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ESD/Family Planning Initiative

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Table of Contents

Acronyms	2
Executive Summary.....	3
I. Project Description.....	5
II. Achievements.....	7
A. Strengthening national, provincial, and district level capacity to advance FP service delivery	7
1. Technical assistance and advocacy to the MOH, PHD, and DHD.....	8
2. National Health Weeks	10
3. Support to PHD and DHD to improve quality FP service provision at facility and community ..	11
4. Development of training curricula, integrated supervision tools, and job aids for HF and community level in collaboration with MOH.....	12
B. Integrating FP with PHC and HIV at the HF and community levels.....	13
1. Health facilities.....	13
2. Community-based integration	17
C. Increasing demand for and access to FP services for adolescents and youth.....	23
III. Conclusions	27
IV. Attachments.....	28
Attachment A: ESD-FPI Endline Survey Report.....	28
Attachment B: Performance Monitoring Plan	45

Acronyms

AIDS	Acquired immune deficiency syndrome
APE	Agente Polivalente Elementar
CBD	Community-based distribution
CBO	Community-based organization
CHC	Community health committee
CHW	Community health worker
CMC	Co-management committee
CYP	Couple years protection
DHD	District Health Directorate
ECP	Emergency contraception pill
ESD-FPI	Extending Service Delivery – Family Planning Initiative
FP	Family planning
GBV	Gender-based violence
HF	Health facility
HIP	High-impact practice
HIV	Human immunodeficiency virus
HP	Health provider
HTC	HIV testing and counseling
MB	Mobile brigade
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MOH	Ministry of Health
NHS	National Health System
NHW	National Health Week
PHC	Primary health care
RH	Reproductive health
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SWAP	Sector-wide approach
TBA	Traditional birth attendant
TOT	Training-of-trainers
TWG	Technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WRA	Women of reproductive age
YFS	Youth-friendly services

Executive Summary

The ESD Family Planning Initiative (ESD – FPI), a four-year project funded by the United States Agency for International Development (USAID) from 2010-2014, integrated family planning (FP) services into existing primary health care (PHC) and HIV services to decrease the unmet need for FP in Mozambique and contribute to the reduction of maternal and child mortality.

ESD-FPI achieved its goals through the following four strategic results: integration of the delivery of FP counseling and services into PHC and HIV and AIDS services in 157 health facilities (HFs); increased availability and demand for both FP and HIV and other sexually transmitted infection (STI) services for students, faculty, and staff in seven pre-service training institutions; improved community capacity to increase the access to and quality of FP services; and greater access for youth to FP/ reproductive health (RH)/HIV services through youth-friendly services (YFS). The project's achievements can be summarized through three cross-cutting areas: *strengthening national, provincial, and district level capacity to advance FP service delivery; integrating FP with PHC and HIV at the HF and community level; and increasing demand for and access to FP services for adolescents and youth.*

The ESD-FPI project built the capacity of the Mozambique health system to provide quality FP services. In order to strengthen the systems and policies related to family planning in Mozambique, ESD-FPI provided technical assistance to the Ministry of Health (MOH), the Provincial Health Directorates (PHD), and District Health Directorate (DHD) through the MOH's Reproductive Health Sector-wide Approach (SWAP) technical working groups (TWGs), the National Health Weeks (NHWs), and other meetings and initiatives including the recent guideline to initiate family planning in mobile brigades (MBs). The project advocated for and piloted task-shifting through community-based distribution (CBD) of short-acting methods by community health workers (CHWs) and expansions to the country's contraceptive method mix to further advance quality access to and options for service. For the success and sustainability of interventions, MOH leadership was present during the implementation period at all levels (central, provincial, and district) through joint planning of activities, including successful interventions to the National Economic and Social Plans, monthly monitoring and evaluation meetings at district and provincial levels to facilitate evidenced-based decision making, and through trainings-of-trainers (TOTs) for scale-up and expansion of interventions.

Integration efforts took place at both the HF and community levels. At the HFs, the project focused on institutionalizing integration of quality contraceptive services with HIV and PHC services, and improving the HF capacity to respond to demand for contraception generated at the community level. This was done by training non-maternal and child health (MCH) nurse providers in FP counseling and, where possible, method provision, including long-acting, reversible methods (LARC) such as implants. During project implementation, 2,082 clients that went to HIV care and treatment also received an FP method. Community and client input obtained through exit interviews, community health committees (CHCs), and co-management committees (CMCs), was used to improve quality of FP services. Over the course of the project, there were 1,324,154 visits to project-supported facilities (443,060 new FP visits, 354,205

return FP visits, and 259,315 PNC visits). The baseline/endline survey findings indicate positive achievements in integration of family planning counseling into general health visits for women or their child (from 48.4% at baseline to 58.2% at endline), within ANC services (from 63.5% at baseline to 72.8% at endline), within maternity services (from 51.9% at baseline to 63.9% at endline), and within postpartum services (from 52.5% at baseline to 62.8% at endline). The percent of women who received family planning counseling concurrently with HIV testing also increased from 28.7% at baseline to 44.0% at endline. Community-based efforts centered around integrating FP provision for new and continuing clients through MBs, including the provision of LARC; a performance-based payment scheme to increase the number of household visits by CHWs; and CBD of OCP resupplies and injectables through a pilot intervention. In total, 130,497 household visits were conducted by CHWs and traditional birth attendants (TBAs), and 109,814 referrals were made by CHWs, TBAs, and peer educators (PEs) for FP and sexual and reproductive health services. The endline survey found no significant changes in contact with CHWs, or exposure to other community interventions, which may indicate that facility-level integration was the main contributing mechanism to increasing contraception in the intervention areas.

In order to address the specific issues related to adolescents and youth, the ESD-FPI project advanced services at HFs, pre-service institutes, and within communities while also enhancing the linkages among them. This was done through YFS in 16 facilities and 7 pre-service institutes, and through community engagement and behavior change initiatives. One such initiative, mCenas!, was an innovative approach to community outreach using mHealth technology. It targeted youth in Matola and Inhambane Cities between aged 15 - 24 with tailored stories and messages, reaching a total of 2,005 youth. Other community engagement and behavior change initiatives included PEs and outreach via pre-service training institutions. This intervention led to uptake of SRH/contraception services to 239,531 by Adolescent and Youth during project lifetime.

Collectively, the ESD-FPI project interventions successfully contributed to greater availability and use of FP services among the target population in the 16 project-supported districts. Findings from the baseline and endline household surveys in project intervention areas showed that the proportion of women in union aged 15 – 49 using any method of contraception increased significantly from 25.9% at baseline to 41.5% at endline. The greatest increase was in injectable use, from 6.9% at baseline to 14.4% at endline. Also of note was the use of implants (2.5% at endline), as implants only became available in mid-2012. Unmet need for FP has decreased from 30.8% at baseline to 34.1% at endline, total demand for FP increased from 57.6% at baseline to 65.5% at endline, and a greater proportion of the total demand for family planning is being met (from 45.7% at baseline to 63.4% at endline), suggesting that the project has successfully increased and responded to demand for contraception services.

From 2010-2014, ESD-FPI supported the provision of 275,839 Couple Years of Protection (CYP) in Mozambique. Per MSI's Impact 1.2 Calculator,¹ these services averted an estimated 97,800 unintended pregnancies, 13,850 abortions, 66,800 unintended births, and 367 maternal deaths in Mozambique. This indicates that the CYP provided during a relatively short period of time will have a substantial impact in the future.

¹ Corby, N., Boler, T., Hovig, D. (2009, updated May 2011). The MSI Impact Calculator: Methodology and Assumptions (1.2). London: Marie Stopes International.

I. Project Description

Project Dates: July 2010 to July 2014

Life of Project Funding: US \$12,697,644

Geographic Focus: Cabo Delgado, Inhambane, Gaza, and Maputo provinces

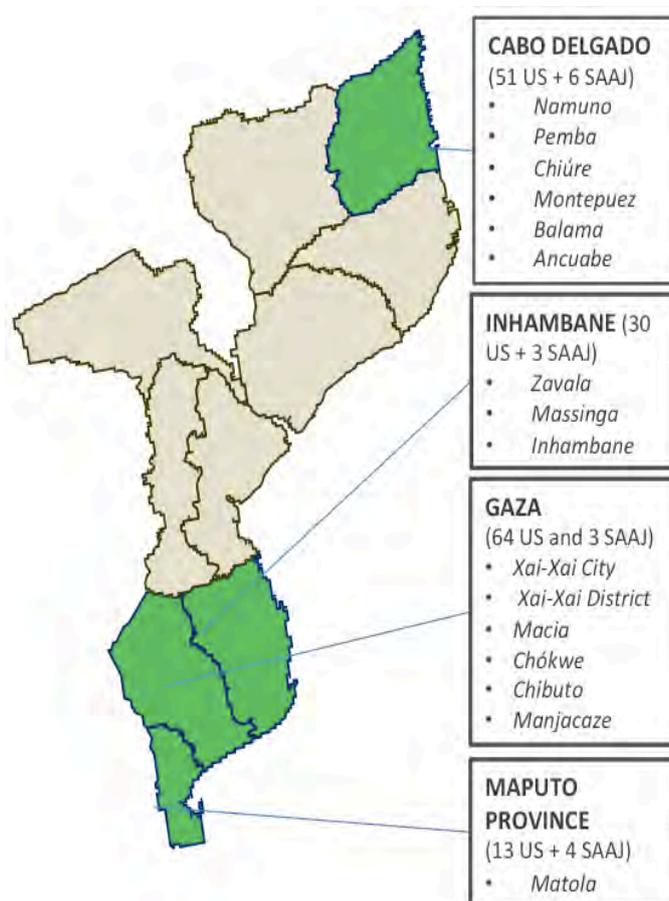
The ESD Family Planning Initiative (ESD – FPI), a four-year project funded by the United States Agency for International Development (USAID) from 2010-2014, integrated family planning (FP) services into existing primary health care (PHC) and HIV services to decrease the unmet need for FP in Mozambique and contribute to the reduction of maternal and child mortality.

ESD-FPI achieved its goals through the following four strategic results:

1. Integration of the delivery of FP counseling and services into PHC and HIV and AIDS services in 157 health facilities (HFs).
2. Increased availability and demand for both FP and HIV and other sexually transmitted infection (STI) services for students, faculty, and staff in seven pre-service training institutions.
3. Improved community capacity to increase the access to and quality of FP services.
4. Greater access for youth to FP/reproductive health (RH)/HIV services through youth-friendly services (YFS).

Pathfinder worked in Cabo Delgado, Inhambane, Gaza, and Maputo provinces in 16 districts, 157 HFs, and 16 YFS.

