**MOZAMBIQUE, HEALTH SECTOR**
**Roadmap to support from the Global Financing Facility for Every Woman and Every Child**

## Introduction

1. Mozambique has been included as one of the Global Financing Facility (GFF) countries in support of Every Women Every Child (EWEC). The GFF is an initiative supported by a number of multilateral agencies and donor countries aimed at scaling up country-led efforts to improve reproductive, maternal, newborn, child, and adolescent health (RMNCAH). At the country level, the GFF seeks to support with an integrated approach that looks for the best solutions for better RMNCAH outcomes through results oriented smart, scaled up and sustainable financing.

## Context & Process

2. The GFF mobilizes increased resources in health by combining external, domestic, and other innovative sources of financing, including from the private sector. Specifically, it uses grants from a multi-donor trust fund (the GFF Trust Fund) to mobilize additional funding from the International Development Association (IDA) and other development partners including the private sector.

3. In Mozambique scaling up investment in RMNCAH is critically important given the current trend of poor health status of women, newborns, children and adolescents. Despite progress over the last decade RMNCAH indicators are still precarious (table 1).

**Table 1: Evolution of selected health indicators in Mozambique, 1997-2011**

| Health Indicator | DHS 1997 | DHS 2003 | DHS 2011 |
|---|---|---|---|
| IMR per 1,000 LB | 135 | 101 | 64 |
| U5MR, per 1,00 LB | 201 | 153 | 97 |
| MMR per 100,000 LB | **692** | **408** | **408** |
| % contraception use (women 15-49) | 6 | 17 | 12 |
| % children<5yr stunted | 35.9 | 41 | 42.6 |

4. Moreover, the health system's ability to effectively deliver quality health services is impaired by factors including structural (general to the country, and specific to health) and financial that have been prevailing for a long time with adverse effects on the coverage and quality of inputs for service delivery. While spending on health has been relatively below regional benchmarks, more health for the available money could be attained through better efficiency gain by aligning spending with priority high impact intervention, and improving public financial management functions and fiduciary arrangements. In addition, improved procurement and financial management are catalytic to effective service provisions.

5. The GFF process rests on two pillars: the Investment Case (IC) for RMNCAH and the Health Financing Strategy (HFS). The elaboration of the IC is an important step to clarify priorities and coordinate investments for the next five years while keeping a longer term vision, i.e., 2016-2030, within the Sustainable Development Goals (SDG) contexts. The HFS is critical to increase domestic sources of funding from both public and private sector, payment mechanisms, including issues of value for money and linkages to results/indicators, and to ensure adequate financial protection for users in a sustainable manner. The development of the IC and the HFS will be strongly linked as the selected interventions of the IC will depend on the available financing envelope and this may require building scenarios to guide decision making. Ultimately, the IC and HFS should provide

the policy and operational guidance for the country to reach the Universal Health Coverage (UHC) that underpins the GFF partnership in support to EWEC.

**Contribution**

6. ***IC:*** The Ministry of Health (MOH)'s policy, strategic documents and studies contains essential elements to build an IC that meets the needed requirements to guide current and future investments in health. The Government possesses important policy and strategic documents upon which a strong IC can be developed, such as the Health Sector Strategic Plan, the Plan of Action for the MDG 4 and 5, the Human Resources for Health, the National Development Plan, and other existing plans/programs in the health sector. While these strategic documents offers fundamental directions to the sector, they can benefit from a rigorous process to select high impact and cost-effective interventions to further accelerate the progress on RMNCAH. In addition, the IC should assess feasibility of effective implementation at scale and identify activities to strengthen implementation. This is particularly important given the relatively low institutional capacity, especially at the periphery.

7. The development of the IC should be done in a participatory manner and should be validated by relevant development partners and approved by the Government. However, such an IC must be comprehensive and acceptable to the Government and development partners alike, and the GFF is expected to make significant contributions throughout the process.

