Accelerating RMH Outcomes: Rapid Assessment and Investment Options for DFID

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<tr>
<td>ACA</td>
<td>Annual Joint Government-Cooperation Partners’ Evaluation</td>
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<td>ANC</td>
<td>Ante-natal Care</td>
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<td>APE</td>
<td>Community Health Workers <em>(Agente Polivalente Elementar)</em></td>
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<td>BEmONC</td>
<td>Basic Emergency Obstetric and Neonatal Care</td>
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<td>CBO</td>
<td>Community-based Organization</td>
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<td>CEmONC</td>
<td>Comprehensive Emergency Obstetrics and Neonatal Care</td>
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<td>CEP</td>
<td>Citizen Engagement Program</td>
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<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
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<td>CIP</td>
<td>Center for Public Integrity <em>(Centro de Integridade Publica)</em></td>
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<td>CME</td>
<td>Continuing Medical Education</td>
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<td>CUT</td>
<td><em>Conta Única do Tesouro</em></td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>DLI</td>
<td>Disbursement Linked Indicators</td>
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<td>DPC</td>
<td>Directorate for Planning and Cooperation</td>
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<td>EGPAF</td>
<td>Elizabeth Glazer Pediatric AIDS Foundation</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccine</td>
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<td>GF</td>
<td>Global Fund</td>
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<td>GFF</td>
<td>Global Financing Facility</td>
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<td>GRM</td>
<td>Government of the Republic of Mozambique</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>IFE</td>
<td>External Funds Survey <em>(Inquerito de Fundos Externos)</em></td>
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<td>IFPP</td>
<td>Integrated Family Planning Program</td>
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<td>IGS</td>
<td>General Health Inspection <em>(Inspecao Geral de Saude)</em></td>
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<td>INE</td>
<td>National Statistics Institute</td>
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<td>INS</td>
<td>National Institute for Health</td>
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<td>IOF</td>
<td>Household Expenditure Survey <em>(Inquerito de Orçamento Familiar)</em></td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MCHIP</td>
<td>Maternal and Child Health Integrated Program</td>
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<td>MCSP</td>
<td>Maternal and Child Survival Program</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>NHA</td>
<td>National Health Accounts</td>
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<td>OVC</td>
<td>Orphans and Other Vulnerable Children</td>
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<td>PBF</td>
<td>Performance-based Financing</td>
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<td>PEFA</td>
<td>Public Expenditure and Financial Accountability</td>
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<td>PES</td>
<td>Socio-Economic Plan (<em>Plano Economico-Social</em>)</td>
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<td>PESS</td>
<td>Health Sector Strategic Plan (<em>Plano Estrategico do Sector da Saúde</em>)</td>
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<td>PfR</td>
<td>Pay for Performance</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission of HIV/AIDS</td>
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<td>PMU</td>
<td>Project Management Unit</td>
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<td>RMNH</td>
<td>Reproductive, Maternal and Neonatal health</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>UNICEF</td>
<td>United Nations International Children's Emergency Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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EXECUTIVE SUMMARY

Progress towards reducing maternal mortality in Mozambique has stalled since 2003, with indications that it has worsened over the last few years. At the same time, modern contraceptive utilization has been steadily decreasing over the last decade and is by far the lowest in the region. Challenges in governance and resource shortages have limited the country’s capacity to meet its service delivery needs. Within this context, DFID is committed to restructuring its foreign assistance engagement into the health sector to optimize value for money, drive systems change, and maximize impact.

System factors constraining RMNH improvements

The gaps in service delivery are many, and vary by province. That said, there are several themes that consistently occur. Geographic access to health services is limited, both due to the insufficient number of facilities as well as inadequate transportation services. Consequently, referral delays are frequent and result in poor maternal outcomes. When accessed, services themselves are of sub-optimal quality. Facilities often lack the basic infrastructure, equipment, medicines, and commodities to adequately care for patients. The system suffers from a poor distribution of health workers, who are often undertrained and under-motivated. Neither health workers nor their management are incentivized to drive systems improvements. Consequently, the patient is often treated without dignity, and has limited formal recourse to voice their input into the system. Consequently, many women continue to prefer traditional care, and just over half of pregnant women deliver in the formal system.

The Government of Mozambique has clearly recognized the urgent need to reduce maternal mortality, and has made public political commitments towards this end from the highest levels of government. That said, the implementation of this commitment has faced many challenges. Policies governing RMNH are fragmented and an overall strategy to tackle the challenges does not exist. Similarly, there are a multitude of partners supporting RMNH using a variety of aid modalities, however their activities are not meaningfully coordinated nor are they held accountable for delivering results. National planning and budgeting systems do not allow for adequate resource prioritization for RMNH, especially at the provincial level.

Development partners’ response to date

The development partner community is supporting improvements in RMNH outcomes through a variety of aid modalities. The common basket fund, PROSAUDE, has faced many challenges related to use of funds, transparency, and accountability for results. Therefore, most partners are seeking alternative support strategies. The Global Finance Facility, a multi-country initiative implemented by the World Bank, holds promise as a potential alternative, however capacity constraints in designing and executing the mechanism could delay implementation. Recognizing the need to provide local support, there is a trend in the donor community to provide provincial-level support, either through projects or direct funding. Many development partners are providing direct technical assistance at the service delivery level, with USG among the largest. These partners must also invest in their own capacity to manage and guide service providers, which requires greater manpower than typical financial aid modalities. By in large, the aid modalities implemented by development partners are not performance-based and, thus, do not deliberately create incentives for results.
**The path forward for DFID**

The assessment team recommends a bold but reasoned strategy to break through the bottlenecks inhibiting strong RMNH outcomes. Our approach consists of three core components: 1) performance-based financial aid; 2) focused technical assistance to improve service delivery; and 3) supporting the establishment and implementation of a national accountability framework for RMNH.

DFID has historically provided financial aid to the Government of Mozambique and is well placed to continue doing so. To improve the effectiveness of this approach, we recommend targeting financial aid on an off-CUT basis to the provincial level, and linking disbursement to the achievement of key RMNH results. This will enhance traceability of funds, as well as attribution to DFID. In addition, DFID should consider implementing performance-based financing at the health facility level in its target provinces. Experience in Mozambique has shown this approach to not only motivate health staff, but also to catalyze broader systems improvements.

The assessment found that while many development partners were engaged in service delivery technical assistance, they were not taking a comprehensive approach but rather focusing on particular priority gaps. Therefore, we recommend that DFID conduct a thorough assessment on key service delivery gaps in its target provinces, and provide focused technical assistance to cover those gaps. This assistance should include both routine strengthening support (Annex 5) as well as piloting and mainstreaming innovations (Annex 6).

Finally, it is clear that a great deal of interest and commitment exists in Mozambique to improve RMNH. That said, the approach is not coordinated, nor are actors held accountable for resources or results. The MOH has expressed a strong desire to improve governance of the RMNH approach and DFID is well placed to provide this support. Specifically, DFID could support the development of a national RMNH accountability framework, provide key analytics to support this framework, and support activities such as resource tracking and results reviews. In addition, DFID could further generate accountability for RMNH by leveraging its deep experience in participatory governance in targeted provinces. Activities would focus on building systems for greater civic engagement, patient redress, and overall responsiveness of the system to the population.

**Operationalizing the vision**

The team recommends targeting the approach to geographies that have limited support from other donors. This will minimize transaction costs related to coordination, allow for greater attribution, and serve to improve the equity of provincial support. As suggested by the MoH and concurred by the assessment team, Manica and Inhambane are ideal provinces to target. Executing the three-pronged approach to improving RMNH will require a mix of aid modalities. Up to three service providers are recommended to provide technical assistance for civic engagement, service delivery strengthening, and central-level support for accountability. In addition, a direct-to-government disbursement mechanism is needed to provide off-CUT provincial financial aid. Focused policy engagement by DFID is also a key element to this approach, thus several DFID staff will need to be regularly engaged with the MOH and selected provinces to shepherd this program. Examples of engagement include agreeing on DLIs, jointly developing an accountability framework, and results monitoring.
1 OBJECTIVES

DFID is currently in the process of examining options for supporting the Mozambican health sector for the next five-year period. DFID’s core objectives are to have a measurable and attributable positive impact on maternal and neonatal health, as Mozambique performance in these areas is still below expectations. DFID also strives to empower women by improving access to and usage of modern family planning methods, especially among adolescents who are the backbone of economic development and yet bare a disproportionately high burden of maternal mortality. To accomplish these goals, DFID strives to strengthen the Mozambican health system to enable improvements in reproductive, maternal, and neonatal health (RMNH) indicators, underpinned by an active engagement in the national policy dialogue.

In this context, the objective of this assessment was to examine options for DFID engagement in the coming five-year period. Our approach has been to 1) assess the current landscape of health systems barriers; 2) assess the effectiveness of existing aid modalities, and 3) recommend an assistance framework that would present high value for money. The results of this assessment are ultimately to be used to define a strategy and develop a strong business case for investment into the health sector.

2 METHODOLOGY

An independent team consisting of mixed national and international experts conducted the assessment. The methodology for completing this assessment consisted of two main components: 1) desk review of relevant documents and 2) semi-structured interviews with key stakeholders. Using these two methods, four key steps were undertaken to identify aid modalities with the highest potential to achieve DFID’s objectives:

We first conducted an assessment of the current state of maternal and neonatal health and family planning in Mozambique and looked at the key service delivery barriers for improving RMNH and FP. To do this, we reviewed available documents, surveys, studies, and national policies, and interviewed key government officials, donors, and implementing partners involved with service delivery.

Second, we looked at current accountability mechanisms in place in the RMNCH, and analyzed the bottlenecks for improved tracking and delivery of current interventions implemented by various stakeholders, from donors, to private sector and civil society.

We then completed a mapping of aid modalities in the Mozambican health sector through interviews with all major donors in country. We looked at each modality’s potential for impact, efficiency, required financial management arrangement, and alignment with both DIFD and government objective.

Based on preliminary assessment results, as well as recommendations from DIFD and MISAU, the team visited Manica and Inhambane to reality test our results.

3 CONTEXT

3.1 HEALTH STATISTICS

The maternal mortality rate (MMR) in Mozambique is persistently high at 489/100,000 live births. Mozambique made remarkable progress in reducing MMR in the first decade
following the civil war, although this is mainly attributable to an extremely high baseline of almost 1,400. However, it has not made much headway since 2003. Not only did MMR stall between the 2003 and 2011 DHS surveys, but the most recent revision of MMR also demonstrates an increase from 408 in 2011 to 489 in 2015 (WHO, et al., 2015). At 489, Mozambique’s MMR remains among the highest in the world, and the second highest in the region behind Malawi (634). This situation translates to approximately 13 women dying every day, and 4,820 dying every year.

Graph 1: Maternal Mortality Rate in Mozambique (1990-2015)

Decreasing family planning utilization has contributed to a rise in total fertility from 5.5 to 5.9 from 2003 to 2011 (DHS). According to the 2011 DHS, utilization of family planning (FP) in Mozambique decreased from 2003 (18.2%) to 2011 (11.3%). This is by far the lowest modern contraception use rate in the region, when compared to Swaziland (63%), Botswana (52%), Lesotho (46%), Malawi (42%), Mauritius (39%), Zambia (33%), and other countries (PRB, 2013). In Mozambique, FP utilization rates are associated with place of residence (urban), education, and wealth. Use of contraceptives is lower among adolescent girls (8.4%) than among any other reproductive age group. A scant 5.9% of married adolescents use contraceptives, compared to 26.9% among their sexually active unmarried counterparts, indicating high incidence of young pregnancies (DHS, 2011).

Low rates of FP utilization have severe implications particularly for young and very young pregnancies, and pregnancies in women with a high number of children. Teen pregnancy rates in Mozambique are the highest in the region at 12.2% for girls under 15 years of age (WHO, 2016). The maternal mortality rate is extremely high among pregnant teens (INE-INCAEM, 2008). High fertility rates and inadequate abortion options have resulted in post-abortion complications contributing to approximately 15% of maternal deaths.

The root obstetric causes of maternal mortality (MM) in Mozambique are postpartum hemorrhage (7.8%), eclampsia (6.5%), sepsis (6.1%) and obstructed labor (4.6%) (Needs Assessment, 2012). The main non-obstetric cause of death is malaria (27%) followed by HIV, which leads to a fifth of maternal deaths before 28 weeks of pregnancy (Needs Assessment, 2009, 2012). As for the “timing” of death, 54% of deaths occur between 28 weeks of pregnancy and one day after delivery, and 62% of those take place within 24 hours of arriving to a health facility. This indicates that complications lead to death because of a cascade of three types of delays in obtaining quality obstetrical care: 1)
delays in the decision to seek institutional care, 2) delays in accessing care, and 3) delays in receiving appropriate care.

**Maternal mortality is closely related to neonatal mortality.** Between 2003 and 2011, there was virtually no improvement in urban neonatal mortality rate (34 deaths per 1,000 live births), following the maternal mortality pattern, although there was a substantial reduction in rural neonatal deaths from 53 to 31 (DHS). The WHO’s estimate for 2015 neonatal mortality rate of 27 is the third highest in the region, after Angola and Lesotho. This means that in 2015, 29,000 babies in Mozambique died in the first 28 days of life, which is approximately 80 neonatal deaths every day. The causes of neonatal mortality are tightly linked to those of maternal mortality, such as complications in pregnancy and birth, including inadequate home-based care that causes almost 28% of all deaths in children under five.

**There is significant provincial variation in RMNH indicators, which creates different needs and different opportunities.** While Sofala, Zambezia, and Cabo Delgado have the worst performance on RMNH indicators overall, maternal and neonatal health situation in all provinces urges for improvement. Manica and Inhambane have comparatively better RMNH indicators, yet that does not mean that mothers and neonates are doing well. Early neonatal mortality rates stand at 9 and 6 deaths per 1,000 live births, fatality rates from obstetric causes are 1.4% and 1%, respectively, while only around 12% of women of reproductive age use FP in both provinces. However, given the relative advantage of Manica and Inhambane over other provinces in the context of RMNH indicators, they are currently receiving comparatively less donor assistance in this space, which may jeopardize future progress.