In order to achieve the project results, Pathfinder emphasized capacity building of the government at the national, provincial, district, and HF levels. This strategy facilitated the sustainable scale-up of high quality, integrated FP services. The project was committed to addressing gender-related barriers and inequities to create the conditions through which women, including adolescents, are empowered to dialogue with partners and make reproductive health decisions, which reduce their vulnerability to unintended pregnancies. Additionally, ESD-FPI supported the institutionalization of community activities that increased



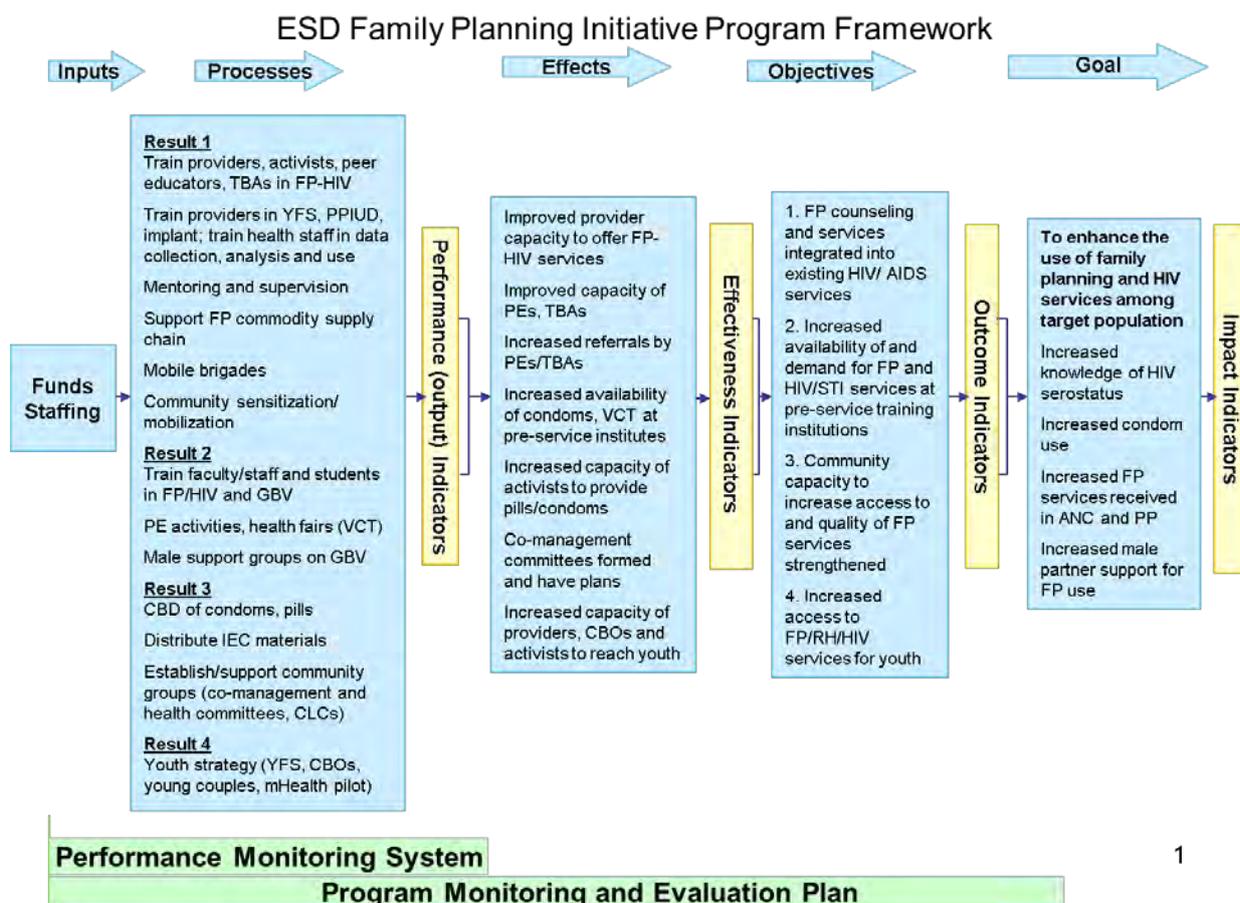
demand generation for, and acceptance of, contraception use by women, men, and adolescents, in both rural and urban areas. Utilizing community involvement as the vehicle to reach these results successfully advanced one of the major priorities of the Ministry of Health (MOH).

Integration of FP services into other services was a key approach in responding to demand generated through community mobilization through peer educators (PEs) at pre-service institutes, community health worker (CHW) networks, and other community events. This was particularly important given the lack of human resources at HF level, since the maternal and child health (MCH) nurses historically were the only ones providing FP services in the facilities.

This report demonstrates how the priorities of the project have been implemented:

- Advanced the institutionalization and reinforcement of FP integration within PHC and HIV services at health facilities and thus improved access to contraception by providing HIV positive women direct access to FP counseling and methods during HIV consultations;
- Maximized and expanded opportunities for training of both MCH and non-MCH providers on the comprehensive package of FP integration with particular emphasis on training of implants and post-partum IUD insertion as well as the provision of YFS. This included training and post-training follow-up aimed to strengthen health providers' (HPs') technical capacity to offer quality FP services while responding to challenges related to staff turn-over at the HFs through the training of new providers;
- Increased access to contraceptives at the community level through expansion of community-based distribution (CBD) of male and female condoms and resupply of oral contraceptive pills (OCP), as well as implementation of the study to pilot the provision of injectable contraceptives at the community level in Montepuez and Chiúre districts in Cabo Delgado.

Figure 1. ESD-FPI Project Framework, July 2014



II. Achievements

The ESD-FPI project successfully contributed to greater availability and use of family planning services in the 16 project-supported districts during the life of the project. The proportion of women in union aged 15 – 49 using any method of contraception increased from 25.9% at baseline to 41.5% at endline. The greatest increase was in injectable use, from 6.9% at baseline to 14.4% at endline. Also of note was the use of implants (2.5% at endline), as implants only became available in mid-2012. Unmet need for FP has decreased from 30.8% at baseline to 24.1% at endline, and a greater proportion of the total demand for family planning is being met (from 45.7% at baseline to 63.4% at endline). The ESD-FPI project’s contributions to these successes can be grouped in three strategic areas: *strengthening national, provincial, and district level capacity to advance FP service delivery; integrating FP with PHC and HIV at the HF and community level; and increasing demand for and access to FP services for adolescents and youth.*

A. Strengthening national, provincial, and district level capacity to advance FP service delivery

A cross-cutting area throughout the ESD-FPI project was the strengthening of national, provincial, and district level capacity to advance FP service delivery to increase the effectiveness, efficiency, and safety of service delivery processes and systems. In order to strengthen the systems and policies

related to FP in Mozambique, ESD-FPI provided technical assistance to the MOH, Provincial Health Directorates (PHD), and District Health Directorates (DHD) through the MOH’s Reproductive Health sector-wide approach (SWAP) technical working groups (TWGs), the National Health Weeks (NHWs), and other meetings and initiatives. Over the four years, the project advanced CBD of contraceptive methods in the country through CHW network, including piloting community-based access to injectables (CBA2I) in order to have evidence-based advocacy around national policies – and first time provision of contraceptive methods in mobile brigades (MBs) through trained HP (excluding IUD, which is referred to the HF level).

1. Technical assistance and advocacy to the MOH, PHD, and DHD

The ESD-FPI project staff contributed to and influenced the advancement of FP services through

ESD-FPI participation in MOH TWGs

- **Co-chair of TWG on Adolescents and Youth**
 - Supported the MOH to convene the Adolescents and Youth National Meeting held in October 2013, and worked with partners to finalize the matrix of recommendations.
 - Supported the development of package of services for adolescents and youth, which is currently under MOH review.
 - Led the discussion and first draft of the national adolescents and youth health strategy.
 - Supported the decision to move for integration of services.
- **Co-Chair of the TWG on Community Involvement**
 - Shared lessons learned and successfully advocated use of CHWs in CBD for OCP, resulting in the inclusion of CBD in the approved training curriculum for APes.
- **Member of TWG on FP**
 - Drafted guidelines for inclusion of LARC in NHWs.
 - Successfully advocated for a dedicated, single dose ECP in the national commodity system. MOH is now procuring ECP.
 - Finalized the draft of the MOH Accelerated Plan for the Advancement of FP with USAID, MCHIP, and UNFPA.
- **Member of TWG on Gender**
 - Provided inputs to the strategic plan on Gender and GBV
- **Member of TWGs on Contraceptive Security and on Quality and Humanization of Health Services**

an active TA and advocacy role within the MOH’s Reproductive Health SWAP TWGs. These participatory forums contribute to advancing the availability of contraceptives and a greater choice of contraceptive methods for the Mozambican population.

Pathfinder, as the co-chair of the TWG on Adolescent and Youth, supported the MOH to convene the Adolescents and Youth National Meeting held in October 2013, and worked with partners to finalize the matrix of recommendations. These recommendations formed the base of the support to the MOH to develop the minimal package of interventions tailored for adolescents and youth, who represent one-fifth of total population in country. The package addresses the higher

unmet needs of adolescents and youth and the taboos and barriers they face in accessing sexual and reproductive health (SRH) services.

Through ongoing technical assistance and collaboration, the ESD – FPI project supported the MOH to advance CBD in Mozambique. As co-chair of the TWG on Community Involvement, the project was able to share experiences, evidence, and important lessons learned from the use of

CHWs in CBD of OCP resupply. Previously only counseling and referral were allowed by MOH, but due to Pathfinder's advocacy, all cadres of CHWs are allowed to provide OCP resupply at the community level. This important change is evidenced by the inclusion of CBD in the nationally approved *Agente Polivalente Elementar* (APE) training curriculum. In order to widen the contraceptive variety available at the community level, injectables are being piloted in two districts of Cabo Delgado Province through APEs and traditional birth attendants (TBAs).

The MOH's inclusion of a dedicated, single dose emergency contraceptive pill (ECP) in the national commodity supply system is further evidence of the project's role in advocating for advancements in the quality of FP. In Mozambique, less than 10% of women and 22 % of men know about ECP.² There were few options to obtain emergency contraceptive services in the country. In the public sector emergency contraception was usually only available to survivors of sexual violence, most commonly through the Yuzpe method.³ A dedicated or single dose ECP was not available other than in some private pharmacies in the country, which limited access to the poor and most vulnerable women and youth.

With the end goal of advocating with the MOH to include ECP as part of the national commodity supply system, Pathfinder developed a plan to pilot the introduction of ECP in public sector facilities. In 2013, Pathfinder received the approval of the MOH to distribute a limited number of dedicated ECPs, acquired through other donor funds, to the National Health System (NHS). Through the PHD in six provinces, including the four project provinces, priority points for ECP availability were defined as follows: 1) FP consultation rooms, 2) YFS, 3) emergency rooms, and 4) one-stop centers for gender-based violence (GBV). Pathfinder closely monitored and documented the distribution and use of ECPs. The data showed a continuous increase of users, and based on these positive results, the MOH decided to include a dedicated ECP on the list of contraceptives acquired by the MOH, requesting that UNFPA purchase 200,000 doses of dedicated ECP to be distributed through the NHS. This represents an important step towards expanding access to a full method mix in Mozambique.

Additionally, ESD-FPI, jointly with USAID, MCHIP, and UNFPA, finalized the draft of the MOH Accelerated Plan for the Advancement of FP, which was presented to the National Coordinating Council Meeting on 23 – 25 of July, 2014.

In line with the recommendations from USAID's 2012 Mozambique FP assessment, the ESD-FPI project provided support to provincial and district planning and budgeting to ensure that FP was a programmatic priority.⁴ As part of this larger effort, the project supported the DHD in all provinces to improve the planning for integrated MBs, including for the availability of methods for new and continuing clients. As a result, the DHD are now coordinating the planning of the MBs with all implementing partners together, instead of each partner planning their support to

² Demographic and Health Survey, Mozambique, 2011

³ Yuzpe method requires taking a high dose of combined oral contraceptive pills as an emergency contraceptive. This was the only available option for women in the public sector prior to the introduction of the dedicated ECP with support from Pathfinder.

⁴ *Evaluation USAID/Mozambique: Family Planning Assessment*. USAID. 2012.

the MBs separately. This more efficient process has resulted in improved implementation of and collaboration on MBs.

ESD-FPI supported quarterly technical meetings for the DHD to discuss MCH and FP outcomes in districts. These meetings added to the project’s efforts to enhance quality FP services by ensuring engagement from government officials to support comprehensive training and ongoing supportive supervision.

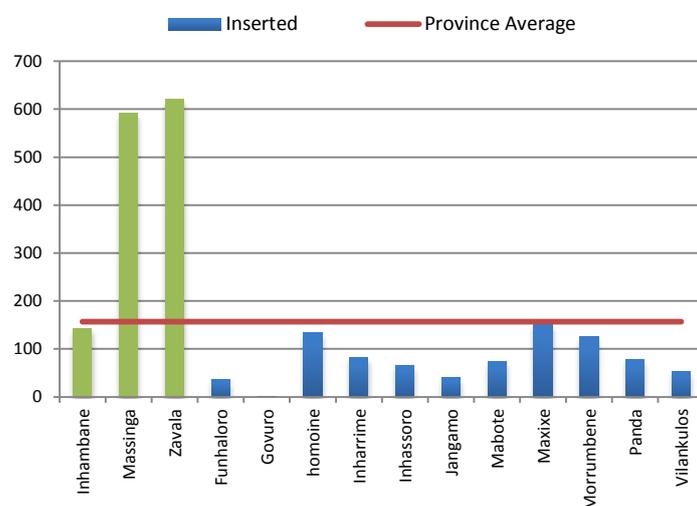
2. National Health Weeks

The NHWs are MOH-led campaigns that began in 2008 with the goal of decreasing infant, child, and maternal mortality, carried out in all districts of the country through both facility-based services and mobile brigades. Child health services include vaccinations, Vitamin A supplementation, deworming, and nutritional screening. Women of reproductive age (WRA) are targeted for FP counseling and method provision. Through radio and TV ads and other mobilization efforts by the community health committees (CHCs) and co-management committees (CMCs) – described later in this report – the NHWs draw large crowds, making them an important means of reaching the community with FP information and services. During project implementation, Pathfinder supported planning, organizing, and monitoring of WRA interventions. In the last NHW (June 2014), there was an increase in uptake in all methods, and a shift to long-acting methods was more evident in districts with a CHW network supported by the ESD-FPI project. For example, in the five days of the NHW, 23,150 implants were inserted across the country, and 30% of those were in project-supported districts.