8. ***HFS:*** The MOH has been developing a HFS for the last 2 years. A draft HFS exists but its contents are not widely known. Building upon the existing draft HFS, the GFF mechanism will help finalize and strengthen the HFS through a collaborative effort of various stakeholders. It is important to stress that while the development of a robust HFS as a key policy and strategic document of the sector is critical; in itself, is not an end. It will be important to identify health financing reform priorities and associated implementation plans, as well as, areas of support from development partners. In addition, quality and efficiency of health expenditures will be reviewed to ensure that health outcomes are commensurate with spending levels. In this context the ongoing work in the area of governance will be continued and expanded. Initially, an assessment of the fiduciary arrangements in the health sector will be carried out to map out the key constraints in procurement, financial management and other fiduciary functions. It is also important that there are clear links between the IC and the HFS.

9. ***Advancing and supporting the Implementation of the IC- New Health Project:*** As part of the GFF process, the Bank will prepare a health sector project with specific focus on RMNCH results. The current Health Service Delivery Project, designed to improve service delivery based on three integrated modes of service delivery, namely (i) community-based interventions; (ii) facility-based interventions; and (iii) expanded population outreach, is coming to an end by December 2016. The core components of the HSDP focus on Maternal and Child Health and Nutrition services. The HSDP is limited in scope both geographically and in its activities. For example, despite observed improvements in maternal and child health, adolescent health, and nutrition status are a cause of concern and disparities exists within provinces and between provinces and regions. The new health project would build on the experience accumulated through implementation of the HSDP to further expand the scope of interventions and coverage in line with the aims of the GFF. In this regards, the GFF process would help better align other development partners' interventions and programs and strengthen coordination, based on a clear resource mapping exercise, as discussed below.

10. It is anticipated that the health project will start sometime in fiscal year 2018, from July 2017, i.e., a year and a half from now. Both the IC and HFS are crucial elements for the preparation of the health sector project focused on RMNCAH. Such project will not duplicate efforts and will use existing coordination platforms between the MOH and health partners, and it is envisaged that the project funds will be channeled through the Common Pool of the sector known as PROSAUDE. Channeling the project funds through PROSAUDE, is considered an important element of the Health Sector Wide Approach (SWAP), and a critical step to improve aid effectiveness and reduce fragmentation of funding to the health sector. Also, the Government supports this financing modality, which uses the Government online financial and administrative system (e-sistafe) to disburse and execute the expenditures. The MOH and Health partners accumulated rich experience and knowledge of managing the PROSAUDE over the last decade and a half from which important lessons can be drawn in respect to efficiency of expenditures. Of particular importance is the need to enhance the technical efficiency of spending and establish clearer linkages between PROSAUDE spending and health indicators, tracking progress in health outcomes, as well as, improvements in health system performance in general. One important element of spending efficiency concerns about strengthening fiduciary capacity and procedures all central and provincial levels to remove constraints to service delivery.

**Scopes and Tasks**

11. The key tasks ahead for the preparation of the IDA/GFF support are the completion of the IC and the HFS, and an assessment of fiduciary arrangements. All the three elements should be developed in close collaboration across various stakeholders under the leadership of the MOH and should also be subject to a validation process endorsed by key stakeholders. To achieve this goal, the MOH and its partners will work collaboratively during the first half of calendar year 2016. This roadmap describes the key tasks, processes, milestones, deliverables, and estimated resources needed to advance the GFF process.

12. There are four main tasks that must be carried out between February 2016 and June 2017:

    a. The Investment Case for RMNCAH to be completed by November 2016;
    b. The Health Financing Strategy to be completed by November 2016;
    c. The Identification of PFM and Fiduciary Challenges and Action Plan to Strengthen Capacity and Build PFM/F Systems in the Sector to be completed by February 2017; and
    d. The Preparation of the Health Project to be completed June 2017.

13. It is anticipated that the Health Project will be submitted for approval to the WB Board of Directors during first quarter of fiscal year 2018 or third quarter of calendar year 2017.

*The Investment case*

14. During the next 3 quarters a stock taking exercise of existing strategic documents will be carried out jointly by the MOH and health partners. The exercise is aimed at distilling key priority RMNCAH interventions of high impact and proven cost-effectiveness. This exercise will use strategic and analytical work done by the Government and health partners under the Health SWAP. Such documents include the costed Health Sector Strategic Plan (2014-2019), the Integrated Plan to Reach the MDG 4 and 5, the Human Resources Development Plan, the Multisectorial Action Plan to Reduce Chronic Malnutrition, the National Malaria Control Program, the HIV and AIDS National Strategic Plan (PEN IV), and other disease related programs most of which were also costed.

15. The IC will contain the following key sections: (i) a summary of key issues and challenges in the health sector including amongst others, analysis of disease burden with a focus on RMNCAH, analysis of equity, brief discussion of key health system bottlenecks and performance issues, and of key health determinants undermining and favoring RMNCAH; (ii) a mapping of resources available to the health sector and analysis of key implementation bottlenecks constraining further progress in RMNCAH and discussion of opportunities for transformation and improvement; (iii) a description of key results to be achieved in five years (2018-2022) and by 2030, taking into account the situation at outset and addressing equity, efficiency and major determinants of RMNCAH outcomes, including demographic changes and other structural issues; ; (iv) a selection of priority interventions (high impact on RMNCAH, health system specific and multisectoral) that would increase the chance of attaining desired results, including a description of what, how, beneficiaries and where (rural-urban and across regions) and criteria and process used to identify priorities; (v) the service delivery modalities and broader implementation arrangements, including the role of public, private, non-state actors, and community involvement; (vi) support systems including HR, supply chain,; (vii) the overall costing of selected priority interventions (build realistic and feasible scenarios), perhaps using available cost-effectiveness tools such as WHO-CHOICE, such that the priorities are implemented within the available resource envelope; (viii) a monitoring and evaluation framework to ensure good tracking of the results and to strengthen the role of Civil Registration and Vital Statistics (CRVS) in the process.

16. The exact structure of the IC will be decided together with key stakeholders and will draw from experiences elsewhere. An important component of the IC is the strengthening of CRVS functions in designated public entities such as, the Ministry of Justice, Ministry of Interior and Ministry of Health, all of them, important sources of CRVS data. The terms of reference for the CVRS work will be further developed in the context of the M&E but will constitute an important task under the purview of the Ministry of Justice with full collaboration of the MOH.

17. Finally, an element of the IC requiring further elaboration concerns about engaging targeted beneficiaries better with mechanisms of awareness generation, social accountability and incentives so that beneficiaries demand, utilize health services and also hold public services on RMNCAH to account. In this regard community mobilization will be key to materialize this engagement.

18. **Process for IC:** From March-May 2016, a desk review of the available documents will be carried out to complete a comprehensive situation analysis of the sector with focus on RMNCAH outcomes. A clear identification of the main problems to be addressed is key as a first step to prioritize RMNCAH interventions. The draft situation analysis should cover points (i), and (ii) above, will be presented to key stakeholders in a one day workshop to build consensus in May, 2016.

19. From May-July 2016 the RMNCAH objectives for the long (2030) and medium-term (2018-2022) periods should be defined. Subsequently, prioritized high impact interventions will be selected and costed based on available information and costing tools. This work will build on the work done under the PESS and other costed plans the MOH has produced. The detailed analysis should be conducted by the technical working groups under the Health SWAP with technical facilitation of experts/consultant if needed. Key bilateral and multilateral partners will participate on the basis of their area of expertise, .e.g. UNFPA, UNICEF and WHO. A core drafting group for the IC representing key stakeholders will be established to compile all contributions and draft the IC, which will be presented and

discussed in a consensus building workshop in July, 2016. After the workshop the drafting group will continue working to complete the IC, including the costing. It is expected that by September 2016 the IC will be completed.

20. After receiving MOH's clearance, the final draft IC will be circulated among key stakeholders and will be validated using the same mechanism that the MOH and health partners use to validate key policy and strategic documents and annual work plans. This will constitute the main quality assurance method for both the IC and HFS. A review/ comment of the IC by independent peer reviewer(s) could be considered by the MOH if needed, especially if consensus is not reached in certain areas. A final adoption of the IC is expected to take place by November 2016. To that effect a national meeting will be organized to ensure wider participation of the health sector and of other stakeholders.

21. The IC will constitute the main pillar to guide RMNCAH investments not only by the IDA/GFF supported project but also by all development partners in the context of the Health SWAP and Aid effectiveness principles.

*Health Financing Strategy*

22. The Health Financing Strategy (HFS) will build upon the ongoing work completed by the MOH with support from the Technical Working Group on Health Finance (GTF), coordinated by the MOH Directorate of Planning and Cooperation (DPC). The HFS will require a broader discussion and engagement of key stakeholders, particularly the Ministry of Economy and Finance (MEF), the National Institute of Social Security, Ministry of State Administration and Civil Service, and Local Governments bodies such as Municipalities and Provincial Governments.

23. The HFS should include but not limited to: (i) a summary assessment of health financing situation in Mozambique, especially an in-depth analysis of current financing gaps, equity considerations (the recent health sector PER may provide important findings that can be useful for the summary); (ii) how to close financing gaps via increased domestic financing in the health sector (mobilization of public and private resources and potential efficiency gains); (iii) discuss the pooling of resources; (iv) discuss realistic options for purchasing health care and required legislation and regulation; (v) designing an implementation plan of the HFS; (vi) monitoring plan; and (vii) costing the HFS.

24. **Process for the HFS:** The time frame for the development of the HFS is the same as for the IC. This will help ensure complementarity and coherence of both IC and HFS.

25. From March-April a stock taking exercise will be done. This will consist of reviewing existing analysis of health financing in Mozambique and the current draft HFS. The end product of this phase should be a summary assessment of the HF landscape in Mozambique. A critical analysis of the draft strategy should also be completed, especially in respect to the feasibility (political and technical) of the options being considered. This analysis should lead to identification of areas for improvement/strengthening that should be further elaborated. In May 2016, a workshop will be organized to present the assessment of the HF, the draft HFS, and supporting analytical documentation e.g. PER/FSA.

26. From April to June the work will concentrate on addressing issues of efficiency both allocative and technical. Improvements in spending efficiency are important to increasing fiscal space within the sector. Efficiency gains that the health sector can realize should also be discussed in this part of the development of the HFS. This analysis should be informed by the overall PER, the Health Sector PER, the FSA, and other similar analysis on projection of revenues. . It will also be important to discuss the existing sources of funds

(general revenue, social insurance and or private insurance) and potential sources to tap on such as community insurance. In this regards, the analysis should consider three criteria: equity, risk pooling, and potential for risk selection that different sources of financing may be associated with. Particular attention will be paid to the private sector as a potential source of funding.

27. During the same period the HFS should clarify the allocation of resources in line with the interventions identified in the IC, while ensuring financial protection and users' satisfaction with services. The payment mechanisms are an important aspect in this regards. The development of the HFS should constitute an opportunity to explore the political feasibility of strategic purchasing of health services and explore the technical conditions to introduce such financing modalities to achieve defined policy and strategic objectives. This is in line with the GFF call for more alignment of financing with results.

28. In July 2016 a consensus workshop will be held to present the work on mobilization of resources, allocation and purchasing of health services. This will be a 2 day workshop for a wide range of stakeholders from Government, private sector, civil society organizations, and academia.

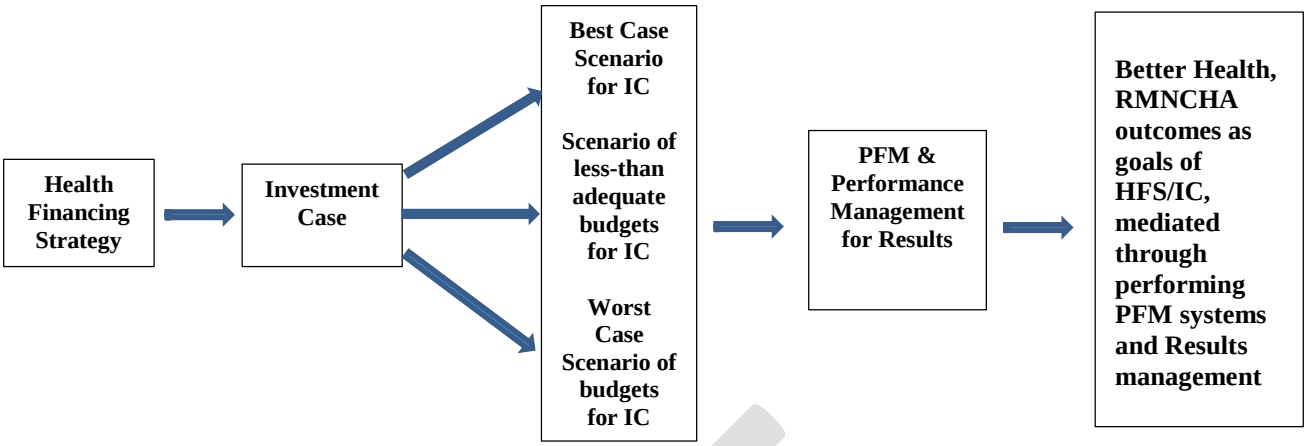
29. From July to September 2016, the HFS should be completed. It may be useful to include annexes in the HFS to discuss possible legal and regulatory implication of proposed financing option or payment mechanisms. Also a monitoring framework would help steer implementation and check progress.

30. The validation of the HFS should occur at two levels: (i) "technical level" including essentially, the health sector, health partners, academia, CSO and others; and (ii) at "political level" a national summit meeting with participation of key line ministries and the Ministry of Economy and Finance (MEF), and possibly the Prime-Minister's office and Health partners. The technical meeting will take place in early October and the national meeting will be held in November 2016 at the same time with the IC (see above).

*Identification of PFM and Fiduciary Challenges and Action Plan to Strengthen Capacity and Build PFM/F Systems in the Sector*

31. The key objective of this task is to identify the weaknesses and gaps in key MOH fiduciary functions that impact on service delivery including but not limited to: (i) procurement and contract management cycle; (ii) financial management; and (iii) performance management for results. On the basis of the above, the development of an action plan to strengthen capacity and build PFM and fiduciary systems will follow with the participation of relevant Government institutions and development partners. This work will be based on several assessments done to date by various agencies, including the assessment of procurement financed by health partners under the coordination of the Technical working group on administration and finance (GTAF) under the health SWAP. An important aspect of the work on PFM/Fiduciary area will include a focus on performance management as it relates with ensuring that planned interventions are financed and converted in health services delivered in accordance with the IC.

32. The ultimate goal is to assist the MOH design a reform and an institutional development program to put in place a strong procurement and financial management capacity at central, provincial and district levels to improve service delivery, and to ensure linkages between funding and indicators/results to further improve delivery at all levels. The links between the IC, HFS and PFM/FA are depicted in the diagram below.




33. **Process for the PFM and FA:** The health sector PFM and fiduciary areas have been subjected to many evaluations and studies. For example, the below partial list taken from ToR[1] designed to review procurement shows the extent to which these areas have received increased attention since 2012 or even earlier. The list includes:

    - 2015, MISAU-DAF, Adaptação do PEFA ao Sector da Saúde
    - 2014, EU: Avaliação de GFP no sector da saúde;
    - 2013 e 2014, Tribunal Administrativo: Relatórios finais de auditorias ao sector da saúde 2011 e 2012;
    - 2013, USAID: Avaliação PFMRAF, fase 2;
    - 2012, DFID: Análise de economia política do sector da saúde;
    - 2012, DANIDA: Avaliação externa do sistema da procura no sector da saúde;
    - 2014, Global Fund: TdR da auditoria a procura;

34. Thus, a first critical step in this task is to critically review the work done to date and determine whether additional analyses are necessary. It would seem important to ascertain the nature of impediments to the implementation of the various recommendations that arose from the studies, rather than adding more recommendations.

35. From March-June 2016, a thorough desk review of existing and ongoing studies will be done in close consultation with the GTAF. A summary of the situation analysis will be completed by June. Particular attention will be paid to the functioning of the PROSAUDE to provide a basis for creating a funding system more aligned with indicators and results. The summary will be presented in a technical workshop to be attended by MOH, MEF and health partners in early July.

36. From July-December, 2016 a fiduciary action plan should be developed that will guide the implementation of measure to strengthen: (i) procurement functions; (ii) contract management; (iii) FM functions; (iv) performance management for results; (v) disbursement arrangements; and (vi) reporting and auditing.

37. A workshop will be held in December, 2016 to present the proposed FM and procurement arrangements in line with the goals described above. The feedback provided will assist the team develop an action plan to strengthen PFM and FA. The action plan will be presented for validation in a workshop by February 2017. The FM and procurement arrangements will be part of the MOU for the PROSAUDE and should gradually be institutionalized by the MOH and applied to the execution of the state budget.

[1] From the ToR for the "*Estudo Preliminar da Área de Procura e Aquisições do Sector da Saúde*", November 2015 version

*The Health Project Preparation*

38. The Concept Note development will start in mid-July 2016. It is expected that the IC, HFS and PFM and Fiduciary assessment will inform the design of the Health Project including the technical contents, funding mechanism and implementation arrangements.

39. The development of the Project document will follow the World Bank processes. A detailed plan for the preparation of the project will be further developed. It is anticipated that the Project will go to the Board during third quarter of calendar year 2017 or first quarter of Bank's FY 2018.

**Work plan, Missions and milestones**

40. The tasks above described will imply several missions that need to be coordinated among development partners, the Bank and communicated to and agreed by the Government. The below is a tentative calendar of key missions to that effect. Also other missions by consultant(s) may take place as needed along the process. The key milestones are also indicated.

| Dates | Missions and activities | Objective | Participating Partners[2] | Milestones |
|---|---|---|---|---|
| **Quarter 1 2016** | | | | |
| March 09 – 23, 2016 | **Mission 1:** Stocktaking on the IC, HFS and PFM and fiduciary assessment (FA) | Launching of the GFF process and start stocktaking on the IC and HFS | All HPG | Official launching of the GFF process by the Government |
| **Quarter 2 2016** | | | | |
| April-May, 2016 | **Activities:** 1. Desk review of key documents concerning the IC and HFS, consultation with key stakeholders<br>2. Desk review of PFM and FA related studies | Obtain a summary of key issues on IC and HFS and a full resource mapping | Canada, DFID, GFATM, SDC, Netherlands, UNFPA, UNICEF, USAID, WB, WHO | |
| May 09-19, 2016 | **Mission 2:** Finalization of stocktaking on the IC, HFS. | Workshop for presentation and consensus building on the summary findings of the IC and HFS | Canada, DFID, GFATM, SDC, Netherlands, UNFPA, UNICEF, USAID, WB, WHO | **By May 31, 2016** the following document should be completed:<br>a) Situation analysis for the IC;<br>b) Issues paper on assessment of HFS completed |
| May-June 2016 | **Activities:** 1. Development of objectives, priority interventions, service delivery and other relevant areas of the IC<br>2. Development of key areas of the HFS, mobilization, allocation and purchasing<br>3. Review of PFM and FA documentation | Preliminary draft IC for discussion | Canada, DFID, GFATM, SDC, Netherlands, UNFPA, UNICEF, USAID, WB, WHO | |
| **Quarter 3 2016** | | | | |
| July 4-14, 2016 | **Mission 3:** Finalization of stocktaking on PFM and FA | Workshop to present and discuss:<br>(a)Complete the Analysis of the PFM and FA arrangements for the channeling of funds<br>(b) IC objective, priority interventions.<br>(c) Main contents of the HFS | Canada, DFID, GFATM, SDC, Netherlands, UNFPA, UNICEF, USAID, WB, WHO | **By July 31, 2016** the following documents will be completed<br><br>a) Situation analysis of the FA functions and institutional arrangements<br><br>b) Draft IC including the following areas: objective and priority interventions, service delivery, support systems, implementation arrangements and costing |

[2] All HPG can participate. The suggested list is meant to indicate those partners who will or may play a specific role in the process (technical input, funding, or other). Ultimately all health partners, through the HPG in the context of the Health SWAP, should be able to participate in the process.

| | | | | |
|---|---|---|---|---|
| | | | | c) Sketch of the HFS covering mobilization or resources, allocation and purchasing options. |
| July-September, 2016 | **Activities:** 1. Development of the IC paper.<br>2. Elaboration of the HFS<br>3. Start drafting the CN for the GFF Project<br>4. Development of the FA plan | Complete a draft IC and HFS<br><br>CN for the GFF Project completed | | |
| **Quarter 4 2016** | | | | |
| October, 2016 | Activities: 1. Final Draft IC and HFS circulated<br>2. Development of FA plan | Obtain comments and feedback before final validation | | |
| | | | | |
| November 14-21, 2016 | **Mission 4:** Finalization of the IC and HFS<br><br>Complete the CN for the GFF Project<br><br>Activities: Development of the FA Plan | Presentation of final IC and HFS draft<br><br>Presentation of the GFF project CN | | **By November 30, 2016**<br>a) IC completed, validated and adopted<br><br>b) HFS completed, validated, and adopted<br><br>c) CN GFF project completed |
| December, 15, 2016 | **Mission 5:** Activities. Conclusion of the FA Plan | Workshop to present the FA plan for discussion | | By December 31, 2016<br>a) PFM and FA plan completed. |
| January, 2017 | Activities: Conclusion of the FA plan | | | |
| February, 2017 | **Mission 6**: Final FA Plan | Workshop to adopt the FA and PFM arrangements | | |

## Resources required

*Skills requirements*

41. The above 4 tasks will require a set of skills form the Bank, partners and expertise. The table below provides and estimation of the skills and staff time required.

| Task | Skills needed | Persons-time | Trips | Accommodation | Workshops |
|---|---|---|---|---|---|
| | | Unit: # weeks | 1 two way trip | Unit: # days[3] | Number |
| **Investment Case** | | | | | |
| | Health Nutrition Population Specialist | 12 | 4 | 10 | 3 |
| | Economist | 12 | 4 | 10 | |
| | *Subtotal* | *24* | *8* | *20* | *3* |
| **Health Financing Strategy** | | | | | |
| | Health Economist | 10 | 4 | 10 | |
| | Health, Nutrition & Population | 4 | 4 | 10 | |
| | Health Systems | 5 | 2 | 10 | |
| | *Subtotal* | *19* | *10* | *30* | *0* |
| **PFM and Fiduciary Assessment** | | | | | |
| | FM | 12 | | 10 | 2 |
| | Procurement | 12 | | 10 | |
| | Public Administration | 8 | | 10 | |
| | *Subtotal* | *32* | *0* | *30* | *2* |
| **Project Preparation** | | | | | |
| | Health Nutrition Population Specialist | 16 | 4 | 12 | |
| | Operations Specialist | 9 | 4 | 12 | |
| | Procurement | 6 | | | |
| | Safeguards | 4 | 2 | 12 | |
| | FM | 8 | | | |
| | Governance | 14 | 3 | 15 | |
| | Health Economist | 6 | 2 | 12 | |
| | *Subtotal* | *63* | *15* | *63* | *0* |
| | **Total** | **138** | **33** | **143** | **5** |

## Estimated costs

42. The table below represents a preliminary estimation of preparation costs including the associated activities. The costs will be partially covered by the GFF TF and possibly other sources.

[3] Number of days mission members will spent in country in each trip

Cost table

| | Cost items | Unit | Average Unit cost (US$) | Quantity | Total |
|---|---|---|---|---|---|
| **1** | **Staff costs** | | | | |
| | Consultants | Days | 600 | 300 | 180,000 |
| | Staff time | | | | |
| **2** | **Trips** | | | | |
| | International | air ticket | 9,000 | 33 | 297,000 |
| | Local | air ticket | 700 | 30 | 21,000 |
| **3** | **Accommodation** | | | | |
| | Maputo | Hotel room | 220 | 130 | 28,600 |
| | Province | Hotel room | 190 | 20 | 3,800 |
| **4** | **MTV** | | | | |
| | | perdiem | 90 | 200 | 18,000 |
| **5** | **Workshops** | | | | |
| | | Room rent | 500 | 5 | 2,500 |
| | | Meals | 2,000 | 5 | 10,000 |
| | | Equipment | 500 | 5 | 2,500 |
| | | Stationary | 400 | 5 | 2,000 |
| | | Printing | 2,500 | 5 | 12,500 |
| **Contingency (5%)** | | | | | 28,895 |
| | **Grand Total** | | | | **606,795** |