**Graphic 1: Provincial Indicator Breakdown**

![Graphic 1: Provincial Indicator Breakdown](image)
Donor support constitutes a substantial part of the current health expenditures in the country, estimated at 38% of the total in 2012. The Health Sector in Mozambique receives support from a significant number of bilateral and multilateral donors, including UN specialized agencies, global initiatives (e.g. Global Fund and GAVI), and a multitude of NGOs. The main funders have been the Global Fund and the US government, who provided earmarked funding to specific programs. Disbursement of Global Fund allocation reached an average of US$58.3 million per year between 2010 and 2014, while USG support is over $250 million, mostly through project support.

Despite large investments to strengthen institutional capacity at central level, there has been limited impact on the overall system. Central level investments range from governance to human resources to information management. Donors have also supported the establishment of coordination mechanisms aimed at a stronger policy dialogue and strategic and operational coordination between the Ministry of Health, donors, and implementing agencies. Financial support and technical assistance have been provided through the un-earmarked common donor fund (PROSAUDE) or through earmarked projects targeting the planning and information system, the development of a health financing strategy, health promotion/community participation strategy, capacity building in human resources and in public financial management, among other areas. However, the public health system at provincial and district level remains weak and with inadequate financing. Health outcomes have not improved significantly and attribution to donor support is difficult to show. Links and complementarity between the national and the provincial strategic plans (PESS), including on allocation of external resources, are lacking.

There has been a gradual shift of donor support from national to provincial and district level. As a consequence, aiming at achieving a greater impact with limited resources, donors are increasingly shifting the focus of their support to the provincial and district level, while keeping their presence at central level through technical assistance and participation in policy dialogue and coordination working groups. Some of the PROSAUDE donors have replicated, at provincial level, the on-budget support through the MoEF mechanisms and procedures (e.g. DANIDA in Tete, Ireland in Niassa and Inhambane, and Canada in Zambezia), varying between un-earmarked support to the provincial health strategic plans as per the request of the provincial health directorates (e.g. DANIDA and Ireland) and softly earmarked support prioritizing maternal health related activities (Canada). While others complement the national on-budget support with programs in specific domains (e.g. SDC on community empowerment in Cabo Delgado Province; the
Netherlands support to sexual and reproductive health and rights and to family planning through UNFPA and PSI; Italian Cooperation bilateral program on pre-service training in the two major public training institutes; and Flanders support to human resources training and retention through WHO). Those donors that prioritized a geographical focus and/or thematic areas early on, as opposed to aiming for national coverage, seem better able to demonstrate results and link them to their investments.

**Provinces receiving more support are the northern provinces of Sofala, Nampula, and Cabo Delgado, while Manica, Inhambane, Maputo Province, and Maputo City are those receiving less support.** The biggest provinces and those with worse maternal mortality and family planning indicators receive support from major bilateral and multilateral donors, namely: USAID in Nampula and Sofala (MCSP project), Denmark in Tete, Canada in Zambezia, and Ireland in Cabo Delgado (and Niassa), most of them providing provincial budget support; the World Bank HSDP in Nampula, Cabo Delgado (and Niassa), with a focus on primary health care, nutrition and APEs. UN/UNFPA operates in the three northern provinces and in Sofala, with a focus on reproductive health and family planning, while UN/UNICEF operates in most provinces with a focus on child health and nutrition.

Most non-governmental organizations operate at district level, in close coordination with the provincial level, and most of them have a focus on HIV/AIDS and community participation and empowerment. Others provide support to institutional strengthening, human resources, and resource management. The biggest concentration of NGOs is in the northern provinces of Nampula and Cabo Delgado and the central provinces of Tete, Sofala and Zambezia, as well as in Gaza.

**Most project support takes on discrete components of the health system, but a comprehensive approach to tackling maternal mortality is lacking.** For example, PROSAUDE pays for staff; USAID program focused on Maternity Modelo and in-service training of MCH nurses, Canada supports rehabilitation and training in Zambezia, Netherlands focuses on sexual and reproductive rights and family planning; UNFPA supports pre-service training of MCH nurses and procurement of commodities and equipment for family planning and obstetric surgery units; and UNICEF supports the APE program. Consequently, many systems gaps persist.

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**4 ASSESSMENT FINDINGS**

**4.1 SERVICE DELIVERY**

**Geographic access and referral systems**

There are not enough primary health care facilities to serve the population. Health infrastructure was specifically targeted for destruction during the war and the rate of reconstruction has lagged behind the population’s needs. Despite the investment in building new facilities, the growth rate of their number over the decade 2004-2014 has been lower (16%) than population growth (31.5%). There are still only 1497 health facilities in Mozambique, each serving an average of 16,700 people.

**Distance and travel time is a major barrier for women to use formal care.** Approximately 68% of Mozambicans live in low-density rural areas, so given the sheer size of the country fewer than 50% of people have access to a health facility less than 45 minutes walking distance (PESS, 2014). A recent survey found that 28-41% of pregnant women live more than 10km from the nearest maternity ward (DHS, 2010; Pathfinder, 2013). Moreover, 25% of rural PHC facilities are more than 100 km away from the next facility equipped
with surgery, thus posing a dire situation when labor complications arise (Needs Assessment, 2012).

**Transportation services to reach formal care are inadequate.** A Pathfinder survey found that 53-63% of women gave birth outside a maternity ward due to transportation problems. Roughly 87% of district hospitals have an ambulance, though it is frequently used for purposes other than obstetric emergencies. At the PHC level, only 17% of facilities have an ambulance (Needs Assessment, 2012), and these also frequently become all-purpose vehicles.

**Coordination systems for referrals are weak.** The lack of an organized system of emergency transportation contributes significantly to delays in accessing life-saving emergency obstetric care. For the most part, individual nurses use personal cell phones to communicate with higher-level referral centers. Beyond that, there is almost no formalized system for referring patients.

**Infrastructure, equipment, and supply chain**

**Poor infrastructure makes adequate care impossible in many facilities.** Roughly 13% of district hospitals do not have piped water within its premises, and only 54% have a back-up source of electricity (grid plus generator). For health centers, 75% do not piped water and 28% lack electricity (only 5.4% have a back-up source of electricity). Health centers therefore cannot offer quality services and referral facilities are often unable to provide comprehensive emergency obstetrics and neonatal care CEmONC. Amongst district and rural hospitals, 63% do not have a newborn ICU. Shortages of specific items range from thermic blankets missing in 70% hospitals, heating lamp missing in 39%, pediatric laryngoscope missing in 71% and epicrane needles missing in 73% (Needs Assessment, 2012; MISAU, MCHIP 2013).

**Frequent stock-outs of key commodities continue to plague health facilities’ ability to adequately address patient needs.** The 2012 Needs Assessment identified significant and frequent shortages of pharmaceuticals and equipment critical to the treatment of obstetric and neo-natal complications. The unreliability of the supply chain for MNCH and FP commodities has been a chronic and multi-factorial problem in Mozambique. Distribution remains a fundamental challenge, especially from the provincial capitals to the districts and PHCs. While many donors have been working to strengthen supply chain, fundamental issues still remain.

**Human resources for health**

**There have been significant increases in the number of providers trained, but their distribution does not match needs and demand.** The numbers of practicing MCH nurses grew from 2700 in 2005 to 4200 in 2013, improving the ratio MCHN/100,000 target population from 33.4 to 41.3 (MISAU/DNRH, Informe 2005-2013). However, their distribution is still inequitable between provinces and districts, both in terms of extreme variations in ratios of HRH/population (MISAU/DNRH, Anuário RH, 2014) as well as average workloads (Cabral, 2015).

**Inadequate clinical competency combined with low motivation of health workers is adversely impacting maternal health outcomes.** Early identification of high-risk pregnancies is key to decreasing preventable maternal mortality. Appropriate screening and identification requires motivated, well-trained staff who have, at their disposal, the diagnostic tools required to identify women at risk for poor maternity outcomes. Health workers are also unable to adequately treat women with the most common causes of preventable MM (Needs Assessment, 2012).
Low levels of motivation among health workers results in suboptimal delivery of health services. The evidence shows that basic MCH nurses provide more than 80% of all of the obstetric care in Mozambique (Análise Situacional de Enfermagem, 2010), and this cadre of nurses is overworked, underpaid, and poorly trained (MS/Eurosys, 2015). Supportive supervision systems are sporadically implemented and of questionable value, and there is currently no formalized continuing medical education system to allow nurses to maintain skills, update their knowledge base, and move along their professional career paths. The downstream effects of this problematic combination is a workforce that is unmotivated and exhibits poor communication with patients, low compliance with protocols, and low effort on communicating health promotion messages to service users: e.g. information to adolescent pregnant women on preparation for delivery is frequently not provided, which contributes to poor decision-making regarding need and time for assisted delivery within this target group (MISAU, MCHIP, 2013).

Clinical competency among those who manage obstetric emergencies is inadequate. The perverse reality in delivery rooms is that the least trained nurses with the lowest degree of training in the management of obstetric emergencies (basic level mid-wives) are the ones attending to the overwhelming number of complicated deliveries while those nurses, better trained to manage emergencies are rarely present in delivery rooms and spend an increasing amount of time on administrative activities (Cumbi, 2010). Many frontline workers are unable to identify women at high risk for poor maternity outcomes (MISAU, MCHIP, 2013). Only 60% of physicians and MCH nurses were able to diagnose correctly N-N asphyxia, and only 27% MCH nurses were able to correctly treat it (Needs Assessment, 2012). In a sample of 47 “model” and “non-model” maternities, only 17% of newborns received all elements of essential newborn care (MISAU, MCHIP 2013). Poor clinical skills are linked to pre-service training constraints, particularly the extremely limited time for exposure to the experience of assisting deliveries and other obstetrical emergencies (Sidat, 2012).

There is limited coordination between health facilities and community level providers (traditional birth attendants, APEs, etc.), thus limiting the possibility of early detection and/or referral at the community level. Pregnant women frequently seek care from traditional birth attendant (TBAs), but there are few formal links between the public health system and TBAs. Largely, APEs are also not adequately linked to the formal health system. Thus, critical elements to prevent, detect, and treat emergencies, such as community mapping of pregnancies and community-based early warning systems that allow for earlier referral of complicated deliveries, are not operationalized.

There is no mechanism to promote a culture of performance for health workers. Health workers career progression is based on level of training and numbers of years in service, with no space for well performing staff to be rewarded. The incentive system for civil servants in vigor by law is not implemented on the ground due to lack of financial resources to pay applicable rewards. The only experiment for staff rewards is implemented in the provinces of Gaza and Nampula via EGPAB Performance-Based Financing project. Results of the impact evaluation of the experiment are showing very strong positive impact, especially for maternal and child health indicators.

Knowledge and use of formal services
Knowledge regarding the availability of services for MCH and delivery throughout Mozambique is high. This is further reflected by the 90% attendance rate for the first ANC visit (DHS 2010). Despite this knowledge, nearly half of the women deliver outside of the health facilities.
The perception of low quality services and poor treatment of patients reduces women’s willingness to seek care through the health system. Data on patient satisfaction from a recent household expenditure surveys shows that patient satisfaction decreased from 73% in 2009 to 53% in 2015 (IOF 2016). Anecdotally, we found that the lack of human-centeredness in the formal health system is a major deterrent for women seeking care. At the same time, traditional birth attendants, curanderas, and other informal providers are highly regarded by many in the community, thus making informal providers a compelling alternative to the formal health sector.

Knowledge and uptake of family planning options among young girls is poor. Mozambique has some of the lowest family planning rates in the world, and those rates are especially low in the adolescent girl population (8.4% among women aged 15-19, according to the 2010 DHS). This, in turn, has led to one of the highest teen marriage and teen pregnancy rates (12.2% for girls under 15) in the world (WHO, 2016), which subsequently contributes to the highest percentage of maternal causes responsible for women’s mortality rate for the 15-19 age group (24.1%) (INE, 2009).

Cultural norms and practices strongly influence care seeking by women. These norms have been well-documented elsewhere, such as early marriage, use of traditional medicines, and preferences for unskilled birth attendants. Girls’ education and ICC programs have attempted to shift these norms, but many cultural practices that influence care-seeking behavior are deeply rooted.

4.2 GOVERNANCE AND ACCOUNTABILITY

Stewardship of policy

Strong political commitment towards improving maternal and neonatal health and reducing mortality exists at high levels of government. The Health Sector Strategic Plan (PESS) for 2014-2019 sets the reduction of maternal and neonatal mortality among its top priorities, together with the urgency to decrease total fertility rates. President Guebuza created a national partnership, led by the First Lady, for the promotion of maternal, neonatal, and child health. This multi-sectorial platform’s objective was to promote cross-sectorial actions to address key barriers for improved RMNCH indicators. Members of the executive committee include representatives of various ministries (Education, Transport, Justice, Women and Social Action, Finance, Agriculture, etc.) as well as civil society and private sector. Despite high enthusiasm at its inception, the partnership has so far failed to be converted into an actionable plan. The Ministry of Health National Directorate of Public Health would welcome a revitalization of such an initiative.

Current RMNH policies are fragmented and difficult to execute. There are numerous policies and plans looking at RMNH interventions, but there is no overall strategy to set goals and critical priorities. The current policies are compiling a long list of needed interventions with no prioritization and executable plans, which undermines the potential to achieve critical targets, especially within a context of resource scarcity and low motivation of health professionals.

Leadership at central and provincial level to coordinate and ensure effective use of resources is weak. Considering the vast number of actors involved in supporting RMNH, it is critical to properly coordinate the different interventions and provide guidance on strategic objectives and priorities. Currently, there are a lot of coordination groups within the Ministry; however, their objective is more centered on information sharing than strategic coordination and implementation. Donors are asked to share reports, but those
are not consolidated to provide overall vision and the government capacity to analyze the reports is weak.

**Data for monitoring and decision-making is hampered by weaknesses in the health information system result.** Despite the development of a comprehensive monitoring plan in the PESS, including all key RMNH indicators, its monitoring is weak. The quality of routine data from *modulo basico* is questionable, and there is no data quality audit or processes for data improvements. Annual joint sector reviews (ACAs) provide an overview of key health indicators, but are limited (only sample facilities) and provide fairly superficial information. Maternal mortality estimates are outdated, and do not take into account the impact of the expansion of Prevention of Mother-to-Child Transmission of HIV/AIDS (PMTCT) programs. Complete and accurate civil registration and vital statistics systems are still lacking. Overall, the MOH lacks technical staff with capacity to consolidate and analyze the existing information in order to trigger actions or even make a reliable determination of ANC coverage rates, MMR, or NMR.

**Planning and budgeting**

There is a lack of strategic planning within the Ministry. Districts and provinces do their annual planning based on recurrent budget needs rather than on activities aimed at achieving key provincial strategic objectives and prioritization taking into account funding availability. This is illustrated, for example, by the high discrepancy between planned and executed activities and the disconnect between resources allocated to investment and subsequent recurrent budget (PEFA 2015). Donor support at the provincial level is often not aligned with the provincial PES, as they are not integrated into the planning process. When collaboration happens at provincial level, it is based on good will and is strongly guided by donor priorities instead of the provincial PESS. Rather than based on gap and priority assessment, there is often duplication of efforts and non-priority activities.

Planning and budgeting exercises are two delinked exercises. Despite a bottom-up approach to planning, where districts and provinces are required to plan for their activities in district and provincial PES, budgeting is made at central level and is based on historical data, with little consideration for sub-national plans. It is difficult to accommodate critical reallocation of funds based on sub-national needs, as there is no need-based formula in place for provincial allocation.

**Accountability for Resources**

There is a considerable amount of off-budget and off-CUT funds. A significant proportion of external donors and implementing agencies supports flows out of the government system. UNICEF estimates this to be one third of total health expenditure. This has been the case, for example, with USAID bilateral funds, which may change with the signature of a bilateral agreement between the USA and Mozambique.

On-budget and off-CUT support is difficult to track. The Ministry of Health National Directorate for Planning and Cooperation (DPC) has developed an excel-based tool (*Inquerito de Fundos Externos IFE*) which captures donor support per program and geography, but its implementation and usage has not been enforced. DPC capacity to collect and mine this information is weak. The recent introduction of program codes for health was intended to provide an opportunity for improvement, but this has been hampered by capacity constraints by districts to accurately record expenses as well as the lack of access to e-sistafe across the country.

Lack of accurate and comprehensive information limits the production of valid National Health Accounts. The general NHA does not capture detailed information on RMNH.
Moreover, the NHA exercise is not routine, and is conducted on an ad hoc basis, as funds are available. Finally, production of NHA data is not timely. For example, data for NHA were last collected in 2012, but because of the lack of information from the private sector, or incorrect estimation of out-of-pocket expenditure, the NHA has still not been officially published as of March 2016.

**Public audit is slow and not adequately transparent.** Internal audits are conducted by *Inspeccao Geral de Saude* (IGS) and external audits of government expenditure are conducted by the Administrative Tribunal. As stated in the PEFA review of November 2015, the Administrative Tribunal has the technical capacity to conduct quality external audits, however, the limited number of the inspectors constrains its ability to execute external audits of government agencies under international standards. This leads to frequent delays in conducting external audits of the health sector, as illustrated by the 2-year delay to produce the required audit reports of the PROSAUDE funds. As stated in the PEFA review, transparent communication of audits also needs improvement.

**Most health donors aid modalities are not performance based.** The only program using DLIs is the World Bank PfR program, with nine DLIs applied for the education and health sectors. This program is on-budget and on-CUT and is managed by the Ministry of Economy and Finance, in close coordination with both line ministries.

**Community Engagement**

**There is no formal mechanism to address community concerns and requests.** Even in the limited cases where *comites de saude* are functioning, there is no platform to ensure that actions are taken based on feedback provided. No institutional grievance system is in place, beyond the initiative of *ad hoc* projects, such as those of Namati or CIP.

**There are no indicators related to community involvement and patient satisfaction in the current PESS.** The PESS monitoring matrix only includes quantitative indicators, which only reflect service delivery indicators. There is no systematic measurement of waiting time or stock out, for example, as key indicators of patient satisfaction. Data on patient satisfaction are collected only through the household survey, occurring every five years (*Inquerito do Orçamento Familiar*). The latest report (December 2015) states that patient satisfaction has decreased from 73% in 2009 to 53% in 2015, making even more crucial the need to carefully monitor health system performance regarding quality of services provided to patients.

**Information about health system performance is not publicized.** There is no online platform to publically display information of key indicators of the health system, with the exception of data produced by the HR Observatory. Other health system performance metric dissemination channels, such as newspaper, radio, and public forums are also minimally used.

### 4.3 ASSESSMENT OF AID MODALITIES

This section provides an assessment of the main potential aid modalities to be considered by DFID for their coming support:

1. Sector budget support through PROSAUDE
2. Sector budget support through the Global Financing Facility
3. Provincial sector budget support
4. Project support
A description and detailed assessment of each modality can be found in Annex 2.

**PROSAUDE**

**PROSAUDE offers limited opportunity for donor funds attribution.** As highlighted in the 2015 PROSAUDE evaluation, the overall result framework for PROSAUDE is weak and does not provide focus for intervention nor clearly links inputs to outputs. The indicators that are tracked refer mostly to vertical programs (HIV/AIDS and Malaria) and very little to reduction of maternal and reproductive health and others equally important. Moreover, the quality of data for their estimation not trusted by the partners.

**The lack of transparency of PROSAUDE has led to mistrust among partners.** The current MOU does not clearly regulate spending, and thus has created too much flexibility for the government to decide on the use of funds. As an example, 21% of PROSAUDE committed funds in 2015 and 27% of those committed in 2016 are disbursed for topping up salaries of central government officials and food subsidies for all workers in the public health system, which was never officially agreed by donors. There also has been no audit of procurement, despite requirement in the MOU. The recommendations of the audits have taken long to be implemented.

**PROSAUDE has had limited success in influencing policy.** Many of the PROSAUDE funders feel that instead of serving as a lever to influence policy, the instrument serves to simply finance recurrent costs such as procurement, salaries, and top-ups. The instrument therefore does not offer the opportunity to engage in policy dialogue. Other forums that are not necessarily linked to PROSAUDE, such as technical working groups, bi-lateral negotiations, or ad hoc meetings/groups, instead serve as more relevant spaces for effective policy dialogue.

**Donor support to PROSAUDE is trending downwards, both in terms of total funding as well as number of partners.** Between 2008 and 2013, total commitments to PROSAUDE amounted to US$615.76 million, an annual average of US$102.6 million. Commitments in 2014 amounted to US$85.3 million, decreasing by 35% (US$55.6 million) in 2015. Commitments in 2016 amount to US$43 million, most of it conditioned to a revision of the instrument and a new MoU. In 2013, the common fund counted on 18 donors. Currently, PROSAUDE counts on ten development partners: Ireland, Canada, the Netherlands (altogether accounting to 70% of the current funding) Switzerland, Denmark, Flanders, Spain, Italy, UN/UNICEF, and UN/UNFPA. Switzerland may withdraw in 2016 and DANIDA will leave by the end of 2017.

**The Global Financing Facility**

The eligibility of Mozambique to receive support from the Global Financing Facility is an opportunity to revive the multi-donor sector support to MOH. Many current donors of PROSAUDE have expressed interest in the new mechanism and preliminary discussion is underway. On top of its global support, Canada has already committed funds to support the development of Mozambique CRVS; UNICEF is considering providing technical and financial support to the preparatory phase, as well as P4H, through the support to the development of the country health financing strategy. GFF could overcome PROSAUDE limitations and be a major policy influencer, thanks to its potential financial size, if grants are effectively matched with IDA support and if a strong framework for performance measurement is set up.

**The design of the GFF disbursement mechanisms requires technical skills which are not currently in place.** The design of the mechanism will involve careful consideration of the technical design: defining the optimal indicators to drive results, developing the
mechanism for disbursement, ensuring information transparency to all committed donors, and putting into place safeguards for appropriate use of funds. A long list of technical assessments is needed before this design can take place, most of which have not been initiated. An intensive process with the MOH is needed to agree on disbursement indicators, which has not yet begun. Overall, the local World Bank office for health is not adequately staffed to undertake the required level of engagement.

**Long delays are foreseen before GFF is implemented.** There is a high risk for GFF to fail due to long delays in developing all required analysis (RMNH business case, health financing strategy) and achieving consensus between all interested donors. The World Bank estimates that two more years will be required to finalize design, obtain agreement on all fiduciary arrangements, and effectively start disbursement.

**Direct provincial support**

A growing number of donors provide sector support at provincial level. The largest players include USAID in Nampula and Sofala, DANIDA in Tete, Canada in Zambezia, Ireland in Niassa and Inhambane, and SDC in Cabo Delgado. Most of donors’ geographically focused support is on-budget and on-CUT. Some donors are more flexible and comprehensive in the allocation of funds (DANIDA in Tete), while others focus on specific areas within RMNCH (Canada funds obstetric surgery-related activities) or impose strong limitations (Ireland funds in Inhambane cannot be used for medical equipment or infrastructure).

The shift from national to provincial support increases the risk of inequities between provinces. Although major donors tend to work in non-overlapping provinces, the size of the financial envelope and the thematic focus chosen by each donor varies significantly. Currently, only six out of the 11 provinces (Maputo City included) receive budget support or project support from a major donor. The size of provincial support also varies considerably: USAID allocates US$5 million per year to Nampula and Sofala, and DANIDA allocates US$2 million per year to Tete. In contrast, Canada allocates US$720,000 per year to Zambezia, Ireland US$300,000 per year to Inhambane and only US$150,000 per year to Niassa.

On-CUT at provincial level ensures money reaches the provincial health directorate (DPS), but with no certainty to be triggered down to district and subordinated institutions. According to government procedures, only those institutions that have financial autonomy can directly budget, manage, and account for funds, government or external. Training centers and district or rural hospitals, which have no financial autonomy, can only use governmental or on-CUT external funds through the DPS, which implies delays and, sometimes, unavailability of the funds.

Off-CUT support is more flexible both for donors and DPS and very much appreciated by subnational entities. A large number of donors are using off-CUT support to provide support to public entities, as either core support (Italy) or complementary to other activities (UN agencies, CDC, USAID). Within this frame, donors and recipient agree on supported activities and on related documentation to be produced for auditing purposes. Attribution is therefore easy for donors, but requires careful financial monitoring, especially if funds are to be disbursed at district and health facility level. On the other side, DPS favor this modality as it gives a clear picture of externally funded activities and facilitates provincial planning.

**Procurement at provincial level is limited and difficult.** Procurement of drugs, consumables, and medical equipment is mostly done at central level. On the other hand,
procurement related to construction is often decentralized to the provincial level. Experience shows that managing construction at provincial level is difficult. This is partly due to the weak technical capacity of local contractors, especially in remote provinces. For instance, DANIDA withdrew support for construction in Tete due to poor local contractor performance. DPSs are also weak in managing the bidding process and subsequent contract, as was the case in the World Bank-administered primary health care project in the three northern provinces. Finally, construction requests risk politicization. For example, in Zambezia, Canada was pressured to build a surgical unit in a rural hospital that did not even have a water supply.

**Competent and embedded technical assistance is seen as a key ingredient to successful provincial support.** Due to limited management and administration capacities at the DPS level, many donors have opted to combine financial aid with dedicated TA. Some donors require a project management unit including a project manager and fiduciary staff (World Bank, Global Fund), while others rely on government staff and concentrated TA.

**Project support**

Project support can lead to major improvements in health by bypassing government systems and bureaucracy. For example, PEPFAR-financed project support of approximately $400 million has catalyzed a massive increase in the number of HIV/AIDS infected people receiving ART treatment – from 240k in 2010 to 800k in 2015. National policies, such as the national quality improvement, framework were also supported through project-based TA.

**Project support requires significant management on the donor side.** Many time-intensive management tasks are necessary to implement project support, including tendering a service provider, managing service provider performance, monitoring and auditing financial information, internal reporting, and coordinating with other projects. Moreover, bi-lateral staff spend considerable time dialoguing with government to obtain alignment and clear bureaucratic hurdles. Bi-lateral aid agencies typically have between 3-5 staff backstopping each project, as is the case for USAID and CDC.

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5 **RECOMMENDATIONS**

5.1 **GUIDING PRINCIPLES**

The principles that guided the recommendations were:

1 **Have measurable and attributable impact on RMH in selected provinces.** The recommended plan of action is focused on demonstrating results and concentrates on programming to have impact in selected provinces.

2 **Existing systems can be made effective through a more enabling environment.** Our approach does not attempt to create dramatically new systems, but rather build incentives and accountability into the existing system to improve results.

3 **Take an integrated, not stove-piped, approach to systems strengthening.** DFID’s approach should draw from the recent experience of Saving Mothers Giving Life, which found that, in order to significantly reduce MMR, a comprehensive approach that addresses all of the key barriers women face when accessing care is more effective than a vertical approach that focuses on a specific component of the care cascade.
4 **Align with Government of Mozambique systems, recognizing fiduciary risk.** The overarching goal of DFID’s engagement is to develop systems that can sustainably improve RMH outcomes. Therefore, our recommendations are structured to be harmonized and aligned with the existing system, while working to reduce fiduciary risk associated with national systems.

5 **Ensure DFID is meaningfully engaged in national policy dialogue.** One of DFID’s core value-add is its ability to influence national policy dialogue so as to have national impact on RMH. Our recommendations are designed to provide DFID with a ‘seat at the table’ nationally while also having direct impact.

6 **Limit management burden to DFID.** Recognizing that DFID has a limited staffing footprint in the health sector, our recommendations are structured to minimize management burden.

### 5.2 Theory of Change

The core of our assessment findings shows that an enabling environment is necessary to achieve strong RMNH outcomes. An enabling environment is the dynamic interplay between aligned incentives, increased service delivery capacity, and focused accountability for results. Therefore, we argue that DFID should focus on activities around these three themes to kick-start an enabling environment. The diagram below visually depicts our theory of change.

- Disbursement linked indicators
- Facility based performance-based financing
- National framework for tracking resources, results and approaches to RMNH
- Increased civic engagement
- Integrated approach to strengthen service delivery
- Changing cultural norms and practices
- Motivated system to deliver results
- Coordinated and more efficient use of RMNH resources
- System-wide accountability for women’s health
- Health system ready to provide quality RMNH care

### 5.3 Technical Approach

**Component 1. Results oriented financial aid through disbursement-linked indicators (DLIs).**

**Sub-component 1. Provincial DLI (preferred)**

**Provide financial aid to selected provinces linked to the achievement of RMH results.** Financial aid to local government is an essential instrument to provide both resources and incentives to achieve RMH results. Provincial governments are closer to the electorate and
less bureaucratic than the central level. The current decentralization processes allow them fiscal autonomy to develop tailored solutions to their maternal mortality challenges. Moreover, our assessment of the DPS in Manica and Inhambane finds an enthusiastic and motivated leadership willing to embrace additional resources to have RMH impact. Therefore, we recommend harnessing this enthusiasm and providing results-based financial aid to further incentivize the provinces to creatively address their maternal health challenges.

**Work collaboratively with provinces to define DLIs, ensuring both results and process indicators are included.** Provincial governments have the mandate and capacity to improve RMH outcomes through better management and governance of the health system. Indicators for disbursement should incorporate both critical process improvements as well as RMH results. Annex 3 includes an illustrative list of indicators. Indicators should be regularly measurable, ideally by a third party verifier.

**Structure disbursements to be off-CUT and managed by a provincial PMU at DPS to ensure efficiency and accountability of funds.** To avoid disbursement delays and bureaucratic inefficiencies commonly associated with the GOM budget cycle, DFID funds should be provided off-CUT to the DPS. As fiduciary risk is elevated at provincial levels, the establishment of a PMU at the DPS level would further mitigate risk and ensure accountability of funds while remaining aligned with GOM systems.

*Sub-component 2. Facility-based performance-based financing (preferred)*

**Work with DPS of Manica and Inhambane to develop a facility-based PBF program to compliment provincial DLIs.** The DPS of both Manica and Inhambane are supportive of a facility-based PBF program to motivate health workers to perform better. Evidence from Gaza and Nampula shows strong impact on MCH services. Finally, incentives at the facility level could be complementary to provincial DLIs, thus ensuring incentives across the system are aligned. Therefore, we recommend a combined approach of provincial DLIs and facility PBF.

**Leverage PBF experience from Gaza and Nampula to inform design and implementation.** Over the last four years, Gaza and Nampula have learned many lessons on how to best structure PBF, what tools to use, and how to efficiently implement the program. Thus, DFID should bring together the DPSs of Nampula, Gaza, Manica, and Inhambane to jointly design a facility-based PBF program, modifying existing systems and tools to the extent possible. DFID could also create a PBF community of practice within Mozambique so that interested provinces could learn from each other’s experience to further enhance results.

*Sub-component 3. Central DLIs (not preferred)*

**If possible, avoid financial aid to the central level.** Past experience of DPS in providing financial aid to the central level has not demonstrated value for money and raised questions on the tractability of funds. A range of development partners are focusing efforts on designing central level financial aid, thus further support from DFID would not substantially fill a major gap. GFF, while intuitively interesting, will take several years before it will be operational and will be largely dependent on World Bank management. Therefore, to ensure maximum impact of DFID funds, we recommend avoiding financial aid to the central level.

**If financial aid to the central level is required, DFID should create its own DLI-based disbursement mechanism.** Capacity constraints and delays in the development of GFF and the next PROSAUDE pose a high risk for DFID were it to rely on these mechanisms for
disbursement. If DFID were to take a trailblazing approach and create its own DLI-based financial aid disbursement mechanism for the central level, it could serve as a model for GFF and/or other partners contemplating central support. Going it alone will also allow DFID to have greater attribution, as well as control over the program.

Table 2: Aid Modality: Summary of Options

<table>
<thead>
<tr>
<th>Modality</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Risk</th>
<th>Potential safeguards</th>
<th>Assessment team Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility PBF</td>
<td>Incentivizes those directly responsible for RMH outcomes</td>
<td>Administratively complex to set up and manage</td>
<td>Sustainability post-DFID, cheating on reporting</td>
<td>Mainstream into provincial system, 3rd party verification of results</td>
<td>Pursue</td>
</tr>
<tr>
<td>Provincial DLI</td>
<td>Leverages and incentivizes locally elected government to focus on RMH</td>
<td>Displacement effect of DFID money</td>
<td>Misappropriate funds, reduction in domestic allocation to health</td>
<td>PMU to manage risk, condition that funds must be additional</td>
<td>Pursue</td>
</tr>
<tr>
<td>Central DLI</td>
<td>Strong RMH advocate leading DPC</td>
<td>Crowded space, limited effectiveness, attribution difficult.</td>
<td>Attribution, traceability, appropriate use, limited impact</td>
<td>Earmarked disbursement linked to achievement of specific RMH indicator</td>
<td>Do not pursue</td>
</tr>
</tbody>
</table>

Component 2. Technical Assistance to improve service delivery at Provincial Level

Target provinces where DFID TA can be comprehensive, rather than complementary.

Provinces such as Nampula and Sofala have external support from USAID and others, whereas provinces such as Manica and Inhambane have almost no external support. Targeting the latter provinces would allow DFID to provide support with greater attribution for results and accountability for resources. Moreover, the stated position of the MOH is for DFID to work in provinces with limited external support, thus allowing for greater political support. Finally, DFID would avoid the complicated task of coordinating with other partners, which has proven to be cumbersome and inefficient.

Conduct comprehensive needs assessment in targeted provinces. As discussed in section 4.1 of the assessment, there are many service delivery barriers that result in unacceptable RMH outcomes. These barriers carry varying degrees of weight from province to province. An illustrative list, based on our rapid assessment, of the most common barriers and proposed solutions is contained in Annex 5 and 6. However, we recommend conducting an intensive and comprehensive assessment of the supply and demand side barriers in the provinces DFID ultimately chooses to support. This assessment should prioritize the most important barriers and design strategies to mitigate these barriers.

Provide project-based technical support to improve service delivery. Based on the results of the comprehensive assessment, we recommend that DFID procure a service provider to provide on-going service delivery strengthening support. The approach should also draw from DFID’s previous experience with innovation, such as PSI’s Movercado platform and social marketing approach or the CHAI supply chain model and point-of-care pre-
Component 3. Technical Assistance to support Accountability for Women’s Health

Subcomponent 1. Support the MOH to hold all actors accountable for improved RMH outcomes

Support MOH to develop national framework for accountability for women’s health. The President, Minister, head of Public Health, and new head of DPC have all stated that improved RMNH outcomes are a key priority for Mozambique. Many development partners have committed to help Mozambique in this fight. Many MOH policies and strategies exist to help guide RMNH outcomes. However, there is no framework or mechanism to hold development partners, provinces, and other actors accountable for results. Therefore, we recommend DFID provide technical assistance to the MOH to develop an accountability framework. Such a framework should include elements of resource tracking and data analytics on outcomes. Initial technical assistance will involve support to design the framework, coordinating inputs from other partners, and initial data analytics. Subsequent assistance will involve on-going support data analytics, donor coordination, dissemination, and special initiatives related to accountability. The design phase of this activity can also serve to complement GFF’s efforts in designing disbursement indicators for RMNH.

Work with MOH to anchor and capacitate “accountability for women’s health” initiative. To initiate this sub-component, we recommend launching an inception phase in which DFID works with DPC to determine where to best house this function (DPC, HRH, or Health Observatory, etc.). In addition, DFID should provide TA to help develop the terms of reference for this initiative, staffing arrangement, and other organizational development issues.

Sub-component 2. Increase civic engagement and participatory governance for RMH

Provide technical assistance to increase civic participation and accountability at province level. Our assessment found that there is limited activity promoting civic engagement and community participation into the health system. At the same time, DFID has positive experience in participatory governance in other sectors through CEP by implementing grievance mechanisms, citizen/community scorecards, and supporting watchdog programs. Given the strong role communities can play in holding the system accountable, we recommend DFID provide focused support to increase accountability for RMH to civil society. DFID should leverage the learning, tools, and management capacity of CEP to implement such a program.

Conduct assessment to determine which participatory governance mechanisms will be most effective, and which provinces to support. Each province has its own political, social, cultural, and economic characteristics that will impact the effectiveness of various methods to increase civic participation. Therefore, we recommend conducting an in depth assessment to examine these characteristics to determine which methods would be most effective. In line with recommendation 2, we recommend a concentrated approach in which service delivery strengthening is coupled with civil society engagement. Thus, to the extent possible, we recommend selecting the same provinces.
5.4 MECHANISMS

To accomplish the recommended technical approach, the assessment team recommends the procurement of two service providers to be managed directly by the DFID health and education office, and one service provider to be procured and managed by CEP (Table 3).

**Service Provider 1: “Purchasing for Results”**. This project would serve as a fiduciary agent with an independent monitoring and evaluation arm. The monitoring and evaluation arm would verify that DLIs or PBF results were achieved by conducting regular verification exercises. Disbursements would be based on the results of this verification exercise. To reduce overhead costs, we recommend that provincial and/or central level disbursements be conducted by DFID directly, whereas PBF disbursements are conducted by the service provider. This service provider would be directly managed by the DFID health and education office.

**Service Provider 2: “Strengthening RMH Systems”**. This project would serve as a technical assistance agency that would provide provincial support for supply and demand side RMH systems strengthening. This entity would also provide central level technical assistance to support the national accountability framework for RMH.

**Service Provider 3: “Civic Engagement for Health”**. This mechanism would operationalize the recommendation to enhance civic engagement, as detailed in component 3.2. Preferably, this would be a separate service provider, as finding a single project that can competently support components 1, 2 and 3 could be challenging. Given the health and education office’s limited management capacity, we recommend DFID work with CEP to manage this new project. If this is not possible, then the alternative recommendation is to merge the service delivery TA with the civil society TA.

**Table 3: Mechanisms**

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ANNEX 1

ANALYSIS OF OPPORTUNITIES IN INHAMBANE AND MANICA

Main opportunities
Both provinces are receiving limited external donor funds and need financial support. In Manica FH1360 is the only significant donor and supports reduction of HIV in the province, while some other organizations provide limited direct financial support to the DPS (AIFO, Save the Children, WHO). The government budget (for non-personnel costs) provided for 2016 to the province (amounting to 112 million MZN, approx. US$2.2 million) shows a reduction of FUNDS to cover acquisition of goods and services (-3.5 millions MT) and a dramatic reduction of PROSAUDE funding every year (from 84 million MT in 2013 to 49 million MT in 2016). The reduction of PROSAUDE funds and late disbursement led to debts, as illustrated by the non-payment of ICS teaching staff in late 2015. The Province of Inhambane receives support from Ireland, UNICEF, and WHO, as well as Medicus Mundi Catalunha, altogether amounting to MZN17.4 million/year (approximately US$350,000), channeled through the DPS.

DPS in Manica and Inhambane have the capacity to manage donor relationships without being overwhelmed with administrative burden. Manica has developed processes for donor management by assigning a focal point person per donor, keeping financial records separately for each partner, and conducting a joint planning exercise every year. In Inhambane, a significant proportion of the DPS development partners channel their funds through the DPS and conduct regular follow-up missions. As for the few NGOs, activities on the ground are implemented together with government health staff.

Geographical situation of both provinces is favorable for efficient support. Provinces are easily reachable by air and road. Support for procurement of medical equipment and materials and for works would be easier in Inhambane and Manica, as both provinces could access suppliers (including the CMAM pharmaceuticals’ warehouses in Maputo and Beira) and more competent contractors in neighboring location (Maputo and Beira, respectively). Access is slightly better in Inhambane as compared to Manica where some districts may be difficult to reach during the rainy season.

Demand for maternal care is already high, but some indicators still need to be improved. The Province of Manica has seen strong improvements in main RMNCH indicators coverage from 2010 to 2014, with coverage for assisted deliveries growing from 75% – 80% (2015), family planning utilization from 12.5% to 35%, and malaria treatment among ANC visitors from 32.5% to 75%. Coverage of ANC visits in Manica was already at 99% in the 2010 DHS (with 60% visiting ≥ twice). In Inhambane, between 2010 and 2015, coverage of institutional deliveries increased from 54% to 66.5%, first family planning consultancy increased from 19% to 46%, while the coverage of first post-partum consultancies remained at 75%. ANC coverage has decreased from 96% in 2010 to 91% in 2015.

There are NGOs and local organizations active in the health sector, which could be potential partners for project implementation. In Manica, some NGOs are providing project support (Save the Children supporting reproductive health, APE program, and CEP; FDC supporting distribution of mosquito net; and soon HAI supporting seven districts for data analytics), offering an opportunity for partnerships with potential interested donors. Some local organizations are active in supporting communities in their right for health. In
Manica, the CEP program started its health activities in November 2015 and supports Nanda, a local organization in assessing community perception of the health system and integrating recommendations, in agreed upon action plans endorsed by the facilities’ co-management committees. Magariro is another local organization working in community development, with experience in behavior changes for health. In Inhambane, the NGOs operating in the province mostly focus on malaria and HIV/AIDS (some dropped important activities such as FP, due to reduction of donor funding). Most have a strong component of community participation through joint work with, and support to, the APEs. CCS provides project-specific technical assistance to the DPS and Pathfinder works closely with several local community-based organizations. A couple of NGOs have very specific interventions including Olhos do Mundo Catalunha in the prevention of avoidable blindness and Architects without Borders in the expansion of the health network.

Both Provinces have local training centers (Institutos de Ciências de Saúde) graduating an increasing amount of health professionals. In 2015, the two locations of the l’bane TC had approximately 800 students and graduated 362 professionals (including 150 MCH Nurses), whereas the Chimoio TC has a more modest student population of approximately 600 students and graduated 271 new professionals (of which 88 MCH nurses). In both TC’s the student/teacher ratio has remained unchanged as the increase in the number of (mainly full-time) teachers has been matched by an increase in the number of students. Attrition rates vary between 3-10% in l’bane TC and an average 14% (variation 3 – 32%) in Chimoio (2015 data). Some courses are financed by external donors: 6 out of 27 in l’bane, and 2 out of 20 in Chimoio. These are “local” courses, which the MoH/HQ agree that the candidates and graduates should belong to each Province.

Physical capacity, to intake students, is underused in l’bane TC (which also has benefitted from a large project from CIDA to upgrade practical training capacity – at two different locations), whereas the Chimoio TC clearly needs greater capacity for classroom, laboratory, and facility-based practical training. Students are regularly transported to referral facilities away from the TC’s locations for practical rotations.

Barriers for RMNH
Access barriers remain important in Manica and Inhambane. Population served per PHC facility can reach 41,300 in the worst served District of Manica. PHC level facilities still lack basic equipment (e.g. sphygmomanometers) and, as in the rest of the country, ambulances are insufficient. In l’bane, the average population served per PHC facility was 12,193 in 2014 (16,126 in the worst equipped district). Medical equipment is insufficient and there is only one ambulance in each district/rural hospitals, which is not enough.

The referral capacity is the main bottleneck in the two provinces. In Manica, for a population of 1.8 million, there are only three hospitals with surgical capacity, and one model maternity. Only 46.1% of facilities have BEmONC capacity and caesarian sections are undertaken in only 2.9% of deliveries. Median time for transportation from a PHC facility to nearest hospital is 2.5 hours. In l’bane, for a population of 1.5 million, there are two rural hospitals and three district hospitals with surgical capacity (readiness for utilization of its full capacity is to be confirmed). In 2012, the proportion of health facilities with BEmONC was 56% and caesarian sections were performed in 3.9% of the deliveries. The number of in-hospital maternal deaths decreased from 72 in 2010 to 47 in 2015. The DPS attributes this improvement to better diagnostic capacity (of high obstetric risk during ANC or complications incurred at time of delivery), timely referral of complicated cases,
increased number of health facilities with surgical capacity, and increased number of senior surgery technicians and MCH cadres. USAID-funded MCHIP Model Maternity operated in 13 districts (exception for I’bane town), and three maternities have been accredited as *maternidades modelo* (MCHIP program is now closed, and the DPS lacks support to further improve the results).

**Health professionals still pose problems in terms of quantity, quality, and proper distribution.** The overall availability of HRH in Manica is just slightly above the “very poorly allocated Provinces” (Tete, Zambézia, Nampula), despite a 39% increase in the number of “clinical professionals” between 2010 and 2014 and a 21% increase in MCH nurses. Misdistribution can lead to the worst allocated district having less than 1/5 MCH nurses (per population) of the provincial average, and an estimated 10% of PHC facilities do not have a single MCH Nurse. Numbers of HRH are more abundant in I’bane (and, consequently, the province has not witnessed increases in recent years, like in Manica), and the inter-district distribution inequities are not as marked as in Manica.

The low level of technical skills of MCH Nurses has been mentioned as an obstacle to both adequate care for obstetric emergencies and to satisfy the growing demand for FP (with a broader variety of contraceptive methods). As in other Provinces, the local HTC-ICS struggle to provide sufficient time and tutorship during practical rotations for acquisition of experience, as well as insufficient integration within the new modular methodology. For example, the skills to insert an IUD are not sufficiently practiced during MCHN courses, this being one of the leading causes for the low utilization of this contraceptive method.

**Preference for aid modality support**

**Manica and Inhambane DPS prefer to receive on-budget, but off-CUT support.** Both DPS in Manica and Inhambane prefer to receive external funds off-CUT, transferred to a commercial bank account. There is a risk of delayed payment when funds are sent on-CUT, because donor disbursements do not follow the government financial calendar, which is required to manage execution of funds through e-sistafe, and also because the allocation of external funds is not decentralized to the DPS subordinated institutions and to the district level. Unless allocation is fully decentralized (as it is done with government budget), on-CUT funds may also be diverted by the DPS for other purposes. When kept in a separate account, financial management is easier for donors and DPS, as the account is managed by a dedicated agent and all related financial documentation is separately kept. It is appreciated when there is a donor counterpart supporting the compliance of beneficiaries with donor rules. Both DPS in Manica and Inhambane expressed concern vis-à-vis financial support provided totally out of the DPS financial system (off-budget and off-CUT).

**Both provinces would welcome the introduction of DLI based financial support.** The World Bank-administered PFM for Result (P4R) program, managed by the Ministry of Economy and Finances in coordination with MoH (and MINED), is already in place in all provinces of the country, and the experience has been deemed positive by recipients in Manica and Inhambane. DPS Manica managed to contract a private provider for the transportation of drugs, which enabled DPS to achieve its target for access to essential medicine in health centers. A program facilitator is in place in both provinces and provides technical assistance to DPS for improved performance on selected indicators. DPS Manica
needs upfront support if it is to implement DLI aid, a condition that was not fulfilled during negotiation with USAID and led to the abandonment of potential support to the province.

**Performance Based Financing is of interest of stakeholders in all provinces.** In Manica, despite the failure of a previous PBF scheme managed by CHASS, DPS, as well as FHI360 (CHASS follow-on), would be interested in restarting the initiative as a way to provide direct support to facilities. The failure of the previous initiative was due to badly managed introduction of staff incentives, leading to internal conflict within facilities. FHI360 may be contracted to conduct quarterly verification of indicators at facility level. In Inhambane, all partners that were aware of PBF are interested in implementing the approach in the province.

**Both provinces would welcome technical assistance.** Areas with greater need of technical assistance are RMNCH-related (both for the curative/obstetrics and preventive components), financial management and procurement, and planning, monitoring and evaluation. The DPS I’bane would also prefer to sub-contract a NGO to support the DPS in community empowerment and participation.

**SNAPSHOT: INHAMBANE**

**CONTEXT**
- Geographical area: 68.613 km²; 1.5 Mill. Population; 24% urban
- 133 health facilities, incl. 11 Postos de Saude (to be upgraded to Health Centers), primary health care level; 2 District Hospitals/3 Rural Hospitals, secondary level; and 1 Provincial Hospital, tertiary level
- 2 Training Centers: I’bane and Massinga (training the same specialties, with small differences)

**STATISTICS – Reproductive Health-related Indicators (refer to Summary 2010-2015 for further details)**
- Antenatal Care (1st CPN): from 96% in 2010 to 91.4% in 2015 (variation -4.6%)
- Assisted/Institutional Deliveries: from 54% in 2010 to 66.5% in 2015 (variation 12.5%)
- 1st Post-Partum consultancy: from 75% in 2010 to 75.4% in 2015 (variation 0.4%)
- 1st FP consultancy: from 19% in 2010 to 46.2% in 2015 (variation 27%)
- Maternal Deaths (in health facilities): 72 in 2010, 47 in 2015
- Specific HR/100000 population: Clinical professionals 79.4; MCH Nurses 64.7
- # of consults/capita/year: 1.68

**MAIN GAPS AND NEEDS/PRIORITIES FOR DFID POTENTIAL SUPPORT**
- Expansion of health network (rehab and new facilities)
- Strengthening the referral system (to 1st level of referral: District/Rural Hospitals), including: medical equipment, transport/ambulance in DH/RH; communications
- Strengthening of community empowerment and involvement – subcontracting NGO
- Institutional technical assistance, with focus on: MCH (both curative/obstetric and preventive); planning, monitoring and evaluation; financial management

**OTHER KEY CONCERNS AND MESSAGES**
- Labor share between the two training centers aiming at greater efficiency in the allocation and use of resources
- Quality of training of MCH Nurses
- PBF/DLIs is most welcome by both DPS/TCs and NGOs
DONORS/IMPLEMENTING AGENCIES PER MODALITY

- On-budget & on-CUT: Ireland, World Bank administered Pfr (via Finances)
- On-budget & off-CUT: UNICEF, WHO, Medicus Mundi Catalunha (directly managed by DPS and CFs)
- Off-budget & off-CUT: managed by CF/AMREF; managed by implementing agencies/all other NGOs

BUDGET

- State budget for 2016: 155.6 million MZN, of which 42% for Salaries; 48% for Bens & Servicos (running costs – incl. Reforco from drugs & consultancies’ taxes); and 10% for Investment
- PROSAUDE: 57.4 million MZN, of which 97% is for salaries & incentives (staff-related expenditures), and 3% is for investment (medical equipment only). Allocation for drugs & consumables through CMAM is unknown
- External funds (managed by the DPS: Ireland, UNICEF, WHO and Medicus Mundi Catalunha), annual estimate: 17.4 million MZN
N.B. Other NGOs’ funding is unknown (direct management by the NGOs)

SNAPSHOT – MANICA

CONTEXT

- 1.866.301 habitants, 24% in urban areas; 61.661 Km²
- 12 districts, 115 health facilities, 2 District Hospitals/2 Rural Hospitals, secondary level; and 1 Provincial Hospital, tertiary level
- 3 hospitals with surgery capacities (Provincial Hospital of Chimoio, District Hospitals of Barue and Mussorize)
- Only 1 Model Maternity (CS 1 de Maio)
- 1 training center with average 250-270 students graduated every year

KEY STATISTICS – Reproductive Health-related and Health System Indicators

- Neonatal mortality: 1.5%
- Assisted deliveries: 79.9% in 2015, 74.8% in 2010
- # of consults/capita/year: 1.49
- Utilization of modern methods for FP: 30.9% in 2014, 12.5% in 2011
- 67.1 clinical professional per 100000 population, 42.9 MCH professional per 100,000 target population (2014). To be compared with national averages of 70.9 and 44.6, respectively
- PROSAUDE needed (2016) at 12 Mill. MZN (compared with 82.5 Mill. in OGE): usually to cover part of the first year at work for newly posted professionals (261, expected for 2016)

MAIN GAPS AND NEEDS/PRIORITIES FOR DFID POTENTIAL SUPPORT

- Improve quality of care by improving MCH nurses training, supporting access to needed material (sphygmomanometers, oxygen manometers, etc.). Expansion of post partum hemorrhage training to 9 Districts – Financial support to DPS and ICS
- Improve MCH nurse distribution to ensure all Health Centers Type II avail at least one MCH nurse in place
- Testing the rehabilitation of SAAJ (request from DPS) – Financial support to DPS
- Building maternity waiting rooms (request from DPS) – Financial support to DPS
- Strengthening of community empowerment & involvement – subcontracting NGO
- Institutional technical assistance, with focus on: MCH (both curative/obstetric and
preventive); planning, monitoring & evaluation; financial management

OTHER KEY CONCERNS AND MESSAGES

- DPS requested financial support to cover absorption of graduates non covered by PROSAUDE (only 25% ensured, for 2016)
- Need for additional ambulances
- Need for additional health facilities

DONORS/IMPLEMENTING AGENCIES PER MODALITY

- On-budget & on-CUT: PROSAUDE (92 million MZN), World Bank administered PfR (1.3 million MZN), GAVI (1.2 million MZN)
- On-budget & off-CUT: FHI 360 (16.5 million MZN), UNICEF (15 million MZN), WHO (8 million MZN), AIFO (321,000 MZN)
- Off-budget & off-CUT: FHI360, Save the Children (APE supervision, Reproductive Health, CEP), FDC (Malaria and HIV)

BUDGET

- DPS government budget 2015 (including INS and SDSMAS Chimoio): 112 million MZN (USD 2,242,000), of which 66% were used to pay salaries.
- SDSMAS government budget 2015: 221 million MZN
- Provincial Hospital government budget 2015: 120 million MZN
- Only DPS, SDSMAS and Hospital Provincial are UGBs. ICS Chimoio currently working to become autonomous.

SNAPSHOT: NAMPULA

CONTEXT

- Geographical area: 81606 km²; 5.13 Mill. Population; 32% urban; 23 Districts (2 new, in 2015)
- 195 health facilities, incl. 39 Postos de Saude (to be upgraded to Health Centres), primary health care level; 2 District Hospitals/5 Rural Hospitals/1 General Hospital (large, in Nacala-Porto), secondary level; and 1 Central Hospital, tertiary level. 1 Psychiatric facility
- Population / Facility (2014): > 25000 (highest among Provinces)
- 1 Training Centre: Nampula-City (third largest in the country). A 2nd. Training Centre expected to open soon in Nacala-Porto. Universidade Lúrio with courses on Medicine, Nursing, Nutrition, etc.

STATISTICS – Reproductive Health-related Indicators (refer to Summary 2010-2015 for further details)

- Antenatal Care (1st CPN): 92.9% in the 2010 DHS; unreliable figures from Módulo Básico (circa / above 100%, in last 2 years)
- Assisted/Institutional Deliveries: 79% in 2013; 55.3% in the 2010 DHS; unreliable figures from Módulo Básico (circa / above 100%, in last 2 years)
- 1st Post-Partum consultancy: 81% in 2013
- FP utilisation coverage: 5% in the 2010 DHS; 31.3% in 2013 (Annual DPS Report)
- Institutional Maternal Mortality Rate (in health facilities): 276 in 2009 (national average 473)
- Case-Fatality Rate for Direct Obstetric Causes (2012): 4.9% (national average 2.4%)
- % Deliveries by Cesarian section: in 2012, Province 2.2% (national average 2.4%); Central Hosp. Nampula, in 2015, 20%
- Facilities with Obstetrical capacity (2012): 13%
- Specific HR/100000 population: Clinical professionals 57.6; MCH Nurses 40.2; Ratio HRH / 1000 Deliveries 3.2;
- # of consults/capita/year: 1.19;

MAIN GAPS & NEEDS/PRIORITIES FOR DFID POTENTIAL SUPPORT

- Expansion of PHC network (rehab & new facilities), because of low Population / Facility rate
- Strengthening the Referral System (to 1st level of referral: District/Rural Hospitals), including: Medical Equipment, Transport/Ambulance in DH/RH; Communications. Transportation needs higher than in most Provinces due to larger rural population
- An historical HRH deficit still to be closed: large training needs and financial capacity for hiring
- Strengthening of community empowerment & involvement – subcontracting NGO’s. Huge challenge in a Province where women’s knowledge and capacity for decision seems lower than in most other Provinces (HIV knowledge, decision on assets, violence) (2009 INSIDA, 2010 DHS)
- Institutional Technical Assistance? Large USAID-MCSP Project about to start in Province. Alternatively, expanded scope of existing PBF could push for quality improvements

OTHER KEY CONCERNS & MESSAGES

- The redressing of the historical HRH deficit has large costs and local training institutions may not have enough capacity to satisfy the needs
- HIV toll on health and demand for health services may rise on medium term: various large development projects and groups of affluent mobile labourers
- Existing experience with large PBF program
- The network of 9 Hospitals (+ academic institutions) can sustain professional associations’ initiatives
ANNEX 2

DETAILED ASSESSMENT OF AID MODALITIES

This annex presents the analysis of the following aid modalities:

- National Budget Support/Polled Funding (PROSAUDE)
- Global Financing Facility
- Provincial budget support (single donor)
- External fund (trust fund, service provider managed)
- Project support using government system (PIU, SPIU)
- Project support using parallel system (service provider)

Each aid modality has been assessed based on the following criteria and ranked based on a High to Low potential.

1 Potential for Impact

This dimension assesses to what extent an aid modality supports the donor’s impact objectives. We will analyze the potential to influence policies, potential to significantly impact health outcomes, and potential to support the host country systems development.

2 Financial Governance

We will evaluate the aid modality based on its fiduciary risk, the level of management control that DFID will retain (on how the money is allocated and accounted for), the level of accountability from all partners, and the traceability of funds and attribution feasibility.

3 Efficiency

This dimension will take into account the potential to leverage other sources of funding, the managerial burden on DFID and the GRM side (are strategies aligned with government PFM processes), and the timeliness of disbursement.

4 Strategic Alignment

We will assess how the aid modality aligns with health sector strategies and overall DFID other key interventions. Further, we will assess government and other partners buy in for selected interventions.

NATIONAL BUDGET SUPPORT/POOLED FUNDING

PROSAUDE

PROSAUDE is a national, multi-donor non-earmarked pooled fund, with an overall objective to contribute to the implementation of the Health Sector 5-Year Strategic Plan (Plano Estrategico do Sector da Saude, PESS). The fund is guided by a code of conduct and a memorandum of understanding signed by all parties involved, and by administration agreements signed between the government and each involved donor. PROSAUDE funds are on-budget, as they are registered in the Government of Mozambique (GoM) budgeting system under a specific code, and also on-CUT, i.e. funds are transferred by donors to a single account at Treasury (Conta Unica do Tesouro, CUT), Ministry of Economy and Finance (MoEF), who processes the transfer to the beneficiary (health) institutions. Each year the allocation of PROSAUDE funds is proposed by the MoH based
on donors’ indicative commitments and a joint MoH-Donor evaluation (Avaliação Conjunta Anual, ACA).

In the late 1990s, Switzerland took the lead on the establishment of the first common funds for running costs, drugs and consumables, and specialized medical assistance for central hospitals outside Maputo, as well as provincial and rural hospitals. In the early 2000s, a SWAP was successfully established by the Ministry of Health (MoH) and its almost 30 partners. Finally, in November 2003, GoM and a group of donors signed a Memorandum of Understanding (MoU) for the establishment of PROSAUDE.

A joint government-donor assessment of PROSAUDE conducted in 2014-15 identified strengths and weaknesses, which are being taken into account in the ongoing review of this mechanism and the respective MoU. The outcome of the review will determine the level of future donor support to this mechanism. Most of PROSAUDE cooperation partners have conditioned disbursements in 2016 to joint approval of the new MoU and, in few cases, also to the signature of a new bilateral agreement with the revised MoU.

Donor support to PROSAUDE has decreased in the last years, in terms of total funding and in the number of partners. Between 2012 and 2015, annual funding decreased from US$102.4 million to US$52.5 million (49% decrease), while commitments in 2016 amount to US$43 mill (20% less than in the previous year). Two major donors - the European Union and the UK - have left this mechanism, and DANIDA will leave by the end of 2017. Currently, PROSAUDE counts on ten development partners: Ireland, Canada, the Netherlands, Switzerland, Denmark, Flanders, Spain, Italy, UN/UNICEF, and UN/UNFPA.

**Evaluation of National Budget Support/Pooled Funding (PROSAUDE)\(^1\)**

**Potential for impact:** Overall rating: MEDIUM

- **Potential to influence policies is currently Medium**, due to loss of financial leverage and absence of policy dialogue. However, it can be High as long as the amount of funding is significant and there is focus on quality technical discussion on health priorities with the support of competent and well-placed institutional technical assistance.

- **Potential to significantly impact health outcomes is currently Low**, considering the multi-dimension/multi-sector nature of health outcomes and lack of strategic fund allocation, as well as the current relatively small size of the common fund.

- **Potential to support the host country systems’ development is High.** PROSAUDE has contributed to improve PFM in the Health Sector (central level), by following the GoM systems, empowering monitoring and auditing procedures, and providing technical assistance.

**Financial Governance:** Overall rating: MEDIUM

- Fiduciary risk is Medium at central level, but High at decentralized level (namely at district level).

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\(^1\) The ratings of PROSAUDE are based on its current situation and the findings of the evaluation recently carried out. This modality has been going through an institutional crisis for the last two years. Its potential revitalization and regain of its original potential depend on whether the MoH is willing and able to respond to PROSAUDE Donors concerns and concrete recommendations for the review of the instrument and respective MoU.
- **Level of management control (by Donor) is Low**, as this is GoM-led mechanism.
- **Level of accountability (from all partners) is Medium.** It all depends on the depth and quality of the joint discussion on the allocation of funds and results achieved (through the Avaliacao Conjunta Annual, ACA).
- **Traceability of funds and attribution feasibility is High up to the provincial level, and Low from provincial to district level.**

**Efficiency:** Overall rating: LOW

- **Potential to leverage other sources of funding is currently Low.** PROSAUDE funding has decreased in 58% since 2012, due to both a reduction of the number of donors and the amounts allocated. An increasing number of donors wish to be able to have quicker health outcomes show attribution.
- **Managerial burden on DFID and GoM is Low as donors rely on GoM systems while, for GoM, alignment with its own procedures reduces transaction costs.**
- **Timeliness of disbursement is Low, due to poor communication and coordination (between donors and GoM institutions and, within GoM, between MoEF and MoH), as well as to donor conditioned disbursements and delays.**

**Strategic Alignment:** Overall rating: MEDIUM

- **Alignment with health sector policies and strategies is, in principle, High.** PROSAUDE supports implementation of PESS. However, lack of in-depth and quality discussion around the strategic allocation of funds has led to distortions.
- **Alignment with DFID objectives is Medium.** Health outcomes and results are mixed; attribution to DFID support is not possible; it has contributed to strengthening GoM PFM systems (at central level).

**Risks**

Unless Donors’ concerns on the thematic priorities and the level of decentralization of funds, as well as on some of the current arrangements, are taken into account by MoH in the review of PROSAUDE and respective MoU, and the latter is quickly submitted and accepted by all involved parties, there is a high risk that more donors will move away from, or reduce their contribution to, PROSAUDE. In addition, an increasing number of donors demand quicker health outcomes and wish to be able to show attribution, which is not possible in PROSAUDE. Between 2012 and 2016, PROSAUDE funds reduced in 58%; further reductions (and/or significant adjustments in the payment of incentives/top-up salaries to staff, mostly at central level) are likely to result in the loss of PROSAUDE leverage for policy dialogue and capacity to attract other donors.

Despite its weaknesses, PROSAUDE has been a platform for donor-coordinated and aligned support to the health sector strategic plan, and for coordinated policy dialogue, with the potential to empower strategic priorities and reduce inequities between provinces. By using common procedures and following the government systems, PROSAUDE has contributed to strengthen PFM at central level and reduce transaction costs. The loss of this national pooled funding mechanism might increase fragmentation and duplication of approaches, as well as inequities.

**GLOBAL FINANCING FACILITY**

The creation of the Global Financing Facility (GFF) was announced in September 2014, with the aim of accelerating efforts to end preventable maternal, newborn, child, and
adolescent deaths. The GFF is meant to be a major vehicle for financing the proposed SDG on healthy lives and should support the UN Secretary-General’s renewed “Global Strategy for Women’s, Children’s, and Adolescents’ Health”. It is based on the analysis that RMNCAH has traditionally been underfunded and actions to improve it uncoordinated. It proposes to combine efforts from a broad set of partners, including government and traditional external donors, private actors and civil society. The two key principles guiding GFF are inclusiveness and transparency.

To support improved RMNCHA indicators, GFF proposes to:

- Develop investment cases for RMNCAH;
- Mobilize financing for investment cases, by supporting increased government investment in RMNCAH; providing grant funding, linked to projects from the International Development Association (IDA) and the International Bank of Reconstruction and Development (IBRD); promoting innovative engagement of global and local private sector resources;
- Support the development of health financing strategies focused on sustainability;
- Invest in global public goods that support RMNCAH results at the country level, particularly civil registration and vital statistics (CRVS).

To complement the work of the broader facility GFF, a multi donor trust fund - the GFF Trust Fund, has been created and hosted at the World Bank. It is expected to provide result-based grant funding, matched with IDA or IBRD financing. As of today, the GFF Trust Fund has received US$800 million from the governments of Norway and Canada. A total of 62 high-burden, low- and lower-middle income countries are eligible to receive grant resources from the GFF Trust Fund. The Democratic Republic of Congo, Ethiopia, Kenya, and Tanzania were first to receive support and Bangladesh, Cameroon, India, Liberia, Mozambique, Nigeria, Senegal, and Uganda were announced as the second wave of GFF countries.

Preliminary discussion between the World Bank, the government, and donors are happening in Mozambique to create a GFF platform but with no concrete roadmap yet defined. Members of DNSP were invited to Kenya for the Global Financing Learning meeting in November 2015. Several donors are interested in the mechanisms, such as Canada, who is committed to providing support to develop Mozambique CRVS, P4H, who is providing support to develop the country health financing strategy, and UNICEF.

Preliminary thinking is to link GFF funds with the SWAP mechanisms, which the Bank may join. Preparation work will occur during the coming two years in order to finalize the country health financing strategy, develop the investment cases, and define the aid modalities.

Ultimate success of the initiative will rely on the ministry capacity to effectively lead the process.

**Evaluation of the Global Financing Facility**

**Potential for impact**: Overall rating: MEDIUM

- Potential to influence policies can be **HIGH**.
- If the platform succeeds to gather partners from diverse key sectors.
If funds are matched with IDA support, level of support may be significant to drive RMNCH agenda.

Impact of health outcomes can be *medium* and will depend on the effective use of funds and allocation formula. The introduction of DLI should improve impact if properly designed.

Support to country system can be *high*. Funds are expected to be on-budget on-CUT, and overall financial control led by the World Bank. Expectations would be to further strengthen PFM capacity, including at provincial level.

**Financial Governance:** Overall rating: *medium*

- **Fiduciary risk can be medium** and will depend on the MOU in place and the financial management processes.
- **Management control by DFID is low** as it will be a pooled funds and financial processes agreed among partners.
- **Accountability can be medium.** Despite the intention to support strong accountability from a diverse set of partners, it will only work if a good result framework is produced and strong leadership from government.
- **Traceability of funds could be medium** and will depend of the feasibility of tracking resources at district levels at the time of implementation.

**Efficiency:** Overall rating: *high*

- **Leverage other sources of funding can be high.** If well designed, GFF trust fund should include donors and private sector contribution both at national and global level.
- **Managerial burden can be low for DFIF and Government** as donors rely on GoM systems while, for GoM, alignment with its own procedures reduces transaction costs.
- **Timeliness of disbursement is expected to be low,** due to donor conditioned disbursements and delays.

**Strategic Alignment:** Overall rating: *medium*

- **With sector policies can be high.** RMNCH is at the core of the major health policies and financing should be aligned with case investment and health financing strategy.
- **With DFID objectives is expected to be medium.** In principle, the focus on RMCNCH and introduction of DLIs matches DFID objectives. The pooling agreement and leadership of the World Bank may undermine DFID’s objective to be a key player at the ministry table.

**Risks**

There are several barriers for GFF to fulfill its potential. The major risk threatening GFF’s success is the cumbersome process of coordinating donors, and developing too many preliminary assessments before funding. If too much time is lost in discussion and RMNCH business case and country health financing strategy development, initial momentum may be lost. Initial conversation with the World Bank already led to an estimation of two years before actual support can be disbursed. The lack of leadership from donors, the World Bank, and the government also threatens the opportunity for GFF to be the key platform for promoting accountability and achievement impact in reducing maternal and child mortality.
PROVINCIAL BUDGET SUPPORT (SINGLE DONOR)
Few development partners provide budget support to specific provinces, with the main objective of contributing to the implementation of the provincial PESS – namely Denmark in Tete Province, Ireland in Niassa and Inhambane Provinces, and Canada in Zambezia Province. All these donors also contribute to PROSAUDE. In principle, the provincial budget support is non-earmarked. However, when planning the allocation of the funds, priority is given to areas of preference of the donors (e.g. mother and child health, nutrition, maternal mortality, etc.). Allocation of funds and evaluation are done together between the provincial health directorate and the donor. Like PROSAUDE, these provincial single budget support mechanisms are on-budget and on-CUT.

Evaluation of Provincial Budget Support (Single Donor)
Potential for impact: Overall rating: HIGH

- Potential to influence policies can be Medium, as long as the amount and stability of funding is significant, there is good communication of results and success stories to the central level (from both government/DPS and donor), and there are quality technical discussions with the support of competent and well-placed institutional technical assistance.
- Potential to significantly impact health outcomes can be High at provincial level, as long as the funding is significant, the period covered is relatively long, and there is competent and well-integrated technical assistance.
- Potential to support the host country systems’ development is High. DANIDA support in Tete has contributed to improve PFM in the provincial health sector, by following the GoM systems, empowering monitoring and auditing procedures, and providing technical assistance.

Financial Governance: Overall rating: MEDIUM

- Fiduciary risk is Medium at provincial level, but High at district level.
- Level of management control (by Donor) is Medium through joint planning and evaluation mechanisms and technical assistance.
- Level of accountability (from all partners) is Medium despite joint planning and evaluation, it all depends on the depth and quality of the analysis.
- Traceability of funds and attribution feasibility is Medium despite being a single donor mechanism. It requires a good set of (attributable) indicators, as well as good planning on the allocation of resources, monitoring and evaluation, and data collection and analysis.

Efficiency: Overall rating: MEDIUM

- Potential to leverage other sources of funding is Low. Aside from few delegated agreements among donors, there is no evidence showing that donors are interested in establishing a multi-donor pooled fund at this level. In addition, major donors tend to share provinces among them rather than working in the same province (which is welcomed by MoH).
- Managerial burden on DFID and GoM is Low. Donors rely on GoM systems while, for GoM, alignment with its own procedures reduces transaction costs.
- Timeliness of disbursement is Low due to poor communication and coordination (between donors and GoM institutions and, within GoM, between MoEF and MoH).

Strategic Alignment: Overall rating: MEDIUM
- **Alignment with health sector policies and strategies is MEDIUM.** Though this modality is principle aligned with provincial PESS, major donors’ own priorities may prevail.

- **Alignment with DFID objectives is High.** Potential impact on provincial health outcomes can be significant; attribution to DFID support is possible; it has contributed to strengthening planning, management and PFM systems at provincial level.

**Risks**

- The Provincial Budget Support by itself (i.e. with no complementary intervention at central level) risks missing the big picture and opportunities to strengthen policy dialogue and influence health policy and strategies at central level.

- Inequities among provinces risk increasing. Politically, it is difficult for GoM to justify the selection of provinces for this approach.

- Major donors focused on one province tend to ignore what is happening in other provinces where other donors follow a similar approach – relevant information and lessons learned are not shared and/or jointly analyzed, and often the same mistakes are repeated. A major donor can easily use its leverage to push for its own priorities (within the provincial PESS).

- Considering the limited leadership and capacity at provincial level, integrated planning with other relevant funding sources (e.g. government budget, UN agencies, NGOs) is often lacking. Poor strategic and operational coordination among the development partners may lead to missed opportunities for synergies and complementarity, thereby decreasing efficiency.

**PROJECT AID**

Several multilateral and bilateral donors (World Bank, Switzerland, Italy), UN agencies (UNICEF and UNFPA), and multi-donor funding mechanisms (Global Fund), provide project support with a specific thematic focus (Switzerland on Community Empowerment; Italy on Training; World Bank on PHC and APEs; GF on HIV/AIDS, TB, Malaria) and, in most cases also a geographical focus (World Bank in the three northern provinces; Switzerland in Cabo Delgado). All but Italy are on-Budget. Some of them are also on-CUT (World Bank, Global Fund and Switzerland), while others are not (Italy and the UN agencies). All of them follow GoM financial and auditing procedures.

**Evaluation of Project Support using GoM procedures**

**Potential for impact:** Overall rating: HIGH

- **Potential to influence policies is Low** as it focuses on very specific areas. *It may be Medium*, if the project focuses on a thematic area; the amount of funds and period covered by the project are significant; and the project counts on competent and well-placed technical assistance.

- **Potential to significantly impact health outcomes can be High in the thematic area of focus** – as long as the funding is significant, the period covered is relatively long, and there is competent and well-integrated technical assistance.

- **Potential to support the host country systems’ development is Low** although, following GoM procedures, these donors focus on very specific areas and do not provide TA to PFM.

**Financial Governance:** Overall rating: MEDIUM

- **Fiduciary risk is Medium** at provincial level, but **High** at district level.
- **Level of management control (by Donor) can be High** if the donor invests seriously on joint planning, monitoring and evaluation.

- **Level of accountability (from all partners) is Medium.** Despite joint planning and evaluation, it all depends on the depth and quality of planning, follow-up, and analysis of data.

- **Traceability of funds is Medium** despite being project funds, it requires a good PFM system and a close follow-up; **attribution feasibility can be High**, as long as the project counts on a set of (attributable) indicators, and there is good planning on the allocation of resources, monitoring and evaluation, and data collection and analysis.

**Efficiency:** Overall rating: LOW

- **Potential to leverage other sources of funding is Low,** except in regards to the development of synergies and complementarity.

- **Managerial burden on DFID and GoM is High.** When relying on GoM procedures, donor close follow-up is needed. For GoM institutions, it requires work out of the GoM system.

- **Timeliness of disbursement is mixed btw Low and High.** It depends on whether the funding is on-CUT (in which case there may be delays in disbursing the funds).

**Strategic Alignment:** Overall rating: MEDIUM

- **Alignment with health sector policies and strategies is Medium.** In principle, the area of project focus is included in the PESS but donors may create distortions in terms of priorities.

- **Alignment with DFID objectives is Medium.** Potential impact on provincial health outcomes can be significant and attribution to DFID support is possible. However, projects do not focus on strengthening GoM systems.

**Risks**

- Geographically focused project approach risks to miss the big picture and opportunities to strengthen policy dialogue and influence health policy and strategies.

- High managerial burden on the provincial authorities. Although, following GoM financial and auditing procedures, planning/management/accountability of these projects is done separately.

- Considering the limited leadership and coordination capacity at central and provincial level, integrated planning with other relevant funding sources is often lacking. Poor strategic and operational coordination among the development partners may lead to missed opportunities for synergies and complementarity, thereby decreasing efficiency.
PROJECT SUPPORT USING PARALLEL SYSTEMS
Few bilateral donors (USAID), most NGOs, and implementing agencies (CDC, PSI) provide project support with a specific thematic focus and, in most cases, also a geographical focus. Most of this support is off-Budget and all are off-CUT. Most follow their own financial management and auditing procedures.

Evaluation of Project Support using parallel systems

Potential for impact: Overall rating: MEDIUM

- **Potential to influence policies can be Medium** as long as the amount and stability of funding is significant, and the donor participates at the technical WGs at central level.
- **Potential to significantly impact health outcomes can be High in the thematic area of focus** as long as the funding is significant, the period covered is relatively long, and the project counts on competent technical assistance.
- **Potential to support the host country systems’ development is Low.** Parallel systems are used, rather than GoM systems.

Financial Governance: Overall rating: MEDIUM

- **Fiduciary risk is Low,** as the funds are directly managed by the donor/implementing agency.
- **Level of management control (by Donor) is High** since, in coordination with the national authorities, planning, management, and evaluation of results is led by the donor/implementing agency.
- **Level of accountability (from all partners) is Low.** Government authorities try to coordinate these approaches and request regular reporting, but there is no joint accountability as such.
- **Traceability of funds is High,** as the funds are directly managed by the donor/implementing agency. **Attribution feasibility is, in principle, High,** as long as there is a set of (attributable) indicators, and good project management, monitoring, and data collection and analysis.

Efficiency: Overall rating: LOW

- **Potential to leverage other sources of funding is Low,** except in regards to the potential development of synergies and complementarity.
- **Managerial burden is High on DFID and Low on GoM.** The project is managed directly by the donor/implementing agency, usually with heavy technical assistance and/or a costly implementation unit, thus reducing efficiency and sustainability.
- **Timeliness of disbursement is in principle High,** as the funds are directly managed by the donor/implementing agency.

Strategic Alignment: Overall rating: MEDIUM

- **Alignment with health sector policies and strategies is Medium.** In principle, the area of project focus is included in the PESS, but donors may create distortions in terms of priorities.
- **Alignment with DFID objectives is Medium.** Potential impact on provincial health outcomes can be significant and attribution to DFID support is possible. However, project support using parallel systems does not contribute to strengthen GoM systems.
Risks

- Unsustainability is a major risk. This modality usually relies on heavy technical assistance and/or project implementation units. On the other side, since this is a donor/implementing agency-led mechanism, GoM ownership is low.
- The geographically and/or thematically focused non-integrated project approach risks missing the big picture and opportunities to strengthen policy dialogue and influence health policy and strategies. Distortion of priorities can happen at central and provincial level.
- Poor strategic and operational coordination among the development partners, due to limited leadership and coordination capacity, may lead to duplication of efforts and missed opportunities for synergies and complementarity, thereby decreasing efficiency.
## ANNEX 3

### POTENTIAL LIST OF DISBURSEMENT LINKED INDICATORS (DLI)

#### QUALITY OF CARE (access to HR and material)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Type I facilities fully equipped</td>
<td>DPS or District</td>
<td>External assessment</td>
</tr>
<tr>
<td># of maternities accredited model maternities</td>
<td>DPS</td>
<td>External assessment</td>
</tr>
<tr>
<td># of district hospital with 2 surgery teams</td>
<td>DPS</td>
<td>External assessment</td>
</tr>
</tbody>
</table>

#### QUALITY OF CARE (Capacity of HR)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of skilled professional among randomly selected sample of graduated students</td>
<td>Training center</td>
<td>External assessment</td>
</tr>
<tr>
<td>% of skilled professional among randomly selected sample of health workers</td>
<td>DPS/Districts/Facilities</td>
<td>External assessment</td>
</tr>
<tr>
<td>% of ANC visits where malaria prophylaxis is provided</td>
<td>DPS/Districts/Facilities</td>
<td>Modulo basico</td>
</tr>
<tr>
<td>% of deliveries with immediate post partum IDU injection</td>
<td>DPS/Districts/Facilities</td>
<td>Modulo basico</td>
</tr>
</tbody>
</table>

#### REFERRAL

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of deliveries occurring at district/rural hospitals</td>
<td>DPS</td>
<td>Modulo basico</td>
</tr>
<tr>
<td>% of neonatal death due to delayed arrival to hospital</td>
<td>DPS</td>
<td>Hospital registry</td>
</tr>
<tr>
<td>% of deliveries referred to hospitals</td>
<td>DPS/Districts/Facilities</td>
<td>Modulo basico</td>
</tr>
</tbody>
</table>

#### DEMAND

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP coverage</td>
<td>DPS/Districts/Facilities</td>
<td>Estimation from Modulo Basico</td>
</tr>
<tr>
<td># of assisted deliveries</td>
<td>DPS/Districts/Facilities</td>
<td>Modulo basico</td>
</tr>
<tr>
<td>% of patient satisfied</td>
<td>DPS/Districts/Facilities</td>
<td>External survey</td>
</tr>
<tr>
<td>% of community designed action planed implemented</td>
<td>DPS/Districts/Facilities</td>
<td>External assessment</td>
</tr>
</tbody>
</table>
## Annex 4

### Risk Assessment of Recommendations

<table>
<thead>
<tr>
<th>Project</th>
<th>Risks</th>
<th>Probability (Low, Medium, High)</th>
<th>Impact (Low, Medium, High)</th>
<th>Mitigation strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Component 1: Provincial DLI</strong></td>
<td>Misappropriate funds</td>
<td>Medium</td>
<td>High</td>
<td>– Create a PMU to manage risk, conduct regular external audits, especially for procurement</td>
</tr>
<tr>
<td></td>
<td>Reduction in domestic allocation to health</td>
<td>High</td>
<td>High</td>
<td>– Disbursement conditional to non-reduction of government funding</td>
</tr>
<tr>
<td></td>
<td>Lack of capacity of DPS/TC to achieve targets</td>
<td>High</td>
<td>Medium</td>
<td>– Provide clinical and financial technical assistance to DPS to define strategies and track results</td>
</tr>
<tr>
<td></td>
<td>Non disbursement if DLIs not achieved</td>
<td>Medium</td>
<td>High</td>
<td>– Provide up-front payment for the first period, set DLIs and target based on baseline analysis and in collaboration with all stakeholders</td>
</tr>
<tr>
<td><strong>Component 1: PBF for facilities</strong></td>
<td>Sustainability post-DFID</td>
<td>Medium</td>
<td>Medium</td>
<td>– Implement program conditional on endorsement of institutionalization plan</td>
</tr>
<tr>
<td></td>
<td>Cheating on reporting</td>
<td>Medium</td>
<td>Low</td>
<td>– Set strong verification processes</td>
</tr>
<tr>
<td><strong>Component 2: Provincial Project Support</strong></td>
<td>Sustainability post-DFID</td>
<td>High</td>
<td>High</td>
<td>– Progressive transfer of capacity to government staff and integration of activities into government processes</td>
</tr>
<tr>
<td></td>
<td>Duplication/overlap with other initiatives</td>
<td>Medium</td>
<td>Medium</td>
<td>– Yearly joint planning with donors</td>
</tr>
<tr>
<td></td>
<td>Lessons learned not shared with national level and other partners</td>
<td>Medium</td>
<td>Medium</td>
<td>– Selection of provinces with limited support</td>
</tr>
<tr>
<td></td>
<td><strong>Component 3: Support civic engagement</strong></td>
<td>Delayed results, difficult to track</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td><strong>Component 4: National level TA for accountability</strong></td>
<td>Limited buy in from stakeholders</td>
<td>Medium</td>
<td>High</td>
<td>– Create a national initiative led by key politicians</td>
</tr>
<tr>
<td></td>
<td>Non acceptance from donor community of DFID funded TA</td>
<td>Medium</td>
<td>Medium</td>
<td>– Carefully link the initiative with GFF</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>– Present project design to donor community before implementation</td>
</tr>
</tbody>
</table>
# Annex 5

## Standard Interventions to Improve RMNCH Indicators

<table>
<thead>
<tr>
<th>Intervention area</th>
<th>Objective</th>
<th>Type of intervention</th>
<th>Resources from the project</th>
<th>Coordination with other actors</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRH: Improve availability of properly trained and motivated professionals for MN Care, at facility level</td>
<td>Increase practical training for competencies/skills, for MCH Nurses</td>
<td>Support to Provincial training institutions (MCH Nurses courses): TA + capacity at practical training sites Technical supervision &amp; on-site monitoring</td>
<td>Local TA &amp; hiring specific TA</td>
<td>Professional associations Other projects (infrastructure &amp; small equipment; supply chain for commodities)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TA to DPS-HRH Department on allocation criteria</td>
<td>Local TA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve the distribution/allocation of MCH Nurses to facilities, according to need/type of facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readiness capacity for obstetrical complications</td>
<td>Ensure presence of critical commodities on delivery rooms and surgery theatres</td>
<td>Improve facility management skills (including forecast for commodities) of facility directors – formal training conducive to career progression Technical supervision &amp; on-site monitoring</td>
<td>Local TA &amp; hiring specific TA</td>
<td>Other HSS projects</td>
</tr>
<tr>
<td>Access/delay phase 2</td>
<td>Improve transportation of near-to-delivery and obstetrical complications</td>
<td>Engaging village committees &amp; CHW’s Integrate data on needs &amp; response Availability of working telecommunications</td>
<td>Local TA for coordination with local governments (including SDSMAS) and communities</td>
<td>Other CHW’s projects</td>
</tr>
<tr>
<td></td>
<td>Number &amp; comfort at maternity waiting homes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention area</td>
<td>Objective</td>
<td>Type of intervention</td>
<td>Resources from the project</td>
<td>Coordination with other actors</td>
</tr>
<tr>
<td>-------------------</td>
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<td>---------------------------</td>
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</tr>
<tr>
<td>Adolescent health</td>
<td>Provide services in secondary schools</td>
<td>Bring HRH to schools for regular visits</td>
<td>Local TA for coordination with SDSMAS and District Education Boards</td>
<td>Projects supporting technical supervision</td>
</tr>
<tr>
<td>Family planning</td>
<td>Use contacts to increase supply to at-risk groups and broaden the list of available methods/MCH Nurses skilled on offering these</td>
<td>Compliance with clinical protocols for post-partum contraception Re. improved practical graduate training, for MCH Nurses</td>
<td>Local TA for coordination with other actors</td>
<td>Professional associations Projects supporting CHW’s Logistics of contraceptives</td>
</tr>
<tr>
<td>Improve quality and coverage of data (services &amp; demand)</td>
<td>Improve accountability and management</td>
<td>Data integration platforms Analytical capacity On-site feed-back</td>
<td>Adaptation of data integration platforms Specific analytical TA Local TA to organize dissemination</td>
<td>Projects supporting data integration platforms Other HSS projects</td>
</tr>
</tbody>
</table>
### Potential Innovations for Key RMNH Barriers

<table>
<thead>
<tr>
<th>Intervention area</th>
<th>Potential innovations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the ability to identify high risk pregnancies</td>
<td>Pilot the use of POC pre-eclampsia screening in peripheral health facilities.</td>
</tr>
</tbody>
</table>
| Use data platforms to improve the ability of the health system to understand the landscape of pregnant women in the communities they serve | Use GIS mapping software to establish a data platform with information that maps the location of pregnant women and estimated dates of delivery based on information provided to the health system at the first ANC visit. This information should be available to the district and provincial health authorities to allow them to understand whether the resources available align with the need at a local level.  
  
  This functionality will allow MCH providers to plan and appropriately allocate resources, while also giving a big-picture overview of RMH in the district/province. |
| Improving transportation to access health network                                   | Establish a system of mapped, locally networked transportation resources to be accessed during labor by pregnant women that would ensure rapid, reliable transportation to referral facilities in the case of an obstetric emergency.  
  
  - Establish local focal points that can identify local transportation options  
  - Map local transportation options  
  - Create a data platform that links the location of available transportation resources with the local health center maps  
  - Overlay the transportation resource map with the GIS mapped locations of pregnant women in the community  
  - Inform pregnant women of the available transportation option throughout the course of their pregnancy so that, when the time comes, the women know where to turn  
  
  Support the development of a private network of transporters and/or volunteer drivers.  
  
  Consider the creation of a transportation reimbursement system that uses vouchers or mobile payments to pay for transportation of pregnant women. |
| Reduce teen pregnancies                                                            | Establish links with the education programs in the areas with lowest rates of adolescent FP and highest rates of teen pregnancy, and devise strategies to get and keep young girls in school.  
  
  Mount a national campaign, focused on teen pregnancy, with other partners focused on this area. Leverage the expertise of existing partner (e.g.: PSI) to effectively reach these populations. |
<table>
<thead>
<tr>
<th>Intervention area</th>
<th>Potential innovations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase knowledge among target groups</td>
<td>Develop mobile-based communication to provide targeted health messages for pregnant women during pregnancy and beyond. Establish a platform from which targeted pregnancy and breastfeeding messages are sent, via SMS, to pregnant women throughout the course of their pregnancy. Eventually, this platform could serve as an interactive forum through which pregnant women can engage with the health system.</td>
</tr>
<tr>
<td>Improve maternal mortality tracking</td>
<td>Establish a system to track maternal death in communities, using identified focal points and/or SMS platform (could leverage CIP platform).</td>
</tr>
<tr>
<td>Measurement of patient satisfaction</td>
<td>Establish a routine exit interview platform using mobile technology to send simplified patient satisfaction questionnaires and allow for anonymous responses.</td>
</tr>
<tr>
<td>Establish a system to track maternal death in communities, using identified focal points and/or SMS platform (could leverage CIP platform).</td>
<td></td>
</tr>
<tr>
<td>Increase in health workers knowledge</td>
<td>Develop tele resources for MCH nurses to establish an online platform for provision of CME and updating nurses on best practices. Establish a knowledge center whose task it is to disseminate key messages to healthcare providers regarding MCH.</td>
</tr>
<tr>
<td>Consider working with the nurses association to establish a renewable accreditation process for MCH.</td>
<td></td>
</tr>
<tr>
<td>Create a local map of housing resources near referral centers in order to shelter women with high risk pregnancies</td>
<td>In areas without well equipped waiting homes, establish a list of local community housing resources willing to shelter a pregnant woman as she awaits labor. Establish a reimbursement system for payment.</td>
</tr>
<tr>
<td>Donor / Implementing Agency</td>
<td>Thematic / Geographical focus</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Ireland</strong></td>
<td>National (PROSAUDE) Niasa 'bame</td>
</tr>
<tr>
<td><strong>Netherlands</strong></td>
<td>National (PROSAUDE) Sexual &amp; Reprod Health &amp; Rights through UNFPA and PSI (most provinces)</td>
</tr>
<tr>
<td><strong>DANIDA</strong></td>
<td>National (PROSAUDE) Tete</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>National (PROSAUDE) Zambezia</td>
</tr>
<tr>
<td><strong>Switzerland/SDC</strong></td>
<td>National (PROSAUDE) C.Delgado (Ancuabe &amp; Chiure districts)</td>
</tr>
<tr>
<td>Funding Source</td>
<td>National (PROSAUDE)</td>
</tr>
<tr>
<td>Italian Coop</td>
<td>Pre-service training</td>
</tr>
<tr>
<td>Flanders</td>
<td>National (PROSAUDE)</td>
</tr>
<tr>
<td>USAID</td>
<td>Nampula and Sofala</td>
</tr>
<tr>
<td>WB (HSDP)</td>
<td>Thematic focus on PHC &amp; APes Niassa Nampula C.Delgado</td>
</tr>
<tr>
<td>Global Fund</td>
<td>Nationwide, thematic focus on HIV/AIDS, TB, Malaria, as well as HSS</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>UNFPA</td>
<td>National (PROSAUDE) Provincial level: C.Delgado, Nampula, Zambezia and Sofala Thematic focus on FP, Fistula and post-partum hemorrhage</td>
</tr>
<tr>
<td>UNICEF</td>
<td>National (PROSAUDE) All provinces (tbc) Thematic focus on Child Care/EPI &amp; APEs Program</td>
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# Annex 8

## List of Persons Interviewed

<table>
<thead>
<tr>
<th>Institution</th>
<th>Key Interviewee</th>
<th>Title</th>
<th>Contact</th>
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<tbody>
<tr>
<td><strong>Government of Mozambique</strong></td>
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<tr>
<td>MOH</td>
<td>Dr. Mbofana</td>
<td>National Director Public Health</td>
<td></td>
</tr>
<tr>
<td>MOH</td>
<td>Marina Kariagianis</td>
<td>National Director for Planning &amp; Cooperation</td>
<td>+258 82 391 0695</td>
</tr>
<tr>
<td>MOH</td>
<td>Dr. Norton Pinto</td>
<td>Deputy National Director HRH</td>
<td></td>
</tr>
<tr>
<td>DPS Manica</td>
<td>Dr. Chico</td>
<td>Head of Provincial Dept Saude Publica</td>
<td></td>
</tr>
<tr>
<td>DPS Manica</td>
<td>Dr. Humberto Jone</td>
<td>Head of Provincial Dept Planning &amp; Cooperation</td>
<td></td>
</tr>
<tr>
<td>DPS Manica/TC</td>
<td>Dra. Esperança</td>
<td>Head, MCH</td>
<td></td>
</tr>
<tr>
<td>DPS Inhambane</td>
<td>Naftal Matusse</td>
<td>Provincial Director</td>
<td>+258 84 320 4520</td>
</tr>
<tr>
<td></td>
<td>Stelio</td>
<td>Medico-Chefe</td>
<td><a href="mailto:Stelio2212@yahoo.com.br">Stelio2212@yahoo.com.br</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>+258 84 790 9020</td>
</tr>
<tr>
<td><strong>Multilateral Donors</strong></td>
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</tr>
<tr>
<td>UNFPA</td>
<td>Pilar de la Corte Molina</td>
<td></td>
<td><a href="mailto:pmolina@unfpa.org">pmolina@unfpa.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>+258 82 417 6250</td>
</tr>
<tr>
<td>UNICEF</td>
<td>James McQuen Patterson</td>
<td>Chief, Health &amp; Nutrition</td>
<td><a href="mailto:jmcsquenpatterson@unicef.org">jmcsquenpatterson@unicef.org</a></td>
</tr>
<tr>
<td>World Bank</td>
<td>Humberto Albino Cossa</td>
<td>Health Specialist</td>
<td><a href="mailto:hcossa@worldbank.org">hcossa@worldbank.org</a></td>
</tr>
<tr>
<td>Global Fund</td>
<td>Kirsi Viisainen</td>
<td>Senior Fund Portfolio Manager</td>
<td><a href="mailto:Kirsi.Viisainen@theglobalfund.org">Kirsi.Viisainen@theglobalfund.org</a></td>
</tr>
<tr>
<td><strong>Bilateral Donors</strong></td>
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<tr>
<td>USAID</td>
<td>Peter Cloutier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDC</td>
<td>Dr. Marilena Urso</td>
<td>MCH Lead</td>
<td><a href="mailto:xlg2@cdc.gov">xlg2@cdc.gov</a></td>
</tr>
<tr>
<td>Danish International Development Agency (DANIDA)</td>
<td>Kirstine Thyge Nøggaard</td>
<td></td>
<td><a href="mailto:kirnoj@um.dk">kirnoj@um.dk</a></td>
</tr>
<tr>
<td>Italian Agency for Development Cooperation</td>
<td>Ferruccio Vio</td>
<td>Health Programme Officer</td>
<td><a href="mailto:Ferruccio.vio3@gmail.com">Ferruccio.vio3@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>+258 310 5014</td>
</tr>
<tr>
<td>Organization</td>
<td>Name</td>
<td>Position</td>
<td>Contact Information</td>
</tr>
<tr>
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<td>-----------------------------------------</td>
</tr>
<tr>
<td>Canadian International Development agency (CIDA)</td>
<td>Peggy Thorpe</td>
<td>First Secretary</td>
<td>+258 84 310 0545</td>
</tr>
<tr>
<td></td>
<td>Mbate Matandalasse</td>
<td>Health Advisor</td>
<td>+258 84 310 0545 <a href="mailto:Mbate.matandalasse@ccomz.org">Mbate.matandalasse@ccomz.org</a></td>
</tr>
<tr>
<td>The Netherlands Development Cooperation</td>
<td>Monique Kamphuis</td>
<td>Policy Officer for SRHR &amp; HIV/AIDS</td>
<td><a href="mailto:Monique.kamphuis@minbuza.nl">Monique.kamphuis@minbuza.nl</a></td>
</tr>
<tr>
<td></td>
<td>Fatima Aly</td>
<td></td>
<td><a href="mailto:fatima.aly@minbuza.nl">fatima.aly@minbuza.nl</a> +258 84 125 8135/82 281 2510</td>
</tr>
<tr>
<td>Implementing partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer Service Overseas (VSO)</td>
<td>Ria Kulenovic</td>
<td>Country Director</td>
<td><a href="mailto:Ria.Kulenovic@vsoint.org">Ria.Kulenovic@vsoint.org</a></td>
</tr>
<tr>
<td>Population Services International (PSI)</td>
<td>Ryan Kelley</td>
<td>Country Representative</td>
<td><a href="mailto:rkelley@psi.org.mz">rkelley@psi.org.mz</a></td>
</tr>
<tr>
<td>PATHFINDER</td>
<td>Rita Badiani</td>
<td>Country Director</td>
<td><a href="mailto:RBadiani@pathfinder.org">RBadiani@pathfinder.org</a></td>
</tr>
<tr>
<td>JHPIEGO</td>
<td>Edgar Necochea &amp; team</td>
<td></td>
<td><a href="mailto:Edgar.Necochea@jhpiego.org">Edgar.Necochea@jhpiego.org</a></td>
</tr>
<tr>
<td>CHAI</td>
<td>Lise Ellyin</td>
<td>Country Director</td>
<td><a href="mailto:lelyin@clintonhealthaccess.org">lelyin@clintonhealthaccess.org</a></td>
</tr>
<tr>
<td>JEMBI</td>
<td>Alessandro Campione</td>
<td>Programs Director</td>
<td><a href="mailto:alessandro.campione@gmail.com">alessandro.campione@gmail.com</a></td>
</tr>
<tr>
<td>NAIMA+</td>
<td>Alain Kassa</td>
<td></td>
<td><a href="mailto:coordenacao@naima.org.mz">coordenacao@naima.org.mz</a></td>
</tr>
<tr>
<td>PATH</td>
<td>Jordi Fernandez</td>
<td>Mozambique Program Manager</td>
<td><a href="mailto:jfernandez@path.org">jfernandez@path.org</a></td>
</tr>
<tr>
<td>Save the Children (Manica)</td>
<td>Paula Nhambirre</td>
<td>Provincial Manager</td>
<td></td>
</tr>
<tr>
<td>FHI360 (Manica)</td>
<td>Mercia Cazonda</td>
<td>Provincial Technical Director</td>
<td><a href="mailto:MCazonda@fhi360.org">MCazonda@fhi360.org</a></td>
</tr>
<tr>
<td>Maningo (Manica)</td>
<td>Raul Maharate</td>
<td>Program Officer</td>
<td><a href="mailto:raul.maharate@magariro.org">raul.maharate@magariro.org</a></td>
</tr>
<tr>
<td>Malaria Consortium (I‘bane)</td>
<td>Joaquim Chau</td>
<td>Provincial Coordinator &amp; NGO provincial focal point</td>
<td><a href="mailto:j.chau@malariaconsortium.org">j.chau@malariaconsortium.org</a> +258 84 389 9827</td>
</tr>
</tbody>
</table>
ANNEX 9

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