Throughout the life of the project, ESD-FPI was committed to supporting, and played an active role in, the organization of NHWs at the central level and in the project-supported districts. In May 2014, upon MOH request, the project drafted guidelines for the incorporation of FP in both fixed and mobile health posts during the NHWs, including the provision of long-acting, reversible contraceptives (LARC) through the mobile brigades. The ESD-FPI Project Director led the

development of these guidelines for the MOH, and acted as the national coordinating supervisor for FP during the week-long NHW campaign. The inclusion of increased FP access and choice at the NHWs ensures that many more women are able to benefit from FP. Given the size of these events, the NHWs result in a spike in new FP visits. For example, in Year Four, Pathfinder participated in the planning and

Figure 2. Implant Insertion during 2014 NHW - Inhambane



implementation of the December 2013 and June 2014 NHWs. The June NHW was the first in which these guidelines had been successfully implemented. The number of new FP visits in the corresponding project quarter surpassed the results for the first quarter of the project year, during which the December NHW occurred, by 18.4% and greatly surpassed the second quarter by 66.9% as shown in table below.

In all project-supported districts, Pathfinder participated in micro-planning meetings, which are used to plan all logistical and financial details of the NHW, such as the staff, volunteer, and vehicle distribution; medical materials; fuel; and other inputs. These meetings provided the opportunity to reinforce the importance of including LARC, such as implants, in the methods to be offered during the NHW week through MB and implants and IUD at HF. The project nurses who participated and assisted with the logistical planning ensured that the materials needed for the insertion of implants were taken into account. In the project-supported districts, both maternal and child health (MCH) and non-MCH health providers (HPs) had received training on the FP counseling and method provision including LARC, which facilitated the implementation of this component within the NHW. The importance of integration of FP in other PHC and HIV services was reflected in the results. FP uptake, including long-acting methods as IUD and implants, was on average higher in the 16 project-supported districts than in the other districts during NHW. In Inhambane, for example, over half of all implant insertions during the NHW were done in the three project-supported districts of the 14 districts of the province. The combination of HPs trained in integrated FP, and a network of community activists trained in FP to mobilize the community to participate, led to positive results in the uptake of FP during the NHW.

3. Support to PHD and DHD to improve quality FP service provision at facility and community

At Health Facility Level

In all supported HFs, the ESD-FPI project performed monthly monitoring and evaluation supervision and mentoring visits through the District FP Officer. This was another effective strategy for the project, as these officers were not seen as outsiders, but rather as part of the DHD and HF. During these visits, the officers provided on-the-job training to improve data registry and collection and to create an environment for data analysis in each HF. Integrated visits were held with the Provincial and District Supervisors on a quarterly basis to monitor quality of the intervention.

Another important component of the supportive supervision visits was to discuss how to avoid stock outs and improve the monthly request for commodities that is submitted by each HF to the DHD. Throughout the project, the percentage of HFs without stock outs increased by 10%, from 71% to 81%. Through Pathfinder's work on the SWAP TWG, taskforces for FP commodities were established in all provinces beginning in September 2014, to improve the management of FP commodities at all levels within the province and ensure accurate requests to the central level.

There were two important parts in the management of community components and ensuring linkages between the community and the HF: the service provider and the demand. Through the life of the project, 109 CMCs were supported, and they met quarterly to discuss important MCH outcomes at the HF from the catchment area. Each district has one assigned health provider to follow the community component. CBD was supported from PHD, DHD, and each HF from the catchment through resupply of pills and condoms and monitoring the uptake of commodities.

At Community Level

The work with community-based organizations (CBOs), CHW networks, and household visits were key components of demand generation at the community level for SRH service uptake and OCP and condoms refill. DHD and PHD gradually increased ownership of these activities, which is key for the continuation of these efforts.

Here again, monthly supervision to CHWs took place in order to support and guide their interventions within communities. The project's District FP Officer conducted all visits jointly with an assigned health provider from DHD or from the HF of the catchment area. One of the key outputs monitored during these visits were the referrals, 110,624 of which were during the course of the project.

As part of mentorship, some households were jointly visited by the District FP Officer and CHW in order to improve the quality of counseling and the quality of the registry kept by the CHW. These joint visits also provided the opportunity to discuss the main constraints CHWs faced during their work. During the life of the project, 213,851 households were visited in the project intervention areas.

CBOs played an important role in administering all community components to mobilize the population in the project-supported areas and to improve knowledge and awareness in the community. The project supported 22 CBOs with capacity building in community mobilization, behavior change approaches, monitoring and evaluation, and advocacy.

To sustain the community-led interventions aimed at improving FP services uptake at the HF level, quarterly meetings were held with each CMC with participation of the CHW network, community leader councils, and health providers from the HF and DHD.

4. Development of training curricula, integrated supervision tools, and job aids for HF and community level in collaboration with MOH

This project aimed to implement effective interventions in country such as integration of FP into different services, task-shifting and task-sharing, and CBD of OCPs. To support this work, the Pathfinder developed important tools early in the implementation period which were updated over the four years of the project: FP curricula for non-MCH nurse health providers, job aids for this cadre of HP, and job aids for FP counseling at the community level for CHW. All these materials were developed in alignment with national policies and with the participation of MOH. To support all of the above mentioned activities, a set of information, education, and communications (IEC) materials was also developed with approval and consensus from the

MOH's Department of Health Promotion (DEPROS). These materials were handed over to the MOH for national scale-up.

Another important aspect of the improvements at the HF level was the development of tools to capture needed information and assure data collection from other services are reported through the FP sector. This data was collected weekly by FP focal point of each supported HF and included into overall statistics of HF. These tools were recently brought to the first national workshop on integration of FP into HIV and PHC services and were adopted with minor changes to be used national wide.

B. Integrating FP with PHC and HIV at the HF and community levels

1. Health facilities

a. Training

At the HF level, the project institutionalized improved quality of FP services with a focus on integrating contraceptive counseling and provision with other health services and improving the HF capacity to respond to demand generated at the community level. A total of 2,412 HPs received comprehensive training in an integrated package of FP/HIV, FP/PHC, emergency contraception, post-partum care, and care for survivors of GBV. Further training was provided in implants insertion and removal, and at last year of the project training for Post-Partum IUD was provided in selected health facilities.

b. Mentorship

Assisting non-MCH health workers to provide FP counseling and services was an important means to engage them. Integration of FP into existing PHC and HIV services was reinforced by providing continuous support to HPs. As follow-up and ongoing support after these trainings, project nurses conducted monthly mentoring visits to the HPs. These visits included one-on-one sessions at the service province room, groups sessions with all HPs who had been trained at the HF, technical discussions, and update sessions. Through the mentorship visits, important gaps were identified such as lack of knowledge on FP methods to offer according to a client's health condition (FP eligibility wheels required frequent and continuous on the job training) and implant removal skills.

Additionally, nurses assessed the availability of equipment at the HF. Consequently, the ESD-FPI project procured and distributed sphygmomanometers, IUD kits, Post-Partum IUD Kits, WHO FP eligibility wheels, anatomical models, and gynecological lamps in order to improve the quality of the FP consultation at HFs.

c. Integration of FP and facility-based services

It's important to highlight that efforts for integration are being made both within the FP consultation and HIV services. Integration means not only to include FP services into HIV, but also to improve HIV service components at FP consultations, such as starting a clinical screening form and opening the registry form for the client, clinical staging, and requesting lab tests by FP

providers. The image below shows one side of this integration by illustrating how the project supports integration of FP counseling and services into HIV treatment services.

Figure 3: Integration of family planning services at HIV treatment



The image shows one side of this integration by illustrating how the project supports integration of FP counseling and services into HIV treatment services.

In total, 197,883 women were counseled for and received an HIV test at FP services in the 157 ESD-FPI project-supported facilities, and 3,078 women received FP counseling and services while at an HIV consultation. The figures below show the proportion of new FP clients receiving HIV counseling and testing, and the uptake of FP by method within HIV care and treatment services, respectively. Furthermore, the project’s endline survey found that the percent of women who received FP counseling concurrently with HIV testing increased from 28.7% at baseline to 43.6%.

Figure 4. Clients receiving HTC and Referral during FP Visit

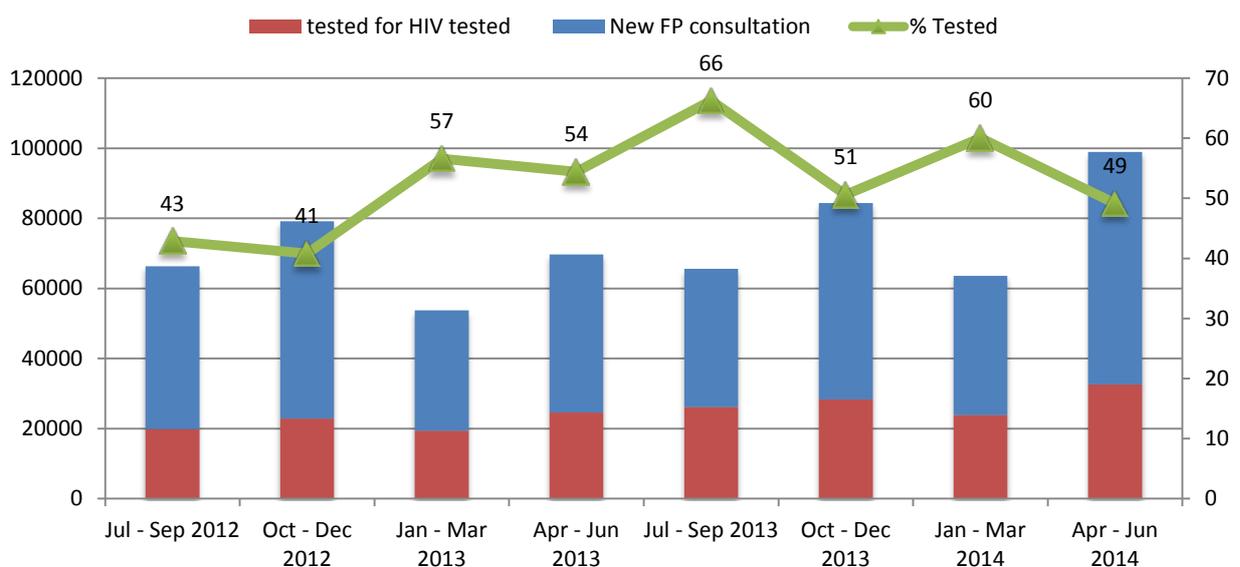
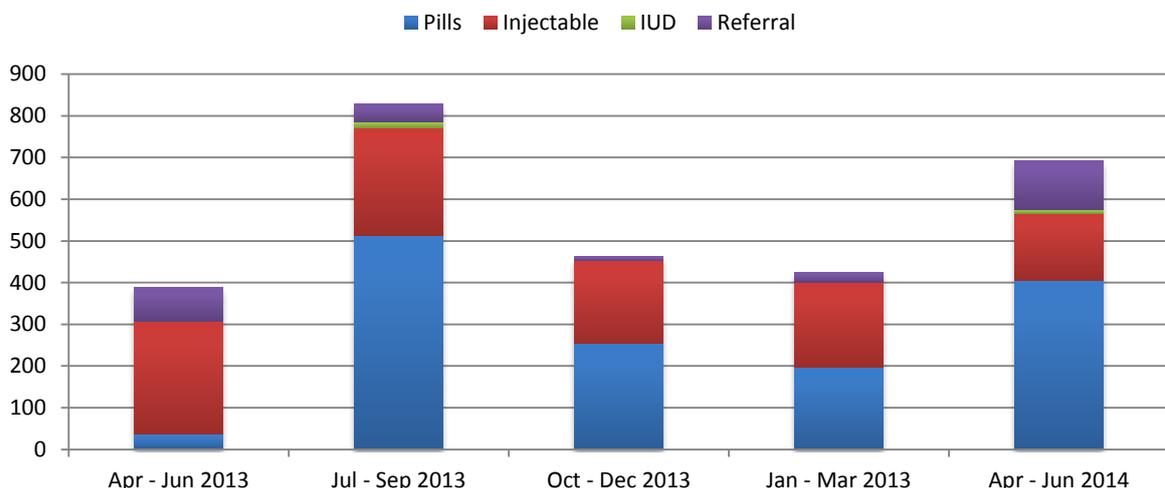


