) in accordance with a minimum of two scorecard assessments in the previous fiscal year	**8**	Percentage	0	100	Bi-annual	Scorecard (completed by Integrated Supervision Committees and independently validated)
		4.2 Percentage of rural health centers in priority districts[26] that received PBA in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year	**9**	Percentage	0	80	Bi-annual	Scorecard (completed by Integrated Supervision Committees and independently validated)

[26] 'Priority districts' refers to two lists in the Investment Case, Annex 3 "Note on the Prioritization of Districts: Population, Health Network, and Services": (i) Table 5- 55 districts which have a high potential for attaining results; and (ii) Table 6/A (Part 3) 42 lagging districts with lower population density, fewer resources, and less actual production of services.

			DLI #	Unit of Meas.	Baseline (2017)	End Target (2022)	Frequency of measurement	Data Source
	4. Health financing	5.1 Domestic health expenditures as a percentage of total domestic government expenditures	**5**	Percentage	Average for the three-year period 2014-2016: 7.9	FY21 actual domestic health expenditure as a percentage of total domestic government expenditure at least 9.5	Annual	e-SISTAFE (independently validated)
		5.2 Health sub-account expenditures in historically underserved areas: (i) three provinces (Nampula, Zambezia, and Tete) and (ii) 28 districts[27]	**6**	US$	(i) 0 (ii) 0	(i) US$36 million (ii) US$16 million	Annual	e-SISTAFE (independently validated)
	5. Information for decision making	6.1 Percentage of deaths certified in health facilities[28] with data on cause coded per ICD 10 reported in SISMA and sent to the Civil Registry	**11**	Percentage	70% of hospitals and 0% of health centers using Hospital Data Management Module (MGDH) to generate information on causes of death	100% of deaths certified in health facilities with data on cause coded per ICD 10 reported in SISMA and sent to the Civil Registry	Annual	SISMA and CR system

[27] The criteria for selection of the three provinces and 28 districts is detailed in the POM.
[28] Health facilities here refers to Type I Rural and Type A Urban Health Centers, and District, General, Provincial, and Central Hospitals

ANNEX 2: Disbursement Linked Indicators, Disbursement Arrangements and Verification Protocols

MOZAMBIQUE:
Primary Health Care Strengthening Program-for-Results

Disbursement-Linked Indicator Matrix

	Total Financing Allocated to DLI (US$ Mil) [29]	*As % of Total Financing Amount*	*DLI Baseline*	*Unit of Measurement (No, %, Y/N, text)*	*Indicative timeline for DLI achievement*					
					Y0 or Prior Results	*Year 1*	*Year 2*	*Year 3*	*Year 4*	*Year 5*
DLI 1: Percentage of Institutional Deliveries in 42 lagging districts as defined in the IC			66.1% (SISMA 2016)	%		66.8%	69.2%	71.2%	73.1%	74.9%
Allocated amount (US$ Mil):	16	10%				4.5	4.0	3.5	2.0	2.0
Formula	**Formula Description:** Simple scalability after the DLR 1.1 (DLI Engagement Floor) is met = Allocated Amount x [Actual improvement for the DLR / Targeted improvement] + the undisbursed amount from previous targets met The first year's target for any DLI is the "DLI Engagement Floor" for the Program. Meeting this target commences disbursement for that DLI. From there onwards the disbursements will be scalable in proportion to					F1 - No scalability	F2 – FY Allocated Amount x [Actual achievement up to DLR 1.2[30] – DLR 1.1] / [DLR 1.2 – DLR	F3 – FY Allocated Amount x [Actual achievement up to DLR 1.3 – DLR 1.2] / [DLR 1.3 – DLR 1.2]	F4 – FY Allocated Amount x [Actual achievement up to DLR 1.4 – DLR 1.3] / [DLR 1.4 – DLR 1.3]	F5 – FY Allocated Amount x [Actual achievement up to DLR 1.5 – DLR 1.4] / [DLR 1.5 – DLR 1.4] +

[29] Allocated amounts in the DLI Matrix include indicative financial commitments from the Netherlands (MDTF) and USAID (SDTF), in addition to financing from IDA and GFF, as indicated in Table 1 of the PAD. This reflects the full GFF amount of US$25 million (of which US$10 million is lagged financing. The grant agreement will be signed for a grant of US$15 million to be followed by an amendment to increase the grant by US$10 million).

[30] In 'DLR 1.2' and proceeding references, '1' refers to the DLI number and '2' refers to year corresponding to the targeted Disbursement-Linked Result (DLR)

	DLR achievement. **Note:** To ensure sustainability, disbursements will be made in accordance with the calendar. DLRs will only be rewarded if they are validated for the year in which corresponding prices are due, or thereafter.					1.1] + undisbursed amount from previous targets met	+ undisbursed amount from previous targets met	+ undisbursed amount from previous targets met	undisbursed amount from previous targets met
DLI 2: Percentage of secondary schools offering sexual and reproductive health services (information and contraceptive methods), based on visits by health professionals, at least monthly.			December 2016: 47% (264 secondary schools)	%		53.5%	60%	66.5%	73%	80%
Allocated amount:	15.0	10%				3.5	3.0	3.0	3.0	2.5
Formula	**Formula Description:** Same as DLI 1 *mutatis mutandis*									
DLI 3: Couple Years of Protection (CYPs)			December 2016: 1,722,692	Number		Dec 2018: 2,135,012	Dec 2019: 2,370,046	Dec 2020: 2,582,068	Dec 2021: 2,740,751	Dec 2022: 2,800,000
Allocated amount (US$ Mil):	12.5	8%				3.5	3.0	2.5	2.0	1.5
Formula	**Formula Description:** Same as DLI 1 *mutatis mutandis*									
DLI 4: Percentage of children between 0-24 months of age receiving the Nutrition Intervention Package (NIP) in the 6 Provinces with the highest prevalence of chronic malnutrition (Cabo Delgado, Manica, Nampula, Niassa,Tete and Zambézia)			DLR4.1.: 0 staff trained, M&E system not in place DLR4.2: 0% DLR4.3: 0%	%		Key staff trained on NIP[31] [US$ 2.5million] M&E system finalized [US$ 1.0 million]	30% of children benefiting from NIP	75% of nutrition sites meet the minimum standard of quality	70% of children benefitting from NIP	90% of nutrition sites meet the minimum standard of quality

[31] Key staff include at least 6 trainers (1 per Province), 100% of District Nutrition Representatives (DNR), and 30% of APE's and Volunteers

Allocated amount (US$ Mil):	17	11%				3.5	3.5	3.5	3.5	3.0
Formula	**Formula Description:** Simple scalability after the DLR 4.1 (DLI Engagement Floor) is met = Allocated Amount x [Actual improvement for the DLR / Targeted improvement] + undisbursed amount from previous targets met					F1 - No scalability	F2 - FY Allocated Amount x [Actual achievement up to DLR 4.2 – Baseline] / [DLR 4.2 – Baseline] + undisbursed amount from previous targets met	F3 - FY Allocated Amount x [Actual achievement up to DLR 4.3 – Baseline] / [DLR 4.3 – Baseline] + undisbursed amount from previous targets met	F4 - FY Allocated Amount x [Actual achievement up to DLR 4.4 – DLR 4.2] / [DLR 4.4 – DLR 4.2] + undisbursed amount from previous targets met	F5 - FY Allocated Amount x [Actual achievement up to DLR 4.5 – DLR 4.3] / [DLR 4.5 – DLR 4.3] + undisbursed amount from previous targets met
DLI 5: Domestic health expenditures as a percentage of total domestic government expenditures.			Average for the three-year period 2014-2016: 7.9%	%		FY18 actual domestic health expenditure as a percentage of total domestic government expenditure at least 8.5%	FY19 actual domestic health expenditure as a percentage of total domestic government expenditure at least 8.5%	FY20 actual domestic health expenditure as a percentage of total domestic government expenditure at least 9%	FY21 actual domestic health expenditure as a percentage of total domestic government expenditure at least 9.5%	
Allocated amount (US$ Mil):	13.5	9%				3.75	3.25	3.25	3.25	
Formula	**Formula Description:** Same as DLI 1 *mutatis mutandis*									
DLI 6: Health expenditures made in historically underserved areas (3 provinces and 28 districts) **6.0.1. Sub-account expenditures in Nampula, Zambezia, and Tete**			6.1.1: 0	US$		**6.1.1:** Actual provincial expenditures in the three provinces from the sub-account amount to	**6.2.1**: Cumulative provincial expenditures in the three provinces from the sub-account	**6.3.1:** Cumulative provincial expenditures in the three provinces from the sub-account	**6.4.1:** Cumulative provincial expenditures in the three provinces from the sub-account	

					US$9 million [US$ 1 million]	amount to US$18 million [US$ 1 million]	amount to US$27 million [US$ 1 million]	amount to US$36 million [US$ 1 million]	
6.0.2. Sub-account expenditures in the 28 underserved districts			6.1.2: 0	US$		**6.1.2:** Actual district expenditures in the 28 districts from the sub-account amount to US$4 million [US$ 1.25 million]	**6.2.2**: Cumulative district expenditures in the 28 districts from the sub-account amount to US$8 million [US$ 1.25 million]	**6.3.2:** Cumulative district expenditures in the 28 districts from the sub-account amount to US$12 million [US$ 1.25 million]	**6.4.2:** Cumulative district expenditures in the 28 districts from the sub-account amount to US$16 million [US$ 1.25 million]	
6.0.3. Domestic health expenditures (operational and internal investment) maintained in underserved areas (3 provinces and 28 districts)			6.1.3-6.4.3: Domestic health expenditures account for 36.6% of total provincial expenditures in the three provinces and 19.5% of total district expenditures in the 28 districts (2015)	%		**6.1.3:** Domestic health expenditures for the three provinces and 28 districts maintained as a share of domestic provincial and district expenditures [US$ 1 million non-scalable]	**6.2.3:** Domestic health expenditures for the three provinces and 28 districts maintained as a share of domestic provincial and district expenditures [US$ 1 million non-scalable]	**6.3.3**: Domestic health expenditures for the three provinces and 28 districts maintained as a share of domestic provincial and district expenditures [US$ 1 million non-scalable]	**6.4.3**: Domestic health expenditures for the three provinces and 28 districts maintained as a share of domestic provincial and district expenditures [US$ 1 million non-scalable]	
Total Allocated amount (US$ Mil):	13.0	8%				3.25	3.25	3.25	3.25	
Formula	**Formula Description:** Simple scalability after the DLR 6.1 (DLI Engagement Floor) is met = Allocated Amount x [Actual improvement for the DLR / Targeted improvement] + undisbursed amount from previous targets met					F1 - No scalability	F2 - 6.2.1: FY Allocated Amount x [Actual achievement up to DLR 6.2.1	F3 - 6.3.1: FY Allocated Amount x [Actual achievement up to DLR 6.3.1	F4 - 6.4.1: FY Allocated Amount x [Actual achievement up to DLR 6.4.1	

							– DLR 6.1.1] / [DLR 6.2.1 – DLR 6.1.1] + undisbursed amount from previous targets met 6.2.2: FY Allocated Amount x [Actual achievement up to DLR 6.2.2 – DLR 6.1.2] / [DLR 6.2.2 – DLR 6.1.2] + undisbursed amount from previous targets met 6.2.3: Non-scalable	– DLR 6.2.1] / [DLR 6.3.1 – DLR 6.2.1] + undisbursed amount from previous targets met 6.3.2: FY Allocated Amount x [Actual achievement up to DLR 6.3.2 – DLR 6.2.2] / [DLR 6.3.2 – DLR 6.2.2] + undisbursed amount from previous targets met 6.3.3: Non-scalable	– DLR 6.3.1] / [DLR 6.4.1 – DLR 6.3.1] + undisbursed amount from previous targets met 6.4.2: FY Allocated Amount x [Actual achievement up to DLR 6.4.2 – DLR 6.3.2] / [DLR 6.4.2 – DLR 6.3.2] + undisbursed amount from previous targets met 6.4.3: Non-scalable	
DLI 7: Number of technical health personnel assigned to the primary health care network			11,970	Number		12,569	13,197	13,857	14,550	15,277
Allocated amount (US$ Mil):	13.0	8%				3.5	3.0	2.5	2.5	1.5
Formula	**Formula Description:** Same as DLI 1 *mutatis mutandis*									
DLI 8: Percentage of district/rural hospitals that received performance-based allocations (PBA) in accordance with a minimum of two scorecard assessments in the previous fiscal year			No national mechanism established to compare and reward hospital performance	% Financial transfers		Hospital performance scorecards designed and piloted in 12% of district/rural hospitals,	30% of district/rural hospitals receive PBA in accordance with a minimum of	70% of district/rural hospitals receive PBA in accordance with a minimum of	100% of district/rural hospitals receive PBA in accordance with a minimum of	

						which receive[32] PBA according to their performance	two scorecard assessments in the previous fiscal year	two scorecard assessments in the previous fiscal year	two scorecard assessments in the previous fiscal year	
Allocated amount (US$ Mil):	14.0	9%				4.0	3.5	3.5	3.0	
Formula	**Formula Description:** Same as DLI 1 *mutatis mutandis*									
DLI 9: Percentage of rural health centers in priority districts[33] that received PBA in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year			No national mechanism established to systematically monitor, compare, and reward health center performance	% Financial transfers		Health center performance scorecards with community consultations designed and piloted in at least 10% health centers in priority districts, with health centers receiving[34] financial allocations according to their performance	20% of rural health centers in priority districts receive PBA in accordance with a minimum of two scorecard assessments with community consultations in the last previous fiscal year	30% of rural health centers in priority districts receive PBA in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year	40% of rural health centers in priority districts receive PBA in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year	50% of rural health centers in priority districts receive PBA in accordance with a minimum of two scorecard assessments with community consultations in the previous fiscal year

[32] For hospitals that are Budget Management Units (Beneficiaries or Executors -UGBs or UGEs), "receive" means an assignment of budget authority and funds to the rewarded hospital via e-SISTAFE. For hospitals that are not UGBs or UGEs, "receive" means: (i) the transfer of grants into the bank accounts of rewarded hospitals; or (ii) that the funds are received by hospital from SDSGCAS. Other financial management arrangements for PBA will be detailed in the POM.

[33] 'Priority districts' refers to two lists in the Investment Case, Annex 3 "Note on the Prioritization of Districts: Population, Health Network, and Services": (i) Table 5- 55 districts which have a high potential for attaining results; and (ii) Table 6/A (Part 3) 42 lagging districts with lower population density, fewer resources, and less actual production of services.

[34] For health centers "receiving" means: (i) the transfer of grants into the bank accounts of rewarded health centers; (ii) that the funds are received by health center from SDSGCAS; or (iii) that SDSGCAS are allocated and spend performance grants according to a procurement plan provided by the awarded health center. Other financial management arrangements PBA will be detailed in the POM.

Allocated amount (US$ Mil):	15.0	10%			4.0	3.5	3.0	2.5	2.0
Formula	**Formula Description:** Same as DLI 1 *mutatis mutandis*								
DLI 10 Number of APEs that are trained and active			In September 2017: 3,380 APEs Baseline of the quality of service provision assumed at 60%	No. of APEs Percentage of APEs that deliver services according to minimum quality standards	**10.1:** Dec. 2018: 4,723 APEs trained and active	**10.2.1:** Dec. 2019: 6,023 APEs trained and active [US$ 1.5 million] **10.2.2:** 70% of APEs deliver services according to minimum quality standards [US$ 2.0 million]	**10.3:** Dec. 2020: 7,123 APEs trained and active	**10.4.1:** Dec. 2021: 7,373 trained and active [US$ 1.5 million] **10.4.2:** 80% of APEs deliver services according to minimum quality standards [US$ 2.0 million]	**10.5:** Dec. 2021: 7,623 APEs trained and active
Allocated amount (US$ Mil):	16.0	10%			3.5	3.5	3.0	3.5	2.5
Formula	**Formula Description:** Simple scalability after the DLR 10.1 (DLI Engagement Floor) is met = Allocated Amount x [Actual improvement for the DLR / Targeted improvement] + undisbursed amount from previous targets met				F1 – 10.1: No scalability	F2 – **10.2.1:** Allocated Amount x [Actual achievement up to DLR 10.2.1 – DLR 10.1] / [DLR 10.2.1 – 10.1] + undisbursed amount from previous targets met	F3 – **10.3:** Allocated Amount x [Actual achievement up to DLR 10.3 – 10.2.1] / [DLR 10.3 – 10.2.1] + undisbursed amount from previous targets met	F4 – **10.4.1:** Allocated Amount x [Actual achievement up to DLR 10.4.1 – DLR 10.3] / [DLR 10.4.1 – DLR 10.3] + undisbursed amount from previous targets met	F5 – **10.5.1:** Allocated Amount x [Actual achievement up to DLR 10.5 – DLR 10.4.1] / [DLR 10.5 – DLR 10.4.1] + undisbursed amount from previous targets met

						10.2.2: Allocated Amount x [Actual achievement up to DLR 10.2.2 – Baseline] / [DLR 10.2.2 – Baseline]		**10.4.2:** Allocated Amount x [Actual achievement up to DLR 10.4.2 – 10.2.2] / [DLR 10.4.2 – 10.2.2] + undisbursed amount from previous targets met	
DLI 11 Percentage of deaths certified in health facilities[35] with data on cause of death, coded per ICD 10, reported in SISMA and sent to the civil registry			70% of hospitals, 0% of health centers (2017) using Hospital Data Management Module (MGDH) to generate information on causes of death 0% of certified deaths coded per ICD-10, reported in SISMA, and sent to the civil registry	% of hospitals and health centers using the Hospital Data Management Module (MGDH) % of certified deaths		100% of hospitals and 50% of health centers use MGDH to generate information on causes of death	100% of the health centers use MGDH to generate information on the causes of death	70% of certified deaths coded per ICD-10, reported in SISMA, and sent to the civil registry	85% of certified deaths coded per ICD-10, reported in SISMA, and sent to the civil registry	100% of certified deaths coded per ICD-10, reported in SISMA, and sent to the civil registry
Allocated amount (US$ Mil):	10.34	7%				3.0	2.5	2.0	1.5	1.34
Formula	**Formula Description:** Simple scalability after the DLR 11.1 (DLI Engagement Floor) is met = Allocated Amount x [Actual improvement for the DLR / Targeted improvement] + undisbursed amount from previous					F1 - No scalability	F2 – FY Allocated Amount x	F3 – FY Allocated Amount x	F4 – FY Allocated Amount x	F5 – FY Allocated Amount x

[35] Health facilities here refers to Type I Rural and Type A Urban Health Centers, and District, General, Provincial, and Central Hospitals

	targets met					[Actual achievement up to DLR 11.2 – DLR 11.1] / [DLR 11.2 – 11.1] + undisbursed amount from previous targets met	[Actual achievement up to DLR 11.3 – Baseline] / [DLR 11.3 – Baseline] + undisbursed amount from previous targets met	[Actual achievement up to DLR 11.4 – DLR 11.3] / [DLR 11.4 – DLR 11.3] + undisbursed amount from previous targets met	[Actual achievement up to DLR 11.5 – DLR 11.4] / [DLR 11.5 – DLR 11.4] + undisbursed amount from previous targets met
Total Financing Allocated:	**155.34**	**100%**			**40.0**	**36.0**	**33.0**	**30.0**	**16.34**

ANNEX 3: DLI Verification Protocol Table

#	DLI	Protocol to evaluate achievement of the DLI and data/result verification	
		DLI Definition and Description	Procedure
1	**Percentage of Institutional Deliveries in 42 lagging districts as defined in the IC**	**Numerator:** the total number of pregnant women who delivered their babies in a health facility in all 42 priority districts in a year **Denominator**: the total number of expected childbirths in the same districts in a year.	*An independent agency will be competitively selected for the validation of parts of all of DLIs 1, 2, 3, 4, 8, 9, 10 and 11. Potential candidates include consulting firms, academic and research institutions, professional associations, colleges of specialists, etc. The validation will reinforce the existing Annual Joint Assessment (ACA) of the health sector.* DLI 1 validation on a sample basis to include: health facility registration books and summary forms collected and aggregated annually by DPC.
2	**Percentage of secondary schools offering SRH services (information and contraceptive methods), based on visits by health professionals, at least monthly.**	**Numerator:** the total number of public secondary schools that have offered SRH services (information and contraceptive methods), based on visits by health professionals, at least monthly **Denominator**: the total number of public secondary schools	Independent Verification Agent (same as 1 above)
3	**Couple Years of Protection (CYPs)**	**CYPs:** The estimated protection provided by family planning services during a one-year period, based upon the volume of all modern contraceptives methods sold or distributed free of charge to users during that period. CYP conversions are based on USAID (December 2011) factors. *https://www.usaid.gov/what-we-do/global-health/family-planning/couple-years-protection-cyp*	Independent Verification Agent (same as 1 above) Validation on a sample basis to include: distribution of contraceptives documented through SISMA.

#	DLI	Protocol to evaluate achievement of the DLI and data/result verification	
		DLI Definition and Description	Procedure
4	**Percentage of children between 0-24 months of age receiving the Nutrition Intervention Package (NIP) in the 6 provinces with the highest prevalence of chronic malnutrition (Cabo Delgado, Manica, Nampula, Niassa, Tete and Zambézia)**	**Numerator:** the number of children aged 0-24 months who have received the NIP package in the last year in the 6 provinces **Denominator**: all children aged 0-24 months in the 6 provinces in the same period. The total number of children aged 0-24 months will be estimated from demographic projections from the 2017 population census in the provinces of Cabo Delgado, Manica, Nampula, Niassa, Tete, and Zambézia. Similarly, the number of children who received the NIP will be ascertained in the same provinces, every year.	(i) Independent Verification Agent (same as 1 above) Validation on a sample basis to include: Reports on training, M&E system, and volunteers (ii) FY19 - FY 21: Annual; survey done by a competitively selected firm/organization
5	**Domestic health expenditures as a percentage of total domestic government expenditures.**	**Numerator:** Domestic health expenditures **Denominator:** Total domestic government expenditures **Domestic Health Expenditures:** the sum of health expenditures on operations (*funcionamento*) and internal investment (*investimento interno*) as reported in e-SISTAFE and the Report on Budget Execution (*Relatório de Execução Orçamental,* or REO) for each fiscal year. Domestic health expenditures will exclude external investment (*investimento externo*) and any off-budget vertical funding provided to the health sector. Health expenditures will be calculated based on all spending, regardless of functional classification, in health spending units. Health spending units include all spending units within the Ministry of Health (MISAU) at the central and provincial levels, and district expenditures under the Office of the President under the District Service Units for Health (District Services for Health, Gender, Children and Social Action, or SDSGCAS) and health facilities **Total Domestic Government Expenditures:** the sum of all government expenditures on operations (*funcionamento*) and internal investment (*investimento interno*) as reported in e-SISTAFE and the Report on Budget Execution (*Relatório de Execução Orçamental,* or REO) for each fiscal year.	Data generated by the National Directorate of Treasury (DNT) in the Ministry of Economy and Finance through e-SISTAFE, Budget Execution Reports(REO); Financial reports utilized to monitor funds flow to decentralized level Validation will be done by the Administrative Tribunal
6	**Health expenditures made in historically**	(i) **Sub-account expenditures in Nampula, Zambezia, and Tete:** Cumulative	Data generated by the National Directorate of Treasury (DNT) in the

#	DLI	Protocol to evaluate achievement of the DLI and data/result verification	
		DLI Definition and Description	***Procedure***
	underserved areas (3 provinces and 28 districts identified)	provincial health expenditures financed from the TSA sub-account of the Program (equivalent in USD) in the three underserved provinces (i.e. budget kept at the disposal of provincial-level spending authorities – DPS and hospitals). (ii) **Sub-account expenditures among 28 underserved districts**: Cumulative district health expenditures financed from the TSA sub-account of the Program (equivalent in USD) in the 28 underserved districts as defined in the DLI 6 Technical Note/Program Operations Manual (i.e. budget kept at the disposal of district-level spending authorities – SDSGCASs and district hospitals) (iii) **Domestic health expenditures (operational and internal investment) maintained in the three provinces and 28 districts:** health expenditures on operations (*funcionamento*) and internal investment (*investimento interno*) in the 3 provinces and 28 districts maintained at 2015 baseline levels (36.6% and 19.5% respectively) as a share of total provincial and district expenditures	Ministry of Economy and Finance through e-SISTAFE, Budget Execution Reports(REO); Validation will be done by the Administrative Tribunal
7	**Number of technical health personnel assigned to the primary health care network**	Number of technical health personnel assigned to the primary health care network **Technical health personnel:** all career health professionals belonging to the health "special regime" or *Regime Especial*. This includes the following occupational areas: Nursing, ESMI, 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 **Primary health care network** refers to the following health facilities: Rural Health Centers Type I and II and Urban Health Centers	Data generated from eSip (number of Special Health Regime Technicians assigned to the primary network) and SISMA (health facilities in the primary network) Validation will be done by the Administrative Tribunal

#	DLI	Protocol to evaluate achievement of the DLI and data/result verification	
		DLI Definition and Description	***Procedure***
8	**Percentage of district/rural hospitals that received performance-based allocations (PBA) according to at least two scorecard assessments in the previous fiscal year**	**Numerator**: Number of rural and district hospitals that received PBA according to at least two scorecard assessments in the last fiscal year **Denominator**: Total number of district/rural hospitals **Scorecard**: a composite index based on weighed priority indicators of hospital performance. **Performance-based allocations**: financial rewards for hospitals based on their performance **Rural and district hospital**: legal classifications as set forth in Ministerial Diploma 127/2002.	Independent Verification Agent (same as 1 above) to validate compiled scorecards filled out by Integrated Supervision Committees [36], and financial transfers of PBA
9	**Percentage of rural health centers in priority districts that received performance-based allocations (PBA) according to at least two scorecard assessments with community consultations in the previous fiscal year**	**Numerator**: Number of rural health centers in priority districts that received performance-based allocations (PBA) according to at least two scorecard assessments with community consultations in the last fiscal year **Denominator**: Total number of rural health centers in priority districts **Scorecard**: a composite index based on weighed priority indicators of health center performance. **Community Consultation:** an output that simultaneously measures different aspects contributing to improved quality of services delivered in a health center, namely: i) ability to organize regular meetings with key actors **(Planning and Management);** ii) ability of communities to contribute and participate in problem identification, and problem solving **(Community Participation)**; and iii) ability to implement recommendations of community consultations **(Accountability).** **Performance-based allocations**: financial rewards for health centers based	Independent Verification Agent (same as 1 above) to validate compiled scorecards filled out by Integrated Supervision Committees, and financial transfers of PBA

[36] Integrated Supervision Committees shall consist, at a minimum, of: (i) one government representative (from the central level, from a province or district, or from the Health Inspector General); (ii) a representative from a different health facility; and (iii) an independent third party (a health partner, a civil society member). For DLI 9, the Committees should include a representative that participated in the community consultation.

#	DLI	Protocol to evaluate achievement of the DLI and data/result verification	
		DLI Definition and Description	***Procedure***
		on their performance **Rural health centers**: legal classifications as set forth in Ministerial Diploma 127/2002.	
10	**Number of APEs that are trained and active**	**Number of APEs**: the total number of APEs at the end of each review period that have been trained, certified, and are delivering services **Percentage of APEs that deliver services according to minimum quality standards:** **Numerator:** Number of active APEs that demonstrate capacities to deliver services according to the minimum standard of quality reflected in the APE certification exam **Denominator:** Total number of active APEs (to be determined on a sample basis)	**(i)** *Number of APEs:* Independent Verification Agent (same as 1 above) to validate on a sample basis relevant documentation (reports from trainings, APEs, and supervisors, referrals made to health centers). It is possible that validation can also be facilitated through the UPSCALE tool - an application that is already in use in Inhambane and Cabo Delgado that will be progressively extended to the whole country, which will facilitate record keeping on training, reporting, and the extent of APEs' geographic circulation. **(i)** *Percentage of APEs that deliver services according to minimum quality standards:* An independent study will be conducted by a qualified institution (potentially the same as 4 ii above) to provide this percentage based on a representative sample.
11	**Percentage of deaths certified in health facilities with data on cause coded per ICD 10 reported in SISMA and sent to the Civil Registry.**	**Year 1 and 2:** **Numerator:** Number of hospitals and health centers with internment (Type I Rural and Type A Urban Health Centers, and District, General, Provincial, and Central Hospitals) using the Hospital Data Management Module (MGDH) **Denominator**: Total Number of hospitals and health centers with	Independent Verification Agent (same as 1 above) to validate on a sample basis data and functionality of MGDH, DHIS2-SISMA, and information sent to Civil Registry

#	DLI	Protocol to evaluate achievement of the DLI and data/result verification	
		DLI Definition and Description	Procedure
		internment **Year 3, 4, and 5:** **Numerator:** Number of deaths certified in health facilities with internment in the national health system with causes coded according to ICD-10 with data captured in the Health Information System (DHIS2-SISMA) and sent to the Civil Registry **Denominator:** Total number of deaths certified in health facilities with internment in the national health system	

Annex 4. Program Action Plan

	Action Description	DLI*	Due Date	Responsible Party	Completion Measurement**
			Technical		
1	**Program Operations Manual** The Program Operations Manual shall be adopted by the Recipient in a manner satisfactory to the Association.	☐	Within 6 months of Program effectiveness	MISAU (DPC)	POM
2	**Program Management Unit** The Program Management Unit (PMU) shall be assembled with a Terms of Reference and composition satisfactory to the Association (including experienced fiduciary personnel).	☐	Within 3 months of Program effectiveness	MISAU (DPC)	PMU ToR
			Fiduciary		
3	**Financial Audit** Annual accounts of the health Economic and Social Plan (PES) audited within 12 months after the end of the fiscal year by the Administrative Tribunal; Resulting action plan produced, implemented, and reported on annually.	☐	Within 12 months after the end of the fiscal year	MISAU (DAF)	(i) Audit Report (ii) Report on Action Plan implementation
4	**Procurement Audit** Annual procurement under the PES audited within 12 months after the end of the fiscal year by independent auditing firm, covering procurement regulatory compliance, performance, and value-for-money; Resulting action plan produced, implemented, and reported on annually; Clear remedies against ineligible expenditures and mis-procurement.	☐	Within 12 months after the end of each fiscal year	MISAU (DAF)	(i) Audit Report (N-1) (ii) Report on Action Plan implementation (N-1)
5	**Accounting Capacity** Assurance that adequately trained accounting technicians are appointed in District Services for Health, Gender, the Child, and Social Action (SDSGCAS), and at district hospitals as they become UGEs.	☐	Ongoing	MISAU (DAF)	Training Reports
6	**Fiduciary Capacity Development** Design a medium-term (4 year) targeted capacity development and staffing plan for fiduciary staff at all levels.	☐	Within 6 months of Program effectiveness	MISAU/DAF	Plan
7	**Performance-Based Allocations (PBA) for Health Facilities** (i) Develop and document clear procedures for planning, disbursing, and reporting on PBA for health facilities	☐	Within 12 months of Program effectiveness	Before funds are disbursed to health facilities	MISAU/DPS/ SDSGCAS

	(ii) Ensure PES/budgets are formulated in consultation with health facilities, and include amounts allocated to each health facility (including PBA) (iii) Support district hospitals to open bank accounts, establish connectivity to e-SISTAFE, and hire required FM personnel (iv) Establish a Procedures Manual for health centers to receive and execute PBA				
8	**IC/PES Budgetary Alignment** (i) Align IC costing with Government budget categories to facilitate planning and monitoring of expenditures (ii) Conduct workshops with Provincial and District-level budget holders to mobilize spending shifts to reflect IC priorities and DLIs, and to ensure the Program's list of ineligible expenditures is communicated to all relevant budget holders (iii) Utilize e-SISTAFE data to enable more granular monitoring and follow-up on progressive, prioritized budgetary shift at different levels (i.e. through BOOST)	☐	Annual (N-1)	MISAU (with support from World Bank TA)	(i) IC budgetary alignment (ii) Workshop reports (iii) BOOST analysis
9	**Standard Bidding Documents (SBDs)** (i) Update SBDs to reflect new decree. (ii) While waiting for the updated SBDs, prepare and submit to the Bank for review and acceptance a sample bidding document to be used for NCB procedure.	☐	(i) Within 12 months of Program effectiveness (ii) Within 3 months of Program effectiveness	Functional Unit for Procurement Supervision (UFSA) MISAU	(i) Updated SBDs (ii) Sample Bidding Document
	Safeguards				
10	**Environmental Health Department Training** Satisfactory completion of at least one training of Environmental Health Department technicians at central level and provincial focal points and chief medical officers on the EIA process, focusing on roles and responsibilities of sector personnel at each stage, especially for activities/projects involving construction works, and on project	☐	Within 12 months of Program effectiveness	MISAU (DNSP and Environmental Health Department)	Program Action Plan Implementation Report (PAP IR) Number of people trained in general and per province Screening forms completed by DHE for (a) Project sub-

	screening.[37]				projects; (b) MISAU projects
11	**Health Waste Management (I)** Provide MISAU's Environmental Specialist with training on health facility waste management	☐	Within 12 months of Program effectiveness	MISAU (DNSP and DNAM)	PAP IR Completion of training by Environmental Specialist
12	**Health Waste Management (II)** Preparation and distribution of informational materials on health waste management[38] and delivery of at least one training on health waste management at provincial levels for chief medical officers and for managers of health facilities with in-patient care	☐	Within 12 months of Program effectiveness	MISAU (DNSP and DNAM)	PAP IR Informational materials available at health facilities with in-patient care (80%) Number of people trained in general and per facility
13	**Health Waste Management (III)** Inclusion of waste management in health facility scorecard	☒	Within 12 months of Program effectiveness	MISAU (DNSP and DNAM)	Year 1 DLI validation Scorecard
14	**Health Waste Management (IV)** Ensure that health waste management protocols are included in training curricula for health professionals	☐	Within 12 months of Program effectiveness	MISAU (DNSP, DRH, DNAM)	PAP IR Training curricula Number of courses delivered
15	**Disaster Contingency** Conduct at least one training on new disaster contingency protocols for APEs and SDSGCAS managers in vulnerable districts as defined by the National Institute of Calamities Management (INGC)	☐	Within 24 months of Program effectiveness	MISAU (DNSP/Department of Environmental Health) in coordination with INGC	PAP IR Curriculum Number of people trained
16	**Gender and socio-cultural responsiveness (I)** Engagement of a social development specialist according to a Terms of Reference agreed with the Bank to: (i) provide oversight for gender and socio-cultural sensitivity in TA, service delivery protocols, community awareness campaigns and consultation processes at	☐	Within 12 months of Program effectiveness	MISAU (DPC, DNSP, Gender Unit)	PAP IR (i) ToR developed and agreed with the Bank (ii) Social Development Specialist engaged MISAU

[37] See attached project screening form.

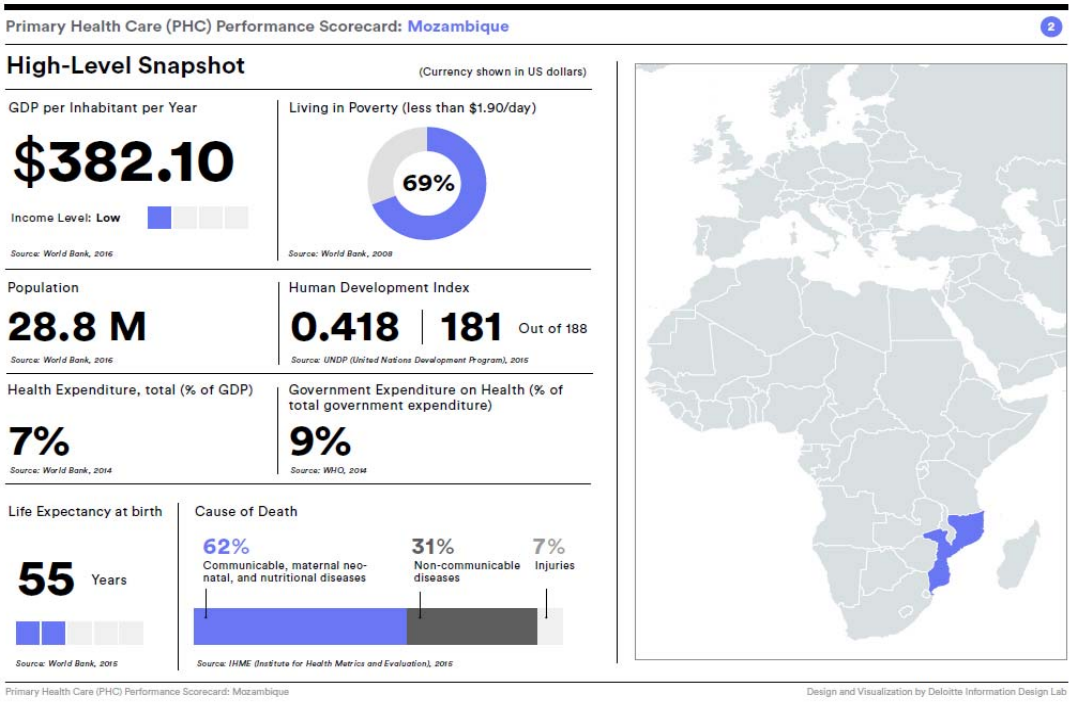
[38] This can include pamphlets and posters, which should be made easily accessible and/or visible in health facilities to ensure personnel have access to information on protocols. Information should be clear, concise, and easily understandable. It should also include management of waste both in the facility and on the facility premises.

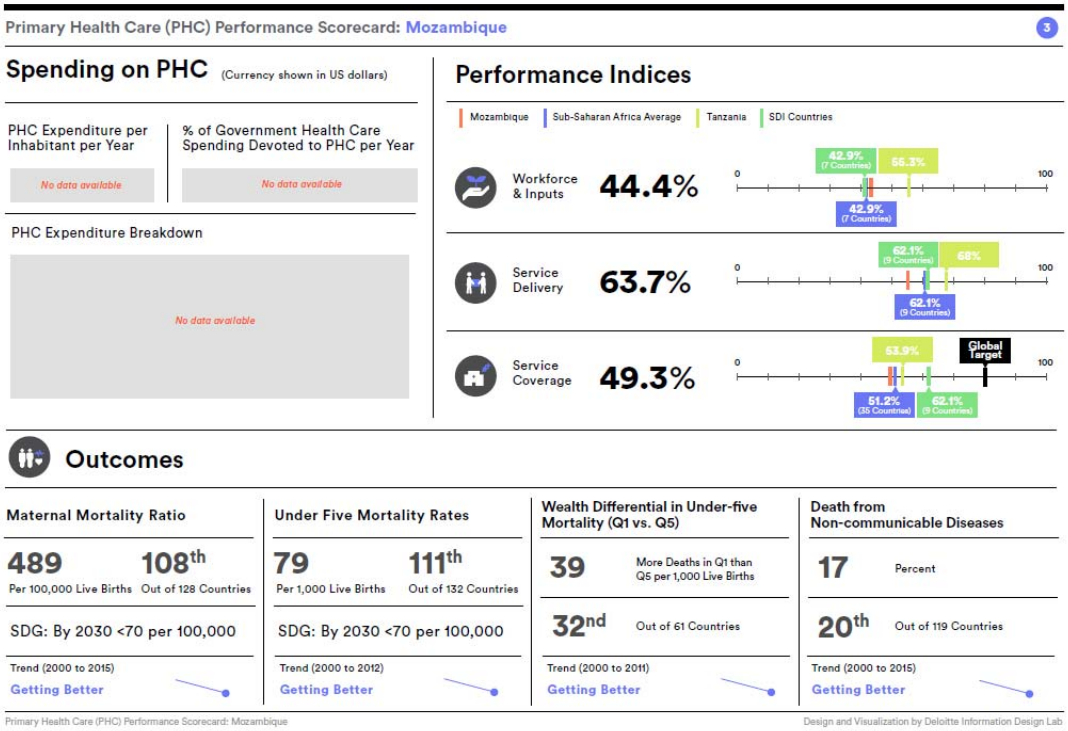
	MISAU, (ii) lead the review and enhancement of existing complaint handling mechanisms				personnel structure adjusted to integrate social specialist
17	**Gender and socio-cultural responsiveness (II)** Ensure approaches to gender and socio-cultural sensitivity are reflected in the curriculum and training of community health workers (APEs) and health center and district/rural hospital staff and supported by appropriate promotional/awareness materials (e.g. checklists, posters, videos)	☐	Within 12 months of Program effectiveness	MISAU (DRH, DNSP, Gender Unit)	PAP IR Curriculum Training materials available at health centers and district/rural hospitals Number of trained staff in general and per facility
18	**Gender and Socio-cultural Responsiveness (III)** Develop community-based intervention to engage men in family planning and sexual and reproductive health activities	☐	Within 12 months of Program effectiveness	MISAU (DNSP)	PAP IR Number of provinces or districts that have community-based interventions to engage men in family planning and sexual and reproductive health
19	**Gender and Socio-Cultural Responsiveness (IV)** Ensure gender-based violence is reflected in the curriculum of health professionals, including APEs	☐	Annual	MISAU (DNSP, DRH/Training Directorate ,Gender Unit)	PAP IR Curriculum Number of health professionals trained
20	**Gender and Socio-cultural Responsiveness (V)** Include prioritized[39] gender and socio-cultural sensitivity and GRM access dimensions in health facility scorecard and community consultations	☒	Within 24 months of Program effectiveness	MISAU (DNSP and DNAM)	Year 2 DLI validation Scorecard
21	**Enhancement of complaints handling mechanisms (GRM)** Ensure installation of complaint and suggestion boxes in all health		Yearly targets at 12, 24 and 36 months	MISAU (DNAM)	PAP IR Curricula and consultation protocols, score

[39] As identified in the Program Gender Analysis and the Ministry of Health Strategy for the Integration of Gender Equality and in the assessments of culturally appropriate service delivery (focused on avoiding bias, discrimination or stigma, and ensuring language and cultural sensitivity in service access and delivery procedures).

	facilities, training for health care providers, dissemination through community consultations, inclusion in scorecard				card Complaint reception and closure registry at facility and central levels

Annex 5. Primary Health Care Performance Scorecard: Mozambique





Performance Improvements

Each number represents the number of indicators

Worst 20th percentile Getting better

- Maternal Mortality
- Density of Nurses and Midwives (Workforce)
- TB Cases Detected and Treated
- Under-Five Mortality

Within middle 60% Stagnant

- ANC4
- DTP3 Coverage
- Adult Mortality from NCDs
- Care Seeking for Pneumonia
- TB Cases Treated

Within middle 60% Getting better

- Antiretroviral Therapy Coverage
- DTP3 Drop Out
- ORT Coverage

Best 20th percentile No trends

- Caseload per Provider

Worst 20th percentile Stagnant

- Needs Met with Modern Contraceptives
- Neonatal Deaths
- Skilled Attendants at Birth

Within middle 60% No trends

- Provider Absence
- Adherance to Guidelines
- Cost as a Barrier
- Diagnostic Accuracy
- Basic Equipment
- Equity in USM
- Proportion Sleeping Under Insecticide Treated Nets
- Facility Infrastructure
- Vaccine Availability

Worst 20th percentile No trends

- Distance as a Barrier
- Essential Drugs

Indicator Snapshot

Comparison to Tanzania

Maximum score is 5 out of 5

Antenatal Care
At least 4 antenatal care visits

1.1 Mozambique | 0.7 Tanzania | 1.6 Sub-Saharan Africa

Neither Mozambique nor Tanzania do well in ensuring women receive appropriate antenatal care in terms of the proportion of women receiving at least four antenatal care visits.

TB Cases Treated

3.9 Mozambique | 4.7 Tanzania | 2.3 Sub-Saharan Africa

Both Mozambique and Tanzania score relatively well in their ability to ensure that those diagnosed with TB complete the treatment protocol, scoring better than average over all LMICs and other Sub-Saharan African countries.

TB Cases Detected and Treated

0.6 Mozambique | 0.5 Tanzania | 1.5 Sub-Saharan Africa

Although both Mozambique and Tanzania do relatively well in ensuring that those diagnosed with TB complete their treatment, they score poorly when looking at the proportion of people with TB have their cases detected and then treated. This difference in the two TB indicators reflects the low estimated TB case detection rates in Mozambique (37%) and Tanzania (38%).

DTP3 Drop Out

1.1 Mozambique | 4.3 Tanzania | 2 Sub-Saharan Africa

The proportion of children who receive their first DPT dose but not their third is much higher in Mozambique than it is in Tanzania. In general, Sub-Saharan African countries do less well in this indicator compared to all LMICs.

NCD Deaths

4.2 Mozambique | 4.4 Tanzania | 2.7 Sub-Saharan Africa

The probability of an adult dying from a non-communicable disease is lower in both Mozambique and Tanzania than in all countries overall or other Sub-Saharan African countries.

Key Findings

Focus on improving the utilization and quality of reproductive, maternal, child and adolescent health and nutrition services, particularly in underserved areas.

Composite indices show performance gaps in availability of inputs, quality of service delivery and coverage of services for the population; results are relatively worse than in Tanzania and generally close to the sub-Saharan Africa average.

Overall performance assessment of PHC system in Mozambique shows several shortfalls in quality of care:

- Provider competence is weak with inadequate provider knowledge. As a result, diagnosis and treatment are inadequate for several conditions
- High levels of dropout for DPT3 immunization show little continuity in care delivery over time
- High level of absenteeism problematic for care continuity and coordination

ART coverage results better than Sub-Saharan Africa average , however service coverage still problematic for:

- Antenatal care coverage
- Family planning
- Proportion of population sleeping under insecticide treated nets

Indicators that compare poorly to other sub-Saharan Africa countries and show little sign of improvement are the % of women whose needs for modern contraceptives are met; neonatal death rates; and the % of skilled attendants at birth.

Despite recent improvement in health outcomes, the country is not yet on track to reach the health Sustainable Development Goals.