PROGRAM-FOR-RESULTS INFORMATION DOCUMENT (PID)
CONCEPT STAGE

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Program Name	Mozambique Primary Health Care Strengthening Program
Region	Africa
Country	Mozambique
Sector	Health, Nutrition, and Population
Lending Instrument	Program-for-Results
Program ID	P163541
{If Add. Fin.} **Parent Program ID**	
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Implementing Agency	Ministry of Health (MISAU)
Date PID Prepared	Mar 29, 2017
Estimated Date of Appraisal Completion	Aug 8, 2017
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Concept Review Decision	Following the review of the concept, the decision was taken to proceed with the preparation of the operation.
Other Decision *{Optional}*	

I. Introduction and Context

1. Prevailing fiscal pressures in Mozambique are likely to continue in the short to medium term. From 2002-2014, Gross Domestic Product (GDP) growth averaged 7 percent and the nation enjoyed macroeconomic stability. Nonetheless, such growth was not paralleled by expected poverty reduction, especially in rural areas and low-income urban areas. In 2016, low global commodity prices, climate related events (droughts and floods), and the recent revelation of previously undisclosed debts caused significant deterioration of the country's economy. As a result, 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 yield in increased public revenues. However, these capital-intensive megaprojects could also further accentuate Mozambique's pattern of non-inclusive growth, reinforced by limited human capital.

2. Social sector spending has been cut by 4.7 percent as a consequence of shrinking fiscal space. Flow of external funds to the health sector has also fallen considerably, as many donors have reduced or withheld direct budget and sector support in response to broader fiduciary concerns. This is particularly relevant for the health sector in Mozambique, where Development Assistance for Health (DAH) constitutes nearly 72 percent of total health expenditures (THE) (Health Public Expenditure Review - HPER, 2016). Other factors compounding the difficult macro-fiscal situation include low tax collection and currency depreciation.

3. Mozambique's fiscal and growth constraints could exacerbate formidable challenges for human development and the improvement of social indicators. While Mozambique has made important progress in some areas, such as the decline in infant and under-five mortality rates, the pace has been slower than expected for the country's level of economic development. Rapid population growth (2.5 percent) is higher than most countries in the region, and has increased dependency ratios and strained already weak public service delivery systems. In 2014, Mozambique ranked 178th out of 187 countries in the Human Development Index. Average life expectancy at birth is just 54 years, and the adult literacy rate is 56 percent. Limited progress has been achieved in improving water and sanitation, and malnutrition significantly worsened between the mid-1990s and 2011. Poverty rates and correlated epidemiological profiles are also marked by wide regional disparities, as highlighted in the recent HPER and Service Delivery Indicators (SDI).

4. In this context, spending efficiency will be critical to improve social development outcomes. The recent HPER and SDI survey further highlight significant opportunities for systemic reforms to strengthen service delivery performance. These reforms are needed to optimize health service delivery support systems, to improve allocative and technical efficiency, effectively target underserved populations, incentivize better performance at all levels, expand community-based and outreach population-based interventions, foster multi-sectoral collaboration, and ultimately enhance utilization and quality of health care. As fiscal pressures are expected to continue in the medium-term, improving efficiency and effectiveness is critical to boost social development outcomes. In the longer-term, stronger, more inclusive institutions, better delivery systems, and increased domestic financing for social sectors will be key to ensuring that expected resource revenues translate into inclusive growth.

B. Sectoral and Institutional Context

Uneven Progress on Health Outcomes

5. Over the past two decades, Mozambique has achieved mixed progress in improving health outcomes. While one Millennium Development Goal (MDG) was met by reducing under five mortalities, neonatal mortality remains a major challenge, requiring concerted efforts to accelerate its decline. Significant progress has been made in improving maternal health (MDG5), and in combating HIV/AIDS, Tuberculosis, Malaria and other infectious diseases (MDG6), however the corresponding MDGs have not been met. Advancements have resulted from improvements in access to services in health care facilities, and expanded outreach and community-based health interventions, as well as increased demand for care. Use of bed nets and access to safe water and sanitation (WASH) have also increased. From 2007-2015, the number of health centers increased by 48 percent, from 755 to 1,300, almost entirely due to an increase in the availability of the lowest level of care (Type II[1] health centers), which serve the most remote rural areas, where the vulnerable and marginalized often live. Since 2012, this expansion was complemented by a scale-up up in community-based interventions, with more than 3,500 community health workers known as *Agentes Polivalentes Elementares* (APE's) trained and deployed in villages at district level.

[1] Type II health centers are the smallest facilities providing Primary Health Care in rural areas: ANC, Immunizations, maternity services, IEC, etc.

6. Mozambique's progress on health outcomes and expenditure lags behind sub-regional and regional averages (Table 1). In all health status indicators Mozambique's ranks below the averages of the Southern African Development Community (SADC) with the exception of HIV prevalence, however the country fares better in relation to Sub-Saharan Africa (SSA) averages on U5MR, Neonatal mortality, and Maternal Mortality Ratio (MMR). Mozambique's THE per capita is below the average of the SADC and SSA. Country comparisons highlight that Mozambique can also achieve more with the current level of spending. For example, with less per capita health spending, Ethiopia achieved a lower Infant Mortality Rate (IMR) and MMR than Mozambique (HPER 2016).

Table 1: Selected indicators in Mozambique and averages of SADC and SSA [2]

Health Indicators	Mozambique		SADC average		SSA average	
	1990	**2015**	**1990**	**2015**	**1990**	**2015**
IMR per 1,000 LB	160	57	81.2	44.8	109	56
U5MR per 1,000 LB	240	79	125.2	62.7	181	83
NNMR per1,000LB	62	27	34.1	21.6	46	29
MMR per 100,000 LB	1,390	489	614	345	987	547
TFR (1990-2014)	6.2	5.4	5.4	4.0	6.4	5.0
HIV prevalence 15-49[3]	4.1	10.8[4]	9.0	10.9	5.1	4.9
Share of THE in GDP[5]	4.6	7.0	4.8	6.5	6.1	5.5
THE per capita (PPP)[4]	18	79	187	428	101	200

7. While increased utilization of health services has translated into positive health outcomes, results have been uneven, particularly for those in rural areas and the poorest quintiles, and for women and children (Table 2). From 2003 to 2015, utilization of maternal and child health services, family planning, and WASH have improved, while narrowing rural-urban gaps. In 2003, pregnant women in urban areas and those in the highest quintile were 2.4 and 3.6 times more likely to deliver their babies in a health facility, relative to their rural and poorest quintile peers, respectively. Women aged 15-49 in the highest quintile and in urban areas also had significantly higher utilization of modern contraceptive methods, and therefore had lower fertility rates. Despite improvements, rural-urban and income divides persist in both health service utilization and health outcome indicators. Similarly, the southern region fares better than the central and northern regions.

Table 2: Coverage and outcome indicators by urban and rural areas, and by income quintiles, 2003-2015

Coverage/Utilization Indicators	2003 (DHS)					2015 (IMASIDA)				
	Avg.	Urban	Rural	Q1	Q5	Avg.	Urban	Rural	Q1	Q5
Child birth at a health facility (%)	47.6	81.0	33.9	25.0	89.5	70.3	90.7	63.1	51.9	95.3
Children 12-23 months fully immunized (%)	63.3	80.5	56.0	45.2	90.3	65.8	77.9	61.7	52.7	85.1
Modern contraceptive prevalence rate 15-49	11.7	23.2	7.0	3.9	34.8	25.3	34.3	21.5	16.7	43.0
IPT for malaria prevention in pregnancy (%)[6]	18.6	26.0	15.7	16.6	25.1	34.2	43.4	31.0	27.1	39.7
Children <5 who slept under an ITN (%)[7]	35.7	42.2	33.1	32.4	39.6	47.9	53.6	45.9	41.1	57.0
Pregnant women who had ≥ 4 ANC visits (%)	53.1	70.7	45.2	N/A	N/A	54.6	65.4	50.9	42.7	72.6
Outcome indicators										

[2] WDI data for Mozambique, SADC, and SSA, except when indicated otherwise. The averages for SADC were calculated by the Bank staff

[3] Figures are for the period1995-2014

[4] Inquérito de Indicadores de imunização Malária e HIV e SIDA (IMASIDA), 2015

[5] THE = Total Health expenditures, WBI data, reference year 2014 (1997-2014)

[6] Intermittent Presumptive Treatment during antenatal visit, at least 2 doses of Fansidar/SP for malaria prevention, and the figures pertain to the DHS 2011.

[7] Data from the DHS 2011 and IMASIDA 2015

Stunting (% children<5)	41.0	29.2	45.7	49.3	20.0	42.6[8]	35.0	45.5	51.1	24.1
Total fertility rate (TFR)	5.5	4.4	6.1	6.3	3.8	5.3	3.6	5.1	N/A	N/A
Age specific fertility rate (15-19 per 1,000)	179	143	207	N/A	N/A	194	134	230	N/A	N/A
Adolescent 15-19 who became mothers or pregnant for first time (%)	41	32	49	60.5	24.6	46.4	35.0	54.0	61.4	26.0
Malaria prevalence among children <5 (5%)	38.3[9]	16.8	46.3	54.9	5.6	40.2	19.4	47.0	60.5	7.4
	2008/9 Household survey					**2014/15 Household Survey**				
Water and sanitation indicators										
HH use of water from a safe source (%)	40.5	64.7	30.5	28.6	64.3	50.9	83.1	36.7	33.2	84.0
HH use of improved latrine (%)	16.0	41.6	5.5	2.6	47.0	20.6	39.0	12.5	9.9	35.4

Note: Q1: Poorest quintile; Q5 Wealthiest quintile

8. At an early stage of demographic transition with an excessively high fertility rate, Mozambique faces significant challenges for human development, per capita economic growth, and poverty reduction. The persistently high total fertility rate, particularly the increasing fertility rate among adolescent girls residing in rural areas, warrants stronger and continued efforts to prioritize reproductive health services in the most under-served areas. Equally important is the need to address educational attainment, in particular for girls, and empowering women to take informed decisions concerning contraception and reproductive health. Thus far, the proportion of adolescents who became mothers or pregnant for the first time increased nationwide, in urban and rural areas and in both the poorest and wealthiest quintiles, when compared to 2003 figures. Relatively higher fertility is associated with poor pregnancy outcomes, increased risk of maternal death, and high levels of stunting, particularly among adolescent. These trends have also contributed to accelerated population growth, resulting in a very young age structure and high dependency ratios.

9. Investing in early childhood development can bring significant returns. The nutritional status of mothers and children is a key contributor to ensuring children can realize their physical and cognitive potential. In Mozambique, chronic malnutrition (stunting) is severe, affecting 43 percent of children under five, and will likely have detrimental and irreversible effects on human capital formation. Contributing factors include lack of dietary diversity and inadequate child feeding practices, in particular, low rates of exclusive breastfeeding and appropriate complementary feeding. This is compounded by the high burden of diseases such as acute respiratory infections, malaria, and diarrhea, and widespread lack of access to clean water and sanitation. In addition to the immediate consequences of malnutrition in early childhood in terms of higher burdens of morbidity and mortality include cognitive and physical impairment, and lower productivity and life-time earning potential. Stunting is particularly severe in 6 of the 11 provinces in the northern and central regions of Mozambique, where recorded levels are above 41 percent.

10. Recognizing the severity of the problem, the Government designed a Multi-Sectoral Action Plan to Reduce Chronic Malnutrition (PAMRDC). A key feature of the PAMRDC is its multi-sectoral approach to undernutrition and related challenges for children from age 0-24 months. The World Bank financed the health component of the PAMRDC through the provision of Additional Financing to the ongoing Health Service Delivery Project, which targets the 3 Northern provinces with the worst child stunting rates in the country: *Niassa* (46.8%), *Cabo Delgado* (52.8%), and *Nampula* (55.3%) (DHS 2011).

[8] The figures are from the DHS 2011 as IMASIDA did not collect nutritional data.
[9] Figures from 2011 DHS

11. Finally, malaria control and prevention warrants special attention and focus given its deleterious effects on pregnancy outcomes and child health. Malaria contributes to 35 percent of child mortality, despite the availability of cost-effective, quickly scalable interventions to prevent it (e.g. bed nets). The proportion of children who slept under an insecticide treated nets (ITNs) increased from 2011 to 2015, however only less than half of children under-five did so in 2015. ITNs and indoor residual spraying should be scaled up and target children and pregnant women because they are highly vulnerable to malaria. Low levels of adherence to clinical guidelines also contributes to easily preventable morbidity and mortality among children, of which malaria remains the most common cause. As shown in Table 2, from 2003 to 2015, the use of intermittent preventive treatment (IPT) for malaria prevention during pregnancy improved, but only for slightly over a third of pregnant women. There is scope to reach more pregnant women with IPT as only around half of them had four or more antenatal care (ANC) visits.

Health Systems Challenges

12. A renewed focus in health system performance is paramount to improve health outcomes. The SDI survey brought to light a myriad of input, process and governance factors hampering access and quality of health care. For example, 23.4 percent of health workers were absent from their work stations at the time of the SDI survey. Only 58.3 percent of health care providers correctly diagnosed five selected tracer cases; only 37.4 percent adhered to clinical guidelines; and only 29.9 percent followed the protocol for management of maternal and neonatal complications. In addition, key inputs were missing and/or dysfunctional: only a dismal 34 percent of facilities were found to meet the basic infrastructure requirements (simultaneous availability of clean water, improved sanitation, and electricity). Of facilities surveyed, only 42.7 percent of priority drugs were in stock and not expired. These statistics cover both hospital and health centers. Hospital perform better than health centers overall, but neither meet basic service delivery standards. While health centers are critical for maternal and child health promotion, forty percent of deliveries occur at district hospitals, which are the first line of reference for specialized care and the delivery of core emergency obstetric and neonatal services.

13. A range of health systems challenges contribute to low access and quality of care:

a. **Mozambique health worker density is the lowest by sub regional and regional standards.** There are 100 health professionals per 100,000 inhabitants, below the WHO standard of 230, leading to high caseload per health professional (SDI). This is linked to insufficient current levels of per capita health expenditure (US $33, PPP equivalent US $79). The SDI report also observes that inadequate provider knowledge and low motivation/efforts result in sub-optimal utilization of paid staff time.

b. **Inequitable distribution of both financial and human resources exacerbates the health workforce shortage.** The existing workforce composition is inefficiently skewed towards more administrative staff, particularly in provinces with lower health worker to population ratios (HPER). While administrative functions are gradually being deconcentrated,

institutional structures remain top-heavy.[10] Fiscal transfers from central to provincial and district levels lack clear, transparent linkages to needs, while tending to disadvantage lower tier facilities that are already overburdened and under-resourced. Some valuable infrastructure is also underutilized due to lack of clinical staff and maintenance. Allocations from donors through the sector common fund to *fora do quadro*[11] administrative staff, lunch allowances and bonuses to central level Ministry of Health (MISAU) staff have also been excessive and have not necessarily contributed to improved results.

c. **Low accountability for results at all levels reinforces inadequacies in provider capacities.** Health facilities do not have any clear service delivery and performance targets to promote accountability for results and enable benchmarking. This is exacerbated by ineffective leave management and internal controls, and weak systems for provider education, in-service training, and career progression, all of which affect staff morale and productivity.

d. **Cumbersome budget systems and fiduciary challenges impede the efficiency of health spending.** Ineffective planning processes result in inefficiencies, misallocations, and shortfalls,[12] aggravated by unpredictability of donor support. Public financial management capacities are limited, particularly at decentralized levels. Significant personnel time is absorbed in outsourceable noncore functions (e.g. cleaning, catering, distribution and transportation of food, medicines, and patients), and user fee policies lack adequate rationalization.

e. **The fragmented and skewed nature of external health financing compounds health expenditure inefficiencies.** The high proportion of vertical financing (64 percent - most of which is disease-specific, with HIV/AIDS having the largest expenditure) has constrained the effectiveness of health financing. In this context, the common fund PROSAUDE was unable to mobilize significant resources (7 percent of THE in 2013), and been further reduced as a result of health partners' (HPs) fiduciary concerns.

Box 1. PROSAUDE
In 2003, MISAU and Health Partners (HPs) established PROSAUDE in the context of the Sector Wide Approach to programming. PROSAUDE was designed to finance the Health Sector Strategic Plan (PESS 2001-2005), improve coordination, and maximize aid efficiency. Notwithstanding its significant gains, namely, more flexibility to respond to arising needs, and to support recurrent costs for provinces and districts, the recent spending pattern shifted disproportionately to staff salaries (*fora do quadro*) and bonuses. This situation has led to a lengthy process of revision of the Memorandum of Understanding (MOU) and Procedures Manual. This included provisions enabling the introduction of results-based financing (a key concern of many HP), and specification of ineligible expenditure

Going Forward - Investment Case (the 'program')

[10] According to the PER (2016), improving efficiency at the Provincial level alone could finance 7% of the financing gap for the essential services package (US$53/capita). There is also low perceived autonomy at the health facility level in terms of decision-making. More than half of facility directors surveyed felt that day-to-day decision making power for their institutions resided mainly with district governments, which they reportedly lacked the capacity to meaningfully influence. (SDI 2015)
[11] Personnel engaged outside the government payroll system.
[12] E.g. discrepancies between multiple budgets prepared based on needs, indicative ceilings and final allocations, reprogramming for allocated budgets when annual spending has already commenced, high burdens of monthly financial programming, increasing unplanned debts of UGEs with contractors, etc.

14. **The government has developed a five-year Investment Case (the 'program') for enhanced delivery of Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) and Nutrition services.** The Investment Case (IC) aims to serve as the main sector investment program, and to which all HPs will align their funding to the sector. It also aims to develop capacity for the National Health Service as a whole. It ensures effective prioritization of health resources through the government's own-budget and development partners, with better alignment of vertical disease programs and strengthening health systems. The IC comprises both the *Plano Económico e Social* (PES) – which includes government and PROSAUDE on-budget and on-Treasury Single Account (CUT) health expenditure, as well as other off-budget, off-CUT financing streams. The proposed PforR operation will finance part of the IC's PES component (the '**Program**').

C. Relationship to CPF

15. The proposed operation to support the IC is aligned with Mozambique's Country Partnership Framework (CPF), which sets out the World Bank Group's proposed strategy for FY16-20. In particular, Objective 5 for "Improving Health Service Delivery", within Pillar 2 of "Investing in Human Capital," identifies strengthening health institutions as a key objective, based on the overwhelming evidence that doing so can contribute to improve the impact of expenditures on health outcomes. In particular, the CPF highlights the critical need to focus on early childhood development and accelerate the demographic transition. This focus has been informed by the Systematic Country Diagnostic, particularly Priority 8, which points to critical needs to strengthen public health institutions. The proposed operation's design is also aligned with the CPF's approach to mainstreaming Governance to improve service delivery. All in all, the operation will contribute to the World Bank's twin goals of eliminating extreme poverty and promoting shared prosperity by investing in human capital, with a focus on vulnerable populations and underserved areas.

II. Program Development Objective(s)

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

Key Program Results

- Percentage of Institutional Deliveries in rural areas of 6 lagging Provinces (Zambézia, Nampula, Tete, Sofala, Maputo Province, and Cabo Delgado) (DLI 1)
- Percentage of women aged 15-49 using modern family planning methods, particularly among women aged 15-19 (DLI 3)
- Percentage of children 0-24 months of age receiving the established Growth Monitoring and Promotion (GMP) package of nutrition services in the 5 most lagging Provinces (DLI 4)
- Improved general, rural and district hospital performance[13] through benchmarking (DLI 8)

[13] The focus on general, rural and district hospitals is justified because they are the first line of reference for specialized care. They support primary health care facilities

III. Program Description

16. The proposed PforR operation will finance part of the IC's PES component (the 'Program'). The IC includes both the PES component that comprises on-budget and on-CUT health expenditures, as well as the vertical interventions financed off the budget by HPs. As mentioned above, the IC was developed to operationalize key priorities of the Government's PESS, which orients all interventions in the sector, and is guided by the Government's Five-Year Plan and Poverty Reduction Plan. The objectives of the IC are: 1) to define priorities for the best possible allocation of additional resources to achieve better results in RMNCAH; and 2) to contribute to the strengthening of resource management capabilities and the provision of quality care by the National Health Service. Despite the IC's delimitation of strategic goals for improving the health of specific population groups, its expected impact includes catalytic changes and reforms in both the organization and operation of the public health system, in coordination with other actors. The timeline of its costed implementation strategy runs from 2017 to 2022.

17. The Word Bank and GFF will participate in the implementation of the IC through the proposed Primary Health Care Strengthening Program (the 'Program). The Program will specifically support three focus areas of the Investment Case. The first is for enhancing coverage, quality, and access to essential primary health care services, including outreach and community level interventions. The second area focuses on strengthening stewardship functions and improve efficiency and effectiveness of service delivery, through a range of systems strengthening interventions, with relevant linkages to strategically selected high-level indicators. Finally, the third seeks to enable MISAU to effectively manage the implementation of the IC, through technical assistance, capacity building, monitoring and evaluation (including civil registration and vital statistics), and donor coordination activities.

What will the PforR Program comprise?

18. The Program will comprise activities under three complementary areas of IC: 1) ***enhancing coverage, access, and quality of primary health care services***, including high-impact supply and demand-side interventions, with a focus on underserved areas; **2)** ***strengthening of the health system*** for improved stewardship, efficiency, and effectiveness of service delivery (with relevant linkages to high level targets); and **3)** ***enabling MISAU to effectively manage the implementation of the IC***, through technical assistance, capacity building, monitoring and evaluation, and donor coordination activities.

19. Specific activities are being identified to be carried out under the proposed Program as part of IC implementation. The Program will specifically support enhanced maternal, neonatal, child, and adolescent health, nutrition, and family planning, in addition to systemic improvements to improve equitable distribution of health resources and accountability to results at all levels (including wider, more coordinated mobilization of community health workers). The implementation approach includes improving alignment of tracking and monitoring instruments, strengthening institutional collaboration to address multi-sectoral challenges; enhancing coordination with vertical programs; and strengthening linkages between central, provincial,

district, and facility levels, and between community-based service delivery and different levels of care. The IC provides a robust guiding framework for prioritizing high-impact interventions, drawing from international best practices, and from the findings and lessons from the World Bank's ample analytical work (e.g. Demographic Dividends, PER, SDI, and other Advisory Services and Analytics -ASA) and operational portfolio in the sector. This includes projects that have promoted greater integration of community outreach with health facility-based care (HSDP, FY09-FY17), and the engagement of communities to tackle key impediments to early childhood development through improved nutrition and feeding practices (HSDP additional financing), and early stimulation (Education Sector Support Project). It also includes pilots in the use of social audits to strengthen accountability for improved maternal health outcomes in six districts (GPSA, FY14-18), and experience in promoting systems improvements to strengthen medicines' supply chains under the PFM for Results PforR, as well as other health sector PforR implemented internationally.

20. The Program will include a high degree of technical assistance, capacity development, coordination, and monitoring activities to support the 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. Achievement of results will also require the alignment of incentives and capacities at central, provincial, district, and facility levels (including through the design of institutional performance-based allocations), and improved coordination between community-based service delivery and different levels of care. The team will work with a range of government counterparts to ensure that these components are integrated into the program's design and financing structure. The World Bank is also initiating technical assistance to provide relevant groundwork for the operation. This includes, through the Improving Value-for-Money in Mozambique's Health Sector ASA, support to the design of a more equitable resource allocation formula for health investment expenditure, preparatory work for the roll out of institutional incentive schemes, citizen scorecards, and social audits in health facilities, and research on options for scaling successful interventions to improve the supply and demand for health commodities such as contraceptives and nutrition supplements.

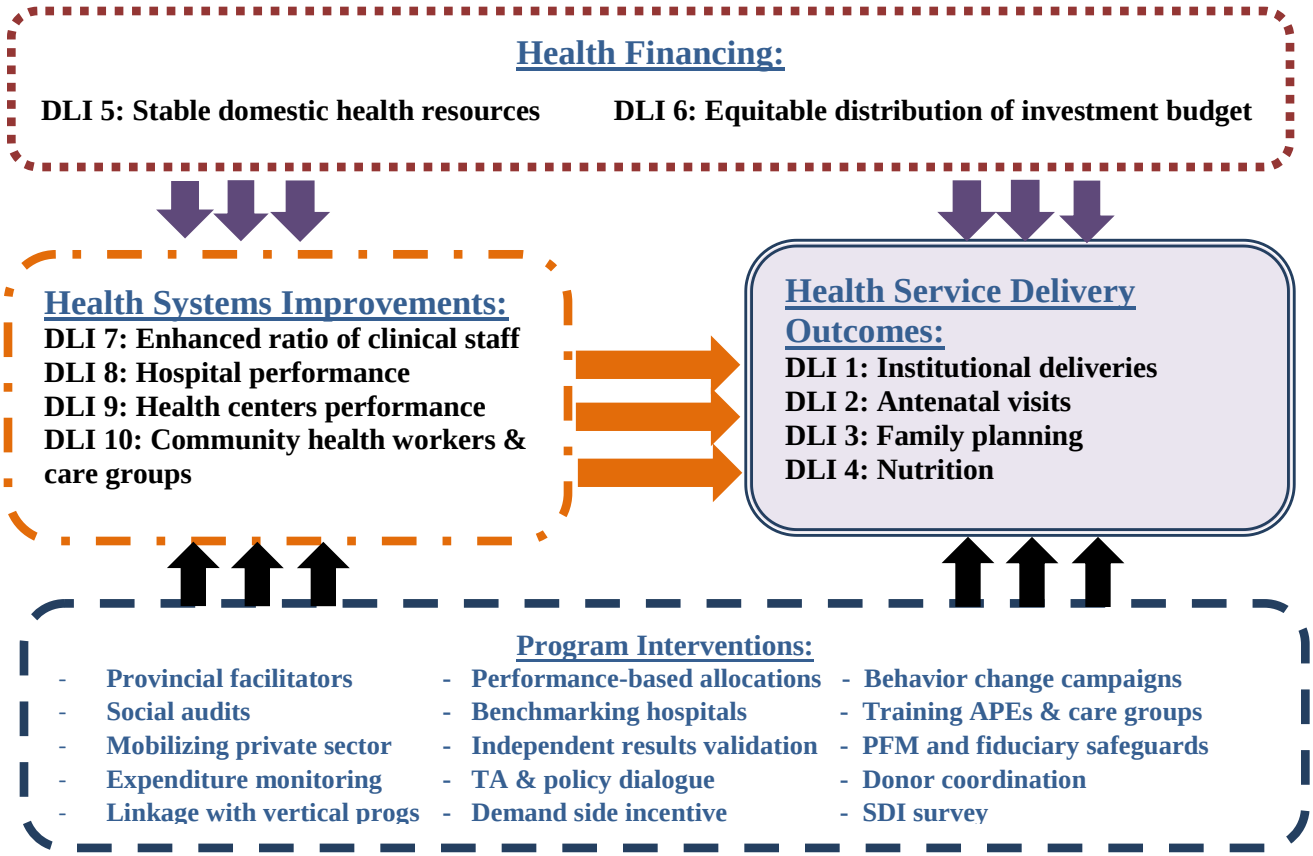
Gender will be a cross-cutting consideration of the Program, in terms of analysis, target groups, and specific interventions to address social norms and inequalities. The IC will provide an opportunity to align existing and planned government and HP interventions for gender equality. This will be guided by MISAU's Strategy for the Inclusion of Gender Equality in the Health Sector, and through structured collaboration with the Ministry of Gender, Children and Social Action (MGCSA), the Ministry of Education and Human Development (MINEDH), and HPs' interventions for the promotion of gender equality. It will also draw from prioritized interventions highlighted in the IC to address the socioeconomic and gender inequalities and social determinants that shape maternal and child health challenges and service delivery barriers, particularly for reducing teenage pregnancy and child marriage, presenting alternatives to large family models, promoting healthier practices for sexual and reproductive health and nutrition, and encouraging health service use. As the IC observes, addressing gender norms and cultural influences will require partnerships outside the health system, including NGOs and community organizations, schools, and private health service providers, as well as local and opinion leaders. It will also require the implementation of gender and culturally sensitive and youth-friendly

interventions for promoting access to information and services and encouraging behavioral change. This section should then provide an overview of the specific elements of the government program that is to be supported by the proposed operation, highlighting, in particular, modifications to the program that may be discussed with government in light of the initial findings, discussed in Section IV below (i.e., technical, fiduciary, environmental and social systems, and integrated risk assessment). If possible, this section should also include an initial proposal regarding DLIs, such as the nature of DLIs (i.e., whether they will be outcomes, outputs or intermediate outputs and/or actions).

Disbursement-Linked Indicators

21. The proposed PforR operation will disburse based on achievement of pre-agreed targets for a set of Disbursement-Linked Indicators (DLIs). An initial set of 10 DLIs were identified jointly with MISAU and HPs (see Table 3). Focus on underserved populations and institutional performance, with the underlying aim of improving the quality of services, constitute cross-cutting themes of DLI design. To ensure predictable financing for enhanced service delivery and essential technical assistance/capacity building, the periodic disbursements will be scalable on the number and extent of achievement of DLIs. A more detailed draft DLI matrix is provided in Annex 3, with a presentation of the underlying theory of change in Annex 4. The matrix will be refined through an ongoing participatory process, engaging relevant stakeholders from the Government and HPs. A detailed technical note will be developed for each DLI, which will document the indicator definition, baseline and targets, implementation and data collection responsibilities, validation protocols, underlying performance-based allocations to selected institutions, etc. Diagram A below presents a schematic view of how DLIs focusing on health financing, health systems improvement, and health service delivery outcomes are supported by various Program interventions.

Diagram A: Disbursement-linked Indicators and Program Interventions



22. The DLIs are being structured through an appropriate mix of high level and intermediate results, balancing ambition and feasibility. Based on the SMART principle, select indicators will draw from the existing 5-year monitoring framework of the IC. Others that are not part of the IC – for example, on disbursement and expenditure, human resource management, and accountability measures at the community/facility level – will be included to incentive systems strengthening and service delivery performance. 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 Credit/Grant) would be recommended at the time of the operation's effectiveness to support activities required to achieve results. Higher weight will also be given to process indicators to initiate results, with a subsequent shift in emphasis to output and outcome indicators.

Table 3: Disbursement-Linked Indicators

DLI 1: Percentage of Institutional Deliveries in rural areas of 6 lagging Provinces *(Zambézia, Nampula, Tete, Sofala, Maputo Province, and Cabo Delgado)*
DLI 2: Percentage of pregnant women who had 4 or more antenatal visits
DLI 3: Percentage of women aged 15-49 using modern family planning methods, particularly among women aged 15-19
DLI 4: Percentage of children 0-24 months of age receiving the established Growth Monitoring and Promotion (GMP) package of nutrition services in the 5 most lagging Provinces
DLI 5: Current health expenditure per capita financed from domestic sources
DLI 6: Increased health investments made [from domestic sources and the common fund] in historically underserved districts using clearly defined criteria for respective fiscal and infrastructure needs in a formula
DLI 7: Improved ratio of staff performing clinical and specialized functions compared to general/ administrative functions
DLI 8: Incentivize improved general, rural, and district hospital performance through benchmarking on a combination of administrative, public financial management, and service delivery criteria
DLI 9: Incentivize improved health center performance through social audits (including resolution of district-level PFM impediments)
DLI 10: Enhanced outreach to underserved populations through community health workers (APEs) (including increased number of APEs, Care Groups trained, and APE referrals to health centers)

IV. Initial Environmental and Social Screening

23. It is anticipated that the proposed Program activities will have positive social and environmental impacts, as they seek to address poor hygiene, malnutrition, and lack of adequate family planning. The program will enhance coverage, quality, and access to essential primary health care services, including outreach and community level interventions. Despite the anticipated positive social and environmental impacts, potential adverse impacts must be adequately identified and dealt with appropriately. These range from challenges in the management of expired medicines to management of hospital waste (which remains a major issue in many health units in the country), as well as investments in health infrastructure.

24. In order to assess the consistence of the Mozambique Primary Health Care Strengthening

Program-for-Results with core principles of OP/BP 9.00, PforR Financing, the borrower Environmental and Social System will be assessed. The Environmental and Social System Assessment (ESSA) will focus on the already identified concerns on management of expired medicines and hospital waste, while assessing the Borrower institutional arrangements and provisions in place to adequately mitigate potential adverse impacts.

25. The ESSA will also assess the Sector Environmental and Social Regulatory framework applicable to the program, taking in consideration lessons learned from current and past PforRs for the Health sector, while assessing the role of key institutions with regards to the provisions of the legal and regulatory framework as well as the Implementing Agency regulatory system for safeguarding environment and human being from degradation. The estimated date of completion of the assessments is June 30, 2017.

26. Based on the assessment results a Program Action Plan will be proposed to address identified risks and gaps. The ESSA findings and recommendations will be discussed with the Government in a participatory manner and will be publicly disclosed in-country and in the info shop prior to appraisal.

27. The ESSA will include gender analysis to identify relevant gaps between women and men, boys and girls, particularly as they relate to the Bank's broader country engagement framework (e.g. CPF, SCD, MISAU's Strategy for the Inclusion of Gender Equality in the Health Sector, etc.). This analysis will be used to identify specific actions that can be supported by the program, to be linked with relevant indicators in the results framework. This analysis will also focus on how the operation will contribute to the four pillars of the World Bank Group Gender Strategy 2016-2023 (to narrow gaps between males and females in human endowments, more and better jobs, ownership and control of assets, and voice and agency).

V. Tentative financing

		($m.)
Source:		
Borrower/Recipient		725.00
IBRD		
IDA/GFF		105.00
Others (Health Partners)		100.00
	Total	930.00

VI. Contact point

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