Figure 5. Clients receiving FP Counseling and Method Provision during HIV Visit



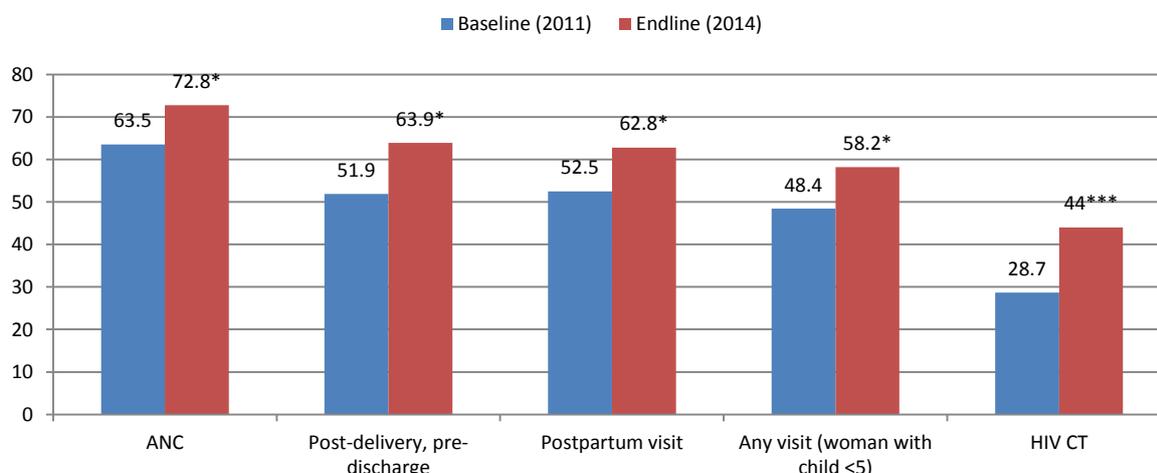
The table below summarizes achievements in key performance indicators for FP/HIV integration.

Table 1: FP/HIV Integration Performance Indicators, 2011 – 2014

Performance Indicators	FY1	FY 2 (Q4)	FY3	FY4	Total
% of health facilities without stock out of FP method and HIV test in the last 3 months ⁵	N/A	71%	81%	81%	81%
# of FP clients that went to a family planning consultation and got tested for HIV and AIDS	N/A	19,903	93,130	84,850	197,883
# of clients that went to a family planning consultation that were HIV positive	N/A	898	13,893	12,016	26,807
# of clients that went to a family planning consultation and were referred for ARV/TIO	N/A	609	3,016	2,954	6,579
# of clients that went to a HIV consultation and also received family planning	N/A	NA	996	2,082	3,078

The results of the baseline and endline surveys reinforce the potential for integration as a means to increase awareness, acceptability, and use of contraception. The proportion of women receiving FP counseling in MCH services increased across the board: at a health visit for themselves or their child (from 48.4% at baseline to 58.2% at endline, $p=0.013$), within ANC services (from 63.5% at baseline to 72.8% at endline, $p=0.016$), within maternity services (from 51.9% at baseline to 63.9% at endline, $p=0.017$), and within postpartum services (from 52.5% at baseline to 62.8% at endline, $p=0.016$). The percent of women who received family planning counseling concurrently with HIV testing also increased from 28.7% at baseline to 44.0% at endline ($p<0.001$). These findings, coupled with positive trends from the performance monitoring data, indicate that the project successfully contributed to increasing provision of FP counseling within a variety of facility-based services.

Figure 6: Percent of women counseled on family planning during health visits at baseline (2011) and endline (2014), by service type



• $p<0.05$, ** $p<0.01$, *** $p<0.001$

⁵ From 157 supported health facilities in four provinces.

d. Community and client input to improve quality of FP services

Exit interviews

An important aspect of advancing FP services is the collection and use of feedback from the clients to address areas for improvement. In Year Three, the project identified the need to collect client feedback to monitor the quality of FP consultations in the project-supported HFs and to guide the on-the-job training to these providers. In April 2013, project staff began to carry out exit interviews with FP clients. On a quarterly basis, an exit interview was administered to five random clients in each supported HF, and results from these interviews were used to address gaps in quality of service provision. A total of 3,073 exit interviews were conducted between April 2013 and June 2014, with 40% of respondents within age range of 15 – 24 Years. The results give an idea of the quality and level of client satisfaction, but are only indicative as it does not reflect a representative sample of FP users. The early findings showed that clients were satisfied with services; they received comprehensive information about contraceptive methods and understood when and why to return for a follow-up visit. However, almost all clients mentioned that providers did not conduct a physical exam (e.g. blood pressure was not measured during the consultation; women were not screened for breast or cervical cancer, etc.). While the full physical exam is not usually required for provision of contraception, including such services improves the overall quality of the facility visit for the woman. As a result, the project and other partners implemented approaches to improve the quality of consultations. These findings informed the project nurses in their provision of onsite mentoring visits to the HPs at the facilities.

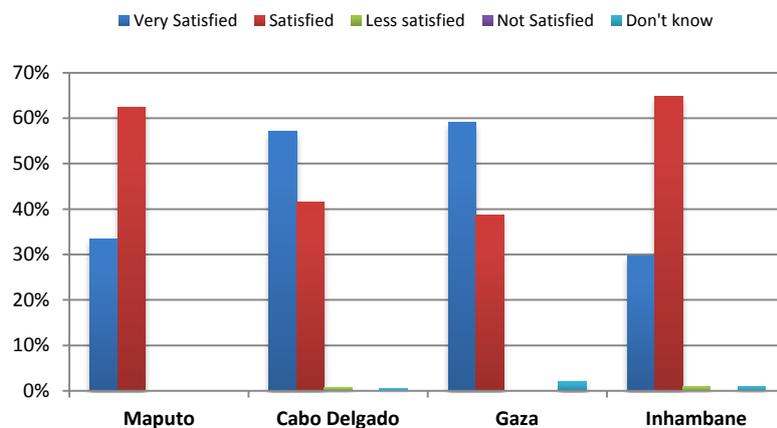
Exit Interview Questions

- 1) Did you receive the services you came for?
- 2) Were you provided with information on all contraceptive methods?
- 3) Did you understand how to use the method you had chosen?

One year after the exit interviews were initiated, the satisfaction with the service received was still high, with women receiving counseling on various methods and explanations of secondary effects as well as when to return to the clinic. Furthermore, the quality of the consultations had improved. When asked if

a physical exam (arterial pressure/breast exam) or HIV test was offered, 71% of the women of Cabo Delgado said yes, up from only half the year before. In Gaza and Inhambane, 46% and 65% respectively reported they received a physical exam, up from only 32% the previous year. The fact that the project purchased sphygmomanometers for all health facilities contributed to this

Figure 7. Satisfaction for FP Services Assessed Through Exit Interviews



increase. HIV tests were offered to 81% of the women in Cabo Delgado, 65% in Inhambane, 63% in Matola, and 59% in Gaza. This was a considerable improvement for Gaza and Inhambane, up from 42% and 50% respectively from the previous year.

CMCs and CHCs

HF CMCs have the potential to improve service quality and strengthen the health system both at the HF and at the community. Providers can share the difficulties they have in meeting targets with community representatives, and they work together to find local solutions for challenges. HF CMCs are composed of community leaders, nurses, responsible HF officials, HF staff, and CHWs, and work to organize community network and activities to support increasing coverage and health indicator achievement. HF CMC meetings are a forum for committee members to propose activities to improve health indicators of their communities; to share information such as upcoming mobile brigades; provide feedback on quality of care and provide a space for CHWs to present challenges they face in their work.

CHCs were established and revitalized under the project to increase participation of the community in quality FP services. CHCs are comprised of CHWs and community leaders and members, who meet regularly to discuss health concerns and ways to address them. These groups have played an important role in creating stronger linkages between the community and the work of the CHWs, including support for CBD of OCP resupply, mobilizing the population to participate in MB and NHWs, and sensitizing the community on the importance of institutional deliveries, FP use, and GBV prevention.

2. Community-based integration

The project's integration work expanded into community-based efforts, the most successful of which were mobile brigades (MBs), community-based distribution (CBD), and household visits by CHWs.

Mobile brigades in Mozambique

MBs are comprised of health workers who travel to hard-to-reach areas to directly deliver services, and have historically focused on vaccination campaigns and PHC services. In line with USAID's recommendations from the 2012 FP assessment, the project has provided support to the MOH to increase the frequency and reach of the MBs.⁶ This support entailed planning, coordination, and implementation of MB to ensure that integrated health teams, consisting of both MCH and preventive medicine staff, could go to remote communities to provide a range of services, including vaccination, FP, antenatal care (ANC), and general consultations. ESD-FPI successfully integrated contraceptives into the package of services provided at the MB, most notably the inclusion of implants. Community activists, CHC members, and other community leaders played a critical role in the mobilization of their communities to come and participate in the MB. ESD-FPI was able to support the DHD and

⁶ *Evaluation USAID/Mozambique: Family Planning Assessment*. USAID. 2012.

HF to implement 1,068 integrated Mobile Brigades over the course of the project. Through the MB, 218,977 people were reached with information on contraception and other health issues, despite difficulties in access caused by problems such as heavy rains at certain times of the year. The MB teams were able to distribute 13,739 cycles of OCPs, provided 17,172 doses of DMPA. A total of 9,649 people were referred to FP consultations at fixed health units for IUD or implants (this information was only collected from FY3).

Household Visits

Another critical aspect of ESD-FPI's community work has been the CHW network. CHWs equip WRA with the knowledge and information to seek contraception services and continue to use their contraceptive method effectively. Quality counseling by CHWs through home visits supports demand generation at the community level and makes for more efficient facility visits, as clients come to the HF better informed and require less time with the HP. A pilot test of an approach consisting of payments to CHWs based on the community work undertaken.

Although CHWs have completed household visits throughout the life of the project, the number of visits fell below the project's target. For example, in Year Three, CHWs completed 103,226 household visits in all of the provinces, just 61% of the annual target (168,231). One challenge was the high turnover among the CHWs, which contributed to the lower than expected numbers. This is consistent with findings from USAID's FP assessment for Mozambique in 2012, where it was noted that a lack of compensation raised concerns about the volunteers' long-term dedication to their work and the sustainability of a voluntary system to generate meaningful FP demand.⁷

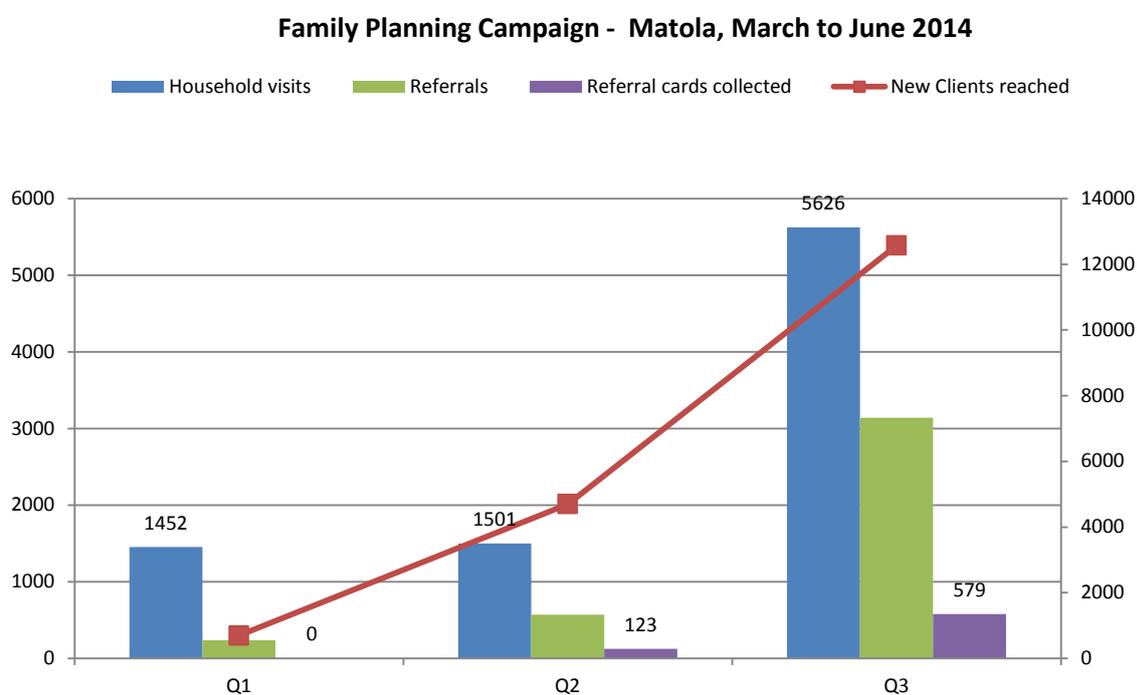
ESD-FPI recognized the need to address this challenge and, following USAID's recommendation from the 2012 FP Assessment Report, undertook a pilot test of a performance-based payment system in March 2014. With the support of the Matola DHD, ESD-FPI implemented the pilot in 12 health facilities in Matola district with 84 CHWs. Under the performance-based system, when a CHW made a referral, she provided two cards to the individual: one was to be kept by the HP at the HF, and the other was to be signed by the HP and returned to the referring CHW by the individual who was referred. The CHW received five meticaís for each confirmed completed referral, regardless of the service received at the HF.

The figure below shows that the number of home visits increased remarkably in the last quarter of the project, reaching 5,626 home visits, approximately 3.7 times more visits than in the previous quarter. There were no referral cards collected in the first quarter of Year Four, but a total of 579 referral cards were collected in the last quarter. This number provides real information about the number of referred women that arrived to health facilities to begin a family planning method. The mean number of home visits per referral card collected in the health facility was 9.7, meaning that in Matola district the CHWs need

⁷ *Evaluation USAID/Mozambique: Family Planning Assessment*. USAID. 2012.

to average 10 home visits in order to achieve one completed referral to an HF to initiate family planning.

Figure 8. Family Planning Campaign Impact, October 2013 – June 2014



The table below summarizes achievements for key performance indicators for ESD-FPI’s community-level interventions.

Table 2. Community-level interventions performance indicators

Performance Indicators	FY1	FY 2	FY3	FY4	Total
Number of community groups developed and supported	151	197	208	246	246
Number of local organizations receiving ICB TA/training	0	24	25	22	22
Number of household visits by CHWs and TBAs	21,772	18,048	103,226	70,805 ⁸	213,851
Number of FP/SRH referrals made by CHWs, TBAs, and PEs	3,393	28,497	47,783	30,141	109,814
Number of individuals reached through USAID-funded FP/SRH/STI/HIV community health activities	54,811	415,555	1,622,724	803,722	2,896,812
<i>Through household visits</i>	N/A	131,798	472,123	285,081	889,002
<i>Through community sessions</i>	N/A	290,306	1,150,601	518,721	1,959,628

Table 3. Cross-cutting performance indicators

⁸ The number of household visits by CHWs and TBAs in FY4 is lower than might be expected given that the year consisted of only three quarters, unlike the previous project years.

Performance Indicators	FY1	FY2	FY3	FY4	Total
Number of people trained with USG funds in FP/SRH, by type	1,309	5,388	1,792	526	9,015
<i>FP providers</i>	783	665	679	285	2,412
<i>Peer educators</i>	175	187	96	124	582
<i>Community health workers</i>	0	4,198	587	29	4,814
<i>TBAs</i>	0	187	177	24	388
<i>Faculty/staff of pre-service institutions</i>	351	151	253	93	848
Number of targeted condom service outlets	157	482	416	346	1,401
Number of condoms distributed through community distribution channels	116,282	122,712	513,071	179,036	931,101

ESD-FPI's interventions at facility and community levels increased new visits to facilities throughout the project life cycle, as shown in the table and figure below.

Figure 9: New FP visits in 16 districts supported by ESD project by quarter, Jan 11 to Mar 14

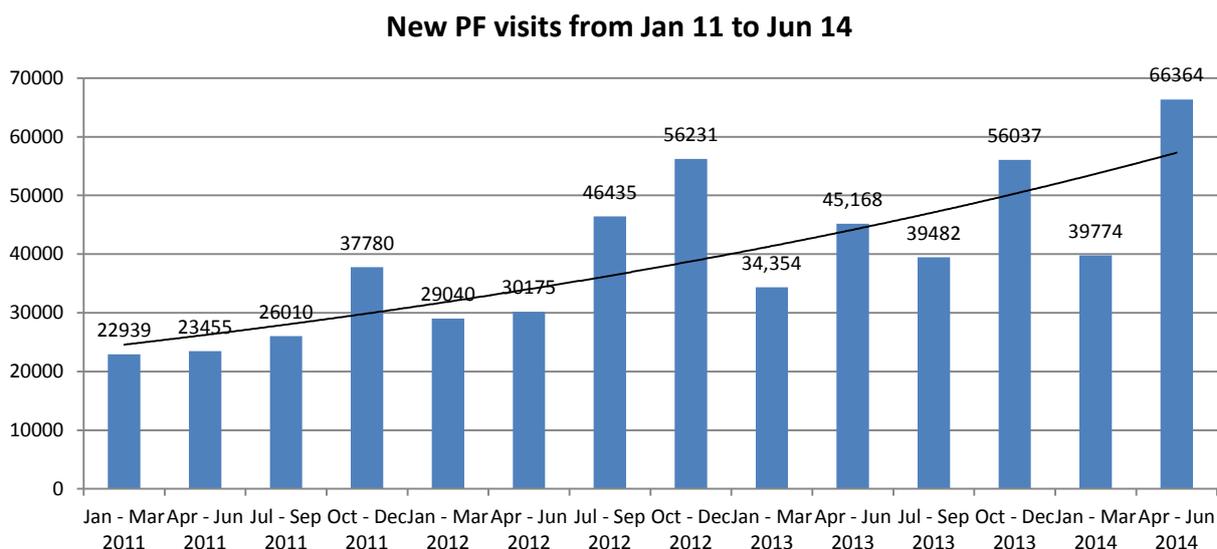


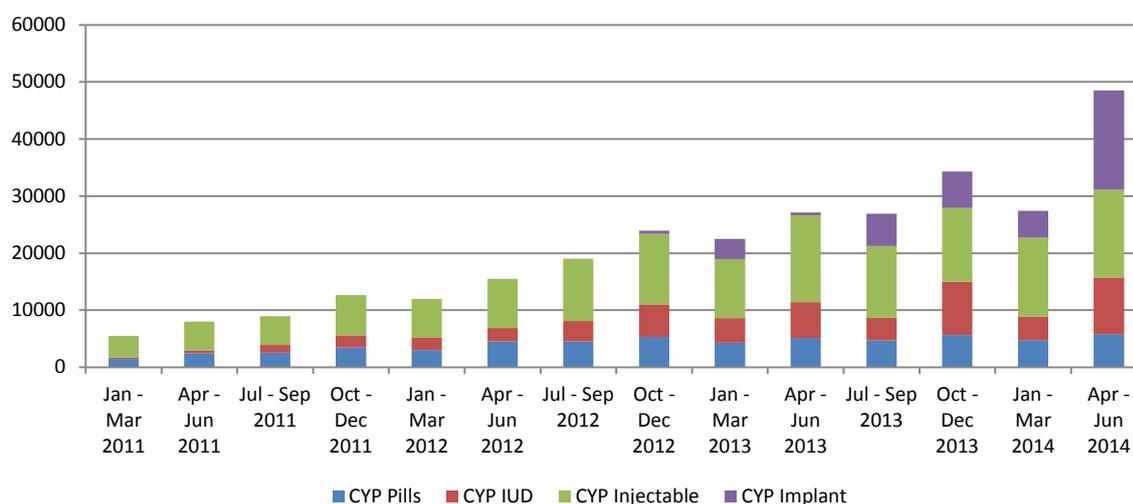
Table 4. FP and PNC visit performance indicators

Performance Indicators	FY1	FY2	FY3	FY4	Total
Number of facility visits, by primary purpose of visit	142,655	219,077	272,929	268,405	862,177
New FP visits	72,404	130,619	175,235	160,066	538,324
Post Natal Care (PNC) Visits	70,251	67,896	97,694	108,339	344,180

The projects' efforts to expand the access and availability of a range of methods, including LARC, contributed to increasing the total CYP in all provinces. With implants becoming more widely available, in both number as well as in provision, and as more HPs are trained in correct insertion and removal, the CYP provided by this method has increased. Fluctuations can be due to the

availability of the method, as well as peaks due to the NHWs. As more clients selected long-acting contraceptive methods, the contribution of these methods to the overall CYP achieved by the project grew, including for young people as described under ‘Adolescents and Youth.’ The figures below show the CYP provided by OCP, IUD, DMPA, and implants in ESD-FPI project areas.

Figure 10. CYP by Method across 16 districts supported by ESD project By quarter since Jan 11 to Mar 14



The baseline and endline survey findings indicate that ESD-FPI’s collective interventions have successfully contributed to increasing use of contraception among women in project areas. The proportion of women in union aged 15-49 who are using a modern contraceptive method increased from 24.1% at baseline to 35.1% at endline ($p=0.004$), and the proportion using any method of contraception increased from 25.9% at baseline to 41.5% at endline ($p<0.001$). The prevalence of implant use (2.5%) at endline is notable, as implants were only recently introduced in Mozambique (2012), and stock outs had been reported. Increases in modern contraceptive use were most notable among women in union with no education (from 11.5% at baseline to 27.8% at endline, $p<0.001$) and primary education (from 27.0% at baseline to 35.4% at endline, $p=0.073$). As the project supported increased access to FP services through public health facilities, it may have contributed to increasing access among women who are more socioeconomically vulnerable. The findings also indicate that unmet need for family planning has decreased from 30.8% at baseline to 24.1% at

Table 5. Contraceptive use by women in union aged 15-49

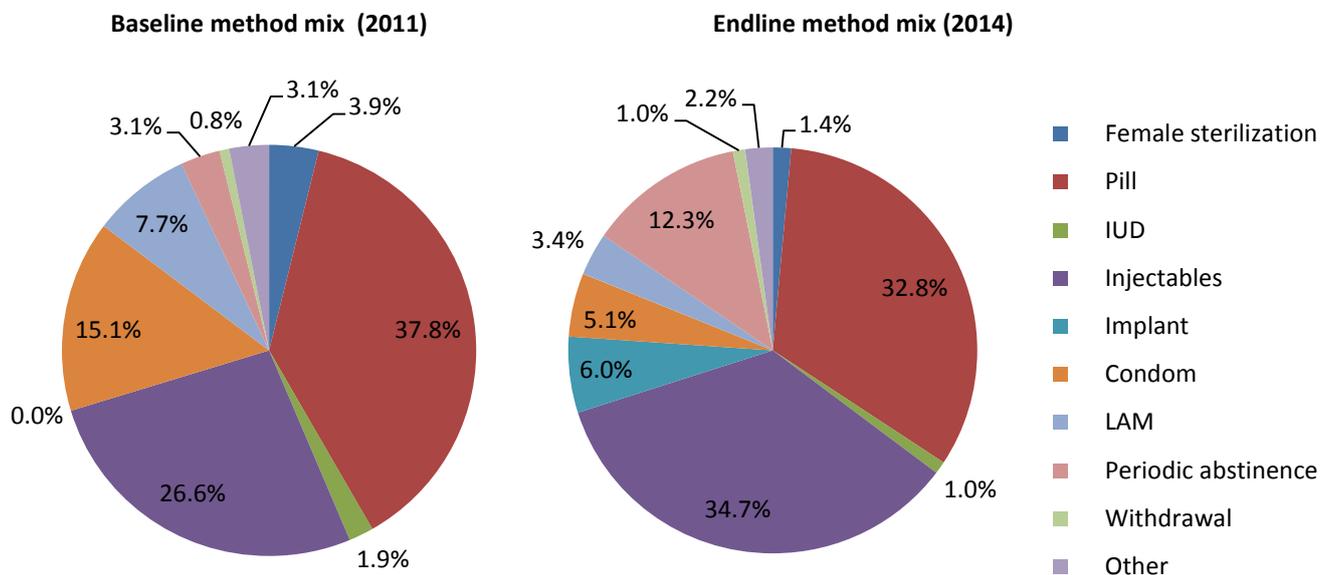
	Baseline (2011)	Endline (2014)
Any modern method	24.1	35.1
Female sterilization	1.0	0.6
Pill	9.8	13.6
IUD	0.5	0.4
Injectables	6.9	14.4
Implant	---	2.5
Condom	3.9	2.1
LAM	2.0	1.4
Any traditional method	1.8	6.4
Periodic abstinence	0.8	5.1
Withdrawal	0.2	0.4
Other	0.8	0.9
Any method (total)	25.9	41.5
Number of women 15–49	945	1068

Table 6. Unmet need for family planning among women in union aged 15-49

	Baseline (2011)	Endline (2014)
Unmet need for FP	30.8	24.1
Unmet need for spacing	12.6	15.1
Unmet need for limiting	18.2	8.9
Met need for FP	25.9	41.5
Using contraception to space	12.7	23.8
Using contraception to limit	13.1	17.7
Total demand for FP	56.7	63.4
Demand to space	25.3	38.9
Demand to limit	31.3	26.6
Percent of demand satisfied	45.7	60.1
Number of women 15–49	945	1068

endline ($p=0.031$) and a greater proportion of the total demand for family planning is being met (from 45.7% at baseline to 63.4% at endline). This is an encouraging sign that demand for family planning is growing in project communities and is increasingly being met through provision of contraceptive services.

Figure 11. Contraceptive method mix among women in union who are current contraceptive users



Community-based distribution of short-acting contraceptive methods

Given the lack of HPs in the country and the barriers to access experienced by populations living in more rural areas, who account for more than 62% of the population, task-shifting to allow for community-based distribution of contraception is an important and proven strategy to safely increase access to contraceptives at the community level. Under ESD-FPI, this was done through the CBD of resupply of OCPs by CHWs, as well as implementation of a study to pilot the community-based access to injectables (CBA2I) at the community level in Montepuez and Chiúre districts in Cabo Delgado.

The project has been able to make great strides with the distribution of OCP resupply at community level since its introduction in Year Three of the project. The DHDs were increasingly supportive, as well as the community. In the last two quarters of the project, the number of OCPs distributed via CHWs surpassed the number of OCPs provided through MB (2,325 vs 2,190), demonstrating the demand and acceptability of CBD at the community level.

In Cabo Delgado, the pilot study of CBA2I through CHWs began in March 2014. The study looks at the rate of women continuing with the method (second and third dose) at community level, satisfaction of the users receiving injectables through CBD, quality of the counseling given by the CHW, and the incidence of complications of the injections received. The pilot has been positive so far: the acceptance of the community to receive this method through CHWs has been good, and the CHWs' role in the community has facilitated the acceptance of this distribution model by women. No

adverse effects have been found with the administration of injectables by CHWs. During April 2014, 520 injectable contraceptives were provided; 548 were provided in May, and 473 in June. In June, 253 second doses were provided. After the closure of ESD-FPI, this pilot study will be continued with support from the USAID-funded Evidence to Action (E2A) project. Results will be disseminated to the MOH, contributing to the body of evidence of successful use of CHWs in the provision of family planning methods at the community level.

C. Increasing demand for and access to FP services for adolescents and youth

Although Result Four was dedicated to improving services for adolescents and youth, the project viewed adolescents and youth as a priority population for all the project's activities, and with good reason. By the time the project started, in Mozambique, only 8% of women between aged 15 – 19 use a modern contraceptive method, and only 15% of the women between aged 20 – 24.⁹ According to the project baseline, however, the unmet need for women aged 15 – 19 in union was 21.3%; for women between aged 20 – 24 , it was 27.5%.

The ESD-FPI adolescent and youth strategy – geared towards young people aged 10 – 24 – strengthened high-quality integrated contraceptive and other SRH services for young people, increased demand for those services through community empowerment and mobilization, and fostered linkages between the community system and the health system. Three areas of success for the project were mCenas!, an innovative approach to community outreach using mHealth technology; YFS in facilities; and outreach via pre-service training institutions.

mCenas!

In 2013, the ESD – FPI project noted the growing use of mobile phones in Mozambique and gaps that young people had in their understanding of contraception and their ability negotiate the many barriers they face in seeking contraceptive services. In response to this, the project developed the first text message-based program targeting youth and addressing contraception in Mozambique. Developed through a participatory process informed by formative research, mCenas! had three main components: 1) a behavior change theory-based story delivered through SMS messages that youth can relate to and draw on for further dialogue and reflection with peers (two months of messaging); 2) informational messages about each contraceptive method adapted from FHI360's Mobile 4 Reproductive Health (m4RH) project (one month of messaging); and 3) an interactive "Frequently Asked



⁹ Demographic and Health Survey, Mozambique, 2011.

Questions” (FAQs) function where youth can ask about a range of SRH topics, including more information on contraception. In addition, mCenas! referred young people to an MOH-run hotline for further information on contraceptive methods. ESD-FPI provided training to the hotline workers so that they could provide accurate information on contraception and refer young people to their nearest YFS.

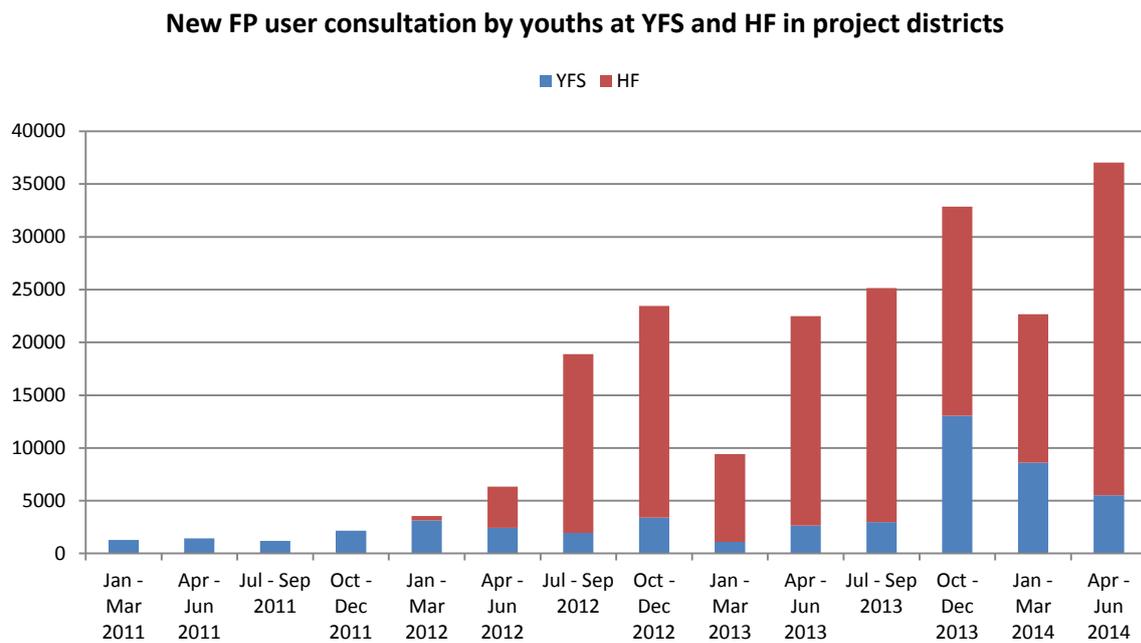
The intervention targeted toward youth aged 15 – 24 with tailored stories/messages for those with children and those without. mCenas! was implemented in Matola and Inhambane Cities. A total of 2,005 youth signed up to receive mCenas! messages; 54% were 15-17 years old, 46% were 18-24; 57% were women, and 33% had a child. The system received 10,451 request for information about SRH. Results from monitoring data revealed that acceptance of the use of SMS in story format was high: 73% responded that they thought the messages were interesting, with less than 2% asking to be removed from the mCenas! messages. The MOH-based hotline ‘Alo Vida’ received 707 phone calls from mCenas! participants between January and June 2014, further validating the effectiveness of the FP and SRH training for the hotline operators supported by the ESD-FPI project.

Youth-Friendly Services

The ESD-FPI project developed its strategy for YFS in line with the MOH’s approach, which calls for a limited number of separate space YFS (i.e., health facilities with separate rooms for young people to receive services) and for all health facilities to offer friendly services to adolescents and youth (an integrated YFS approach). In line with this strategy, the project identified existing separate space YFS (usually at district and provincial hospitals) in the project implementation areas and conducted facility assessments in collaboration with the district officials. Based on the results of the assessment, the project identified which facilities it would support and worked with facility management and the district to develop a facility improvement plans. Over the life of the project, ESD-FPI supported 16 separate space YFS to provide higher quality services to adolescents and youth through improvements in the physical space, training health providers, and ensuring appropriate IEC materials were available. In all project-supported HF, Pathfinder supported integrated YFS by training providers on the specific needs and rights of adolescents and youth, collecting and analyzing age-disaggregated data, improving privacy and confidentiality for adolescents and youth, and linking the health facilities with youth peer educators and community-based interventions for adolescents and youth.

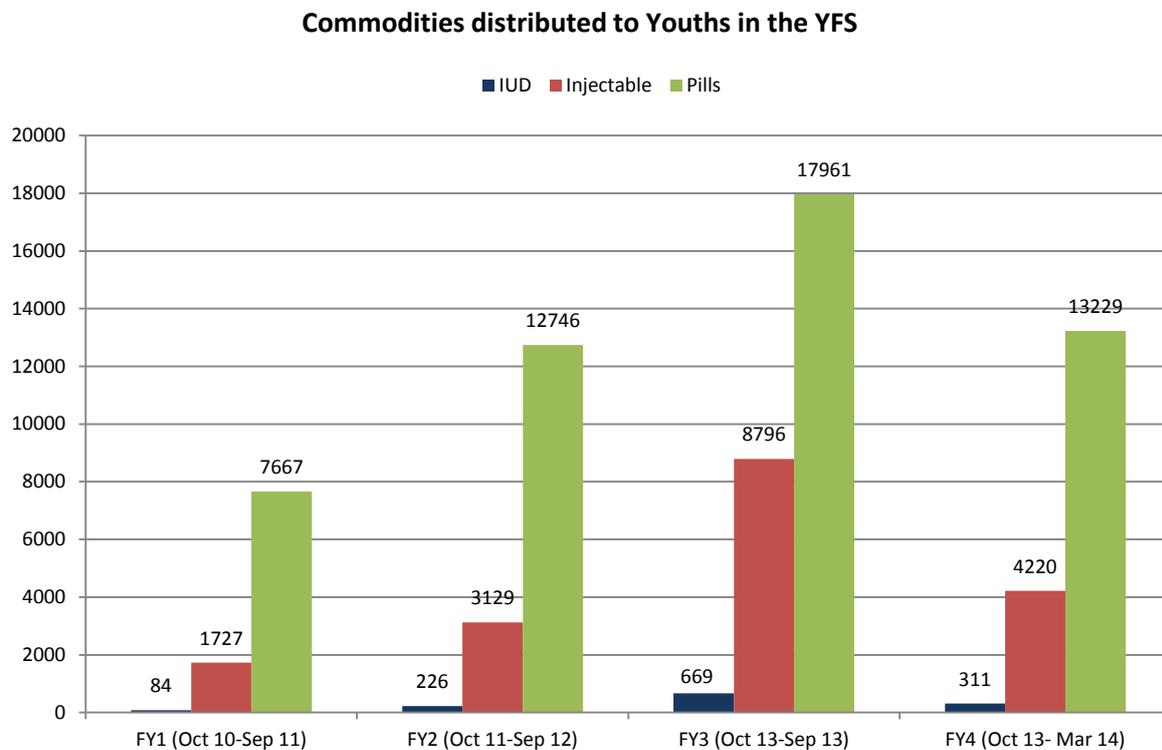
The number of new FP consultations by youth has seen an increase over the life of the project as is shown in Figure 11, not only because since 2012 age aggregated data is available, but also because the absolute number of youth seeking contraceptive services has been growing and is being consolidated. Quality improvements at YFS, an increased number of trained providers and PE activities all played an important role for youth to have access to FP/RH/HIV services.

Figure 12. Number new FP consultation by youth (at health facilities and YFS) in ESD-FPI districts



The graph in Figure 13 shows the use of the different contraceptives by youth at YFS. As the graph shows, the number of long acting contraceptives distributed to youth in FY4 surpassed those the previous years, indicating that the project is helping to meet demand for long acting methods among young women visiting YFS.

Figure 13. Commodities distributed to youth in the YFS in ESD-FPI districts



The table below summarizes key performance indicators related to YFS.

Table 7. Youth-friendly services performance indicators

Performance Indicators	FY1	FY2	FY3	FY4	Total
Number of providers trained in youth-friendly family planning counseling/services	0	130	97	98	325
Number of new FP user consultations by youth at HF and YFS sites in project districts	5,978	26,956	114,001	92,596	239,531
Number of total FP user consultations at YFS sites in project districts	13,172	21,815	39,212	27,178	101,377
Number of peer educators providing FP/SRH support to youth in communities and health facilities, including YFS sites	0	300	336	336	336

At endline, young women aged 15-24 were asked about their uptake of YFS. In the last 12 months, 6.2% (n=37) of young women aged <25 went to a youth-friendly services center. This may reflect the national government's strategy to integrate youth-tailored services into existing health facilities (which are not specifically named YFS), while continuing to invest in a limited number of stand-alone YFS centers (especially those that were functioning). As described above, ESD-FPI supported one to two standalone YFS per province to serve as a center of excellence and a reference point for young people within that province; Inhambane received the most support in this regard, which may have contributed to the higher uptake of YFS in that province (20.4%).

Pre-Service Institutions

The goal of the pre-service institution component was to increase awareness and knowledge about SRH and HIV at seven sites within the education system. The project developed a cohort of knowledgeable personnel by training 765 faculty and non-teaching staff, as well as 543 student peer educators (PEs) in seven pre-service education institutions. Students participated in technical updates related to prevention of unintended pregnancy, gender equality, sexual and reproductive rights, sexuality, HIV, and other topics. Health fairs were organized at the institutes and resulted in increased awareness of and access to SRH services; 75,257 students participated in FP/SRH/HIV education sessions. Activities also included HIV testing and counseling (HTC) and counseling and provision of FP. Over the course of the project, 1,971 students received HTC services and received their test results.

Table 8. Pre-service institutions performance indicators

Performance Indicators	FY1	FY2	FY3	FY4	Total
Number of students, faculty/staff participating in FP/SRH/HIV education sessions	27,314	20,068	23,328	4,547	75,257
<i>Male</i>	14,019	9,954	10,983	2,236	37,192
<i>Female</i>	13,295	10,114	12,345	2,311	38,065
Number of people tested and counseled for HIV and received test results	345	567	443	616	1,971

III. Conclusion

The rationale for integration is to increase the effectiveness and efficiency of the health system and to meet people's needs for accessible, acceptable, convenient, client-centered, and comprehensive care.¹⁰

The endline survey findings indicate that ESD-FPI's collective interventions have successfully contributed to increasing use of contraception among women in project areas. The proportion of women in union aged 15-49 who are using a modern contraceptive method increased from 24.1% at baseline to 35.1% at endline ($p=0.004$), and the proportion of women using any method of contraception increased from 25.9% at baseline to 41.5% at endline ($p<0.001$). In four years of service delivery, there has been a notable contraceptive use uptake in all districts, with more than a 4% increase annually, in Inhambane (27.5% to 50.3%) and in Gaza (32.2% to 51.4%), indicating that Pathfinder's interventions have contributed to increasing access to contraceptive services in project areas. The endline survey also demonstrates the successful integration into antenatal, delivery, postnatal, and HIV and AIDS services that are offered in the facilities. On the other hand, when we review the results of the community work, the data did not necessarily indicate major changes in contact with CHWs, or significant exposure to other community interventions at endline, which might be an indication that integration in the facilities was the main reason for clients using more contraceptives in the intervention sites.

The decline in unmet need from 30.8% to 24.1% at endline, along with the increase in total demand (from 57.6% at baseline to 65.5% at endline) and the increased proportion of the total demand that is being met (from 45.7% at baseline to 63.4% at endline), the project has increased and responded to an increased demand for contraception services within four provinces.

Through the contraception services offered by the project, Pathfinder averted nearly 100,000 unintended pregnancies, 67,000 unintended births, 14,000 unsafe abortions, and 370 maternal deaths.¹¹ This indicates that the CYP provided during a short period of time will have a substantial impact in the future.

Pathfinder's ESD-FPI project is an example of a service delivery integration project on a large scale, and has shown that the design and implementation were efficient where it served the most vulnerable populations in the communities, including women with no education and youth.

¹⁰ Integrating sexual and reproductive health services, Policy Brief-2, WHO, Department of RHR, 2006

¹¹ MSI's Impact 1.2 Calculator was used to estimate the impact of ESD-FPI's contraception interventions, using CYP as the basis for estimates. Corby, N., Boler, T., Hovig, D. (2009, updated May 2011). The MSI Impact Calculator: Methodology and Assumptions (1.2). London: Marie Stopes International.

IV. Attachments

Attachment A: ESD-FPI Endline Survey Report

Attachment B: Performance Monitoring Plan



Extending Service Delivery – Family Planning Initiative (ESD – FPI)

Endline Survey Report

October 2014



Table of Contents

Table of Contents	i
List of Tables and Figures	ii
List of Abbreviations	iii
Executive Summary	iv
Section 1: Background	1
Objectives of the Survey	1
Organization and Methodology of the Survey	2
Sample design	2
Survey instruments	2
Training of field staff	2
Fieldwork	2
Data processing	3
Analysis	3
Sources of error	3
Section 2: Results	4
Characteristics of Respondents	4
Integration of Family Planning with General Health, Maternal Health, and HIV Counseling & Testing Services	5
Exposure to family planning messages in general health service visits	6
Antenatal care	6
Place of delivery	10
Skilled birth attendance	10
Postpartum care	13
HIV/AIDS Counseling and Testing	16
Partner and Household Attitudes Regarding Family Planning	18
Partner approval of health services	18
Household head attitudes toward family planning	19
Exposure to Community-Level Family Planning Interventions and Youth-Friendly Services	21
Contraceptive Knowledge and Use	24
Knowledge of contraception	24
Ever use of contraception	24
Current use of contraception	27
Source of contraceptive method	31
Discussion of contraception with others	31
Condom use	32
Fertility Preferences and Unmet Need for Family Planning	32
Section 3: Conclusion	37
Annex A: Sampling Strategy	38
Annex B: Response Rates and Household Characteristics	39
Annex C: Age of First Sexual Intercourse	42
Annex D: List of People Involved in the ESD—FPI Endline Survey	43

List of Tables and Figures

Tables

Table 2-1: Background characteristics of respondents.....	4
Table 2-2: Cohabitation with partner	5
Table 2-3: Family planning consultations during last health visit.....	6
Table 2-4: Number of ANC visits	7
Table 2-5: HIV testing and counseling during ANC visits	7
Table 2-6: Family planning counseling during ANC.....	9
Table 2-7: Place of delivery	10
Table 2-8: Assistance during delivery	10
Table 2-9: Family planning counseling after delivery in healthcare facilities.....	11
Table 2-10: Contraceptive methods recommended after delivery at health facilities.....	12
Table 2-11: Contraceptive methods used following delivery at a health facility	13
Table 2-12: Timing of postpartum visit.....	13
Table 2-13: Family planning counseling during postpartum visits	14
Table 2-14: Contraceptive methods recommended during postpartum visits	15
Table 2-15: Contraceptive methods used following postpartum visits	16
Table 2-16: Knowledge of HIV testing sites	16
Table 2-17: Coverage of HIV testing	17
Table 2-18: Partner approval of contraceptive use	18
Table 2-19: Partner approval of ANC visits	19
Table 2-20: Acceptance of family planning methods by household heads	20
Table 2-21: Family planning consultation by health provider to household heads	20
Table 2-22: Discussion of family planning by household heads	21
Table 2-23: Exposure to family planning messages by a CHW	21
Table 2-24: Exposure to family planning messages at community events.....	22
Table 2-25: Participation in mobile brigade in past 6 months.....	23
Table 2-26: Knowledge of contraceptive methods.....	25
Table 2-27: Ever use of contraception	26
Table 2-28: Current contraceptive use by women currently in union, by background characteristics	29
Table 2-29: Current contraceptive use by all women aged 15–49	30
Table 2-30: Source of modern contraceptive methods	31
Table 2-31: Talked with someone about FP.....	31
Table 2-32: Need for family planning	35
Table 2-33: Preferred method of contraception	36
Table B-1: Results of the household and individual interviews.....	39
Table B-2: Household composition.....	40
Table B-3: Household characteristics.....	40
Table B-4: Household durable goods.....	41
Table C-1: Age at first sexual intercourse	42

Figures

Figure 2-1: Percent of women counseled on family planning during health visits, by service type	5
Figure 2-2: Contraceptive method mix among women in union who are current contraceptive users	22
Figure 2-3: Use of modern contraception among women in union, by age.....	28
Figure 2-4: Desired fertility among all women aged 15-49	33
Figure 2-5: Total demand (met need plus unmet need) for family planning among women in union, by age and level of education	34
Figure B-1: Population Pyramid	40

List of Abbreviations

ANC	Antenatal care
CHW	Community health worker
EA	Enumeration area
ESD – FPI	Extending Service Delivery – Family Planning Initiative
FP	Family planning
INE	Instituto Nacional de Estadísticas (National Institute of Statistics)
IUD	Intrauterine device
LAM	Lactational amenorrhea method
LAPM	Long acting and permanent methods
PP	Postpartum
PPS	Probability proportional to size
PSU	Primary sampling unit

Executive Summary

The Extending Service Delivery – Family Planning Initiative (ESD – FPI) conducted representative surveys of 1,419 women aged 15–49 at baseline (2011) and 1,578 women aged 15–49 at endline (2014), in the 16 districts of 4 provinces where the project worked. The surveys were designed to produce overall estimates for the project area for key outcome indicators (contraceptive prevalence, partner acceptance of RH practices, etc.), as well as provide information on exposure to project interventions, particularly integration of FP with primary health services including HIV. Data were collected on women’s characteristics; reproductive history; use of antenatal, delivery and postpartum care; knowledge and use of contraceptive methods; marriage and sexual activity; fertility preferences; knowledge and perceptions of HIV/AIDS; and exposure to project interventions. The surveys were conducted by Pathfinder International in collaboration with the National Statistics Institute (INE) and were approved by the Bioethics Committee of the Ministry of Health. Financial support for the surveys was provided by the U.S. Agency for International Development (USAID/Mozambique) through the ESD – FPI.

The results of the baseline and endline surveys reinforce the potential for integration as a means to increase awareness, acceptability and use of contraception. The proportion of women receiving family planning counseling in maternal and child health services increased across the board: at a health visit for themselves or their child (from 48.4% at baseline to 58.2% at endline, $p=0.013$), within ANC services (from 63.5% at baseline to 72.8% at endline, $p=0.016$), within maternity services (from 51.9% at baseline to 63.9% at endline, $p=0.017$), and within postpartum services (from 52.5% at baseline to 62.8% at endline, $p=0.016$). Uptake of family planning methods within delivery and postpartum services remained low, indicating a missed opportunity for immediate postpartum uptake of contraception. Overall use of maternal health services in ESD-FPI areas remained high at endline, with 97.7% of women with a birth in the past 5 years having used ANC, 75.7% delivering in a facility, and 93.4% receiving postpartum care. Coverage of HIV testing has improved, with 72.2% of women at endline having ever been tested and received their result compared to 56.6% at baseline ($p<0.001$). The percent of women who received family planning counseling concurrently with HIV testing also increased from 28.7% at baseline to 44.0% at endline ($p<0.001$).

The survey findings also indicate improved attitudes toward family planning and RH among partners and household members. The percent of women in union who believed their partners approved of contraception increased from 52.3% to 63.0% at endline ($p=0.009$), and partner approval of ANC increased from 93.0% at baseline to 96.4% at endline ($p=0.029$). The proportion of household heads that approve of family planning increased from 64.8% to 79.3% ($p<0.001$), driven mostly by an increase among male household heads (from 59% at baseline to 77% at endline).

The ESD-FPI community strategy included household visits by community health workers (CHWs) as well as other community-based activities. The survey findings show that the percent of women having contact with a CHW in the past year who discussed family planning remained constant from baseline to endline at 14.7%. The endline survey results indicated some exposure to other community-level interventions, with 10.8% of women participating in mobile brigades in the past 6 months and 18.9% participating in community events in the last 12 months (exposure to these interventions was not assessed at baseline).

The ESD-FPI adolescent and youth strategy – geared towards young people 10-24 – aimed to strengthen high-quality integrated contraceptive and other SRH services for young people, increase demand for those services through community empowerment and mobilization, and foster linkages between the community system and the health system. The endline survey findings showed that 6.2% (n=37) of young women aged <25 went to a youth-friendly services center in the last 12 months. This may reflect the national government’s strategy to integrate youth-tailored services into existing health facilities (which are not specifically designated as YFS), while continuing to invest in a limited number of stand-alone YFS centers. ESD-FPI supported 1-2 standalone YFS per province to serve as a center of excellence and a reference point for young people within that province; Inhambane received the most support in this regard, which may have contributed to the higher uptake of YFS in that province (20.4%). Considering the large population of adolescents and youth in Mozambique, there remains a clear need to increase young people’s access to contraception and increase their ability to demand services that are respectful of their rights and unique needs.

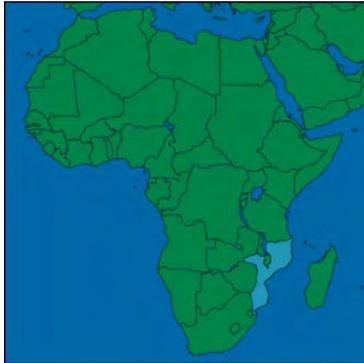
The survey findings indicate that ESD-FPI’s collective interventions have successfully contributed to increasing use of contraception among women in project areas. The proportion of women in union aged 15-49 who are using a modern contraceptive method increased from 24.1% at baseline to 35.1% at endline (p=0.004), and the proportion using any method of contraception increased from 25.9% at baseline to 41.5% at endline (p<0.001). The prevalence of implant use (2.5%) at endline is notable, as implants were only recently introduced in Mozambique (2012), and stock outs had been reported. Increases in modern contraceptive use were most notable among women in union with no education (from 11.5% at baseline to 27.8% at endline, p<0.001) and primary education (from 27.0% at baseline to 35.4% at endline, p=0.073). As the project supported increased access to FP services through public health facilities, it may have contributed to increasing access among women who are more socioeconomically vulnerable. The findings also indicate that unmet need for family planning has decreased from 30.8% at baseline to 24.1% at endline (p=0.031) and a greater proportion of the total demand for family planning is being met (from 45.7% at baseline to 63.4% at endline). This is an encouraging sign that demand for family planning is growing in project communities and is increasingly being met through provision of contraceptive services.

Key ESD-FPI Indicators	Baseline 2011 % (sample size)	Endline 2014 % (sample size)	P value+
Contraception, unmet need and exposure to FP interventions			
Percent of women in union (married or living with a partner) aged 15-49 who are currently using any contraceptive method	25.9 (n=945)	41.5 (n=1068)	<0.001
Percent of women in union age 15-49 who are currently using a modern contraceptive method	24.1 (n=945)	35.1 (n=1068)	0.004
Percent of women in union aged 15–49 with an unmet need for family planning	30.8 (n=945)	24.1 (n=1068)	0.031
Percent of women aged 15-49 with a birth in the last 5 years who had a health visit for themselves or their child in the past 12 months in which they received counseling on family planning	48.4 (n=741)	58.2 (n=853)	0.013
Percent of women aged 15-49 who were visited by CHWs that discussed family planning in the last 12 months	14.7 (n=1419)	14.7 (n=1575)	0.993
Partner and household approval of FP/RH practices			

Percent of women aged 15–49 with a birth in the last 5 years and at least one ANC visit who said their partner approved of ANC	93.0 (n=722)	96.4 (n=839)	0.029
Percent of women in union aged 15–49 who said their partner approves of using a contraceptive method	52.3 (n=945)	63.0 (n=1068)	0.009
Percent of household heads who accept family planning as a method to avoid pregnancy	64.8 (n=1519)	79.3 (n=1621)	<0.001
Antenatal Care			
Percent of women aged 15–49 with a birth in the last 5 years who had 4 or more ANC visits	61.4 (n=739)	68.6 (n=853)	0.048
Percent of women aged 15–49 with a birth in the last 5 years and at least one ANC visit who were counseled on HIV and offered testing during ANC	82.1 (n=722)	95.3 (n=839)	<0.001
Percent of women aged 15–49 with a birth in the last 5 years and at least one ANC visit who were counseled on FP during ANC	63.5 (n=722)	72.8 (n=839)	0.016
Delivery and Postpartum			
Percent of women aged 15–49 with a birth in the last 5 years who delivered in a health facility	67.1 (n=739)	75.7 (n=853)	0.195
Percent of women aged 15–49 with a birth in the last 5 years at a health facility who received FP counseling after delivery	51.9 (n=562)	63.9 (n=673)	0.017
Percent of women aged 15–49 with a birth in the last 5 years at a health facility who received a contraceptive method after delivery	18.0 (n=562)	6.2 (n=673)	<0.001
Percent of women age 15–49 with a birth in the past 5 years who had a postpartum visit	86.7 (n=741)	93.4 (n=853)	0.018
Percent of women age 15–49 with a birth in the past 5 years and at least one postpartum visit who were counseled on FP during PP care	52.5 (n=664)	62.8 (n=803)	0.016
Percent of women age 15–49 with a birth in the past 5 years and at least one postpartum visit who received a contraceptive method in the PP visit	13.8 (n=664)	5.1 (n=803)	<0.001
HIV			
Percent of women age 15–49 who ever had an HIV test and received their results	56.6 (n=1419)	72.2 (n=1575)	<0.001
Percent of women age 15–49 who received FP counseling during HIV test	28.7 (n=1419)	44.0 (n=1575)	<0.001
Percent of women age 15–49 with a non-regular (non-marital, non-cohabiting) partner who used a condom at last sex with that partner in the past 12 months	39.3 (n=196)	29.0 (n=234)	0.154

+ p values from regression using survey commands in STATA to account for clustered nature of data. p<0.05 is considered statistically significant.

Section 1: Background



Mozambique is a low-income country located in south east Africa. After 16 years of civil war which ended in 1992, the country has seen rapid economic growth. For example, from 1997 to 2009, economic growth averaged 8.4% per year (GOM, 2010), and the annual GDP growth rate remained at 7% through 2012 (World Bank 2014). However, the country is ranked 185th of 187 countries on the human development index (UNDP, 2013) and as of 2008, approximately 60% of the population live on less than US\$1.25 a day (World Bank 2014). Mozambique has experienced rapid population growth, with the total population increasing from 16.1 million in 1997 to an estimated 25.0 million in 2014 (INE, 2014). Just over one-third of the population lives in urban areas, and 48% of the population is below the age of 15 (INE, 2011).

Though Mozambique has greatly improved some health indicators in recent years, including a 60% reduction in maternal mortality between 1997 and 2003, the maternal mortality rate remains high at 490 maternal deaths per 100,000 live births (UNICEF, 2010). While antenatal care during pregnancy is nearly universal (90.6% of women attend at least one visit), only 54.8% of women deliver in a facility (INE 2012). The total fertility rate has increased from 5.2 births per woman in 1997 to 5.5 in 2003 and 5.9 in 2011. Years of national underinvestment in contraception and a paucity of donor-funded contraception programs have contributed to a low and declining national CPR (from 14% in 2003 to 12% in 2011), and growing unmet need for contraception (increasing from 18% in 2003 to 29% in 2011) (INE 2012). The need for HIV services is also high. Recent data suggest that the national prevalence of HIV is 11.1%, varying from a low of 3.3% in Niassa province to a high of 29.9% in Gaza province (INS, 2010).

The ESD Family Planning Initiative (ESD – FPI) was a four-year project funded by the United States Agency for International Development from 2010-2014 to enhance the use of family planning and HIV services in four provinces (Cabo Delgado, Gaza, Inhambane, and Maputo Province). The project was implemented by Pathfinder International. To effectively address both the unmet need for family planning and the growing need for HIV prevention and care and treatment services, ESD – FPI worked with health facilities, pre-service institutes, communities and partners to integrate family planning services at all levels. By integrating family planning into primary care services such as antenatal and postnatal care, immunizations, and child wellness visits, the project aimed to minimize costs and maximize opportunities to reach men and women with family planning services.

Objectives of the Survey

The baseline and endline surveys conducted by ESD – FPI in 2011 and 2014, respectively, will enable the project to understand whether health outcomes have improved among the target population of women of reproductive age in the intervention areas, and in concert with the monitoring data, will facilitate an understanding of the role of the program in changes that occur in health outcomes.

The specific objective of the endline survey was to assess changes from baseline in the use of facility-based services, the coverage of community-based services, and knowledge, attitudes and practices about family planning among the target population.

Organization and Methodology of the Survey

Sample design

The baseline and endline surveys were conducted in 16 districts in the 4 provinces covered by the project (*Cabo Delgado*: Cidade de Pemba, Balama, Chiure, Montepuez, Namuno and Ancuabe; *Inhambane*: Cidade de Inhambane, Zavala, and Massinga; *Gaza*¹²: Cidade de Xai Xai, Bilene, Chibuto, Chokwe, Manjacaze, and distrito de Xai Xai; *Maputo province*: Matola). The unit of analysis for the baseline and endline surveys was the households and the women of reproductive age (15 to 49 years) who live in those households in the project districts. Following the sampling strategy described in Annex A, a baseline sample of 1,586 households and 1,429 women aged 15–49 years was selected, and an endline sample of 1,657 households and 1,588 women aged 15–49 years was selected. Each sample was proportionally distributed in the urban and rural strata of each province in the selected enumeration areas.

Survey instruments

Two questionnaires were used for data collection at baseline and endline: a household questionnaire and woman's questionnaire. The household questionnaire included information about the residents of the household, indicators of wealth, and four questions on the household head's knowledge of family planning. It was administered to the head of household or other adult member of the household. The woman's questionnaire was used to collect information from women aged 15–49. The questionnaire was adapted slightly at endline to add questions on exposure to project interventions and calculate unmet need per the standard DHS definition. Women were asked about background characteristics; reproductive history; antenatal, delivery and postpartum care; knowledge and use of contraceptive methods; marriage and sexual activity; fertility preferences; knowledge and perception on HIV/AIDS; and exposure to project interventions (endline only).

Training of field staff

The ESD—FPI recruited and trained field staff to serve as interviewers, field editors and supervisors for the baseline and endline surveys. Potential interviewers were identified by the head of the Statistical Department in each province based on past survey experience and fluency in the local language. The interviewer trainings were held in Maputo and consisted of 30 participants at baseline (June 13-24, 2011) and 25 participants at endline (February 24 - March 5, 2014). ESD—FPI monitoring and evaluation staff and experienced trainers from INE conducted the trainings which included lectures, presentations, practical demonstrations, practice interviewing in small groups and field practice. Supervisors and field editors were selected based on an assessment administered on the last day of training and observations during the training, and received an additional 2 days of training to increase their knowledge of their responsibilities and the team's role.

Fieldwork

The baseline survey fieldwork was conducted from July 1-31, 2011 by five teams of 4 interviewers, a field editor, a field supervisor and a driver, and the endline survey fieldwork was conducted from March 13-April 7, 2014 by four teams of 4 interviewers, a field editor, a field supervisor and a driver. Before field work began in any area, the local authorities were contacted. Approvals were obtained

¹² Gaza province was oversampled in the 2011 baseline survey in order to provide endline estimates for another project; the final weighted baseline data accounted for that oversampling. Gaza province was not oversampled for the endline survey.

from the National Bioethics Committee, the Minister of Health, the Vice-President of the National Statistics Institute, the Provincial Health Directorate and by the administrations of each district covered by the study. Additional supervision of fieldwork was coordinated from the Pathfinder International office in Maputo, with the ESD–FP initiative team visiting survey teams regularly during the field work and maintaining close contact through daily phone calls to assess progress and to discuss any challenges faced. Once data collection was complete in a cluster, data were sent to the appropriate Pathfinder International provincial office and questionnaires were checked in on a log sheet. One randomly selected set of questionnaires from each cluster was reviewed and any problems identified were discussed with the field editors and supervisors. The questionnaires for the cluster were then packaged and shipped to Maputo for data entry.

Data processing

Data processing for the baseline and endline surveys was overseen by a supervisor and assistant supervisor from INE. Data were entered by 20 data entry operators working in two shifts on 10 computers. All data were double entered in CsPRO version 5.0 using a data entry program developed by INE staff for the questionnaires. Any inconsistencies were reviewed against the questionnaire by a data editor and corrected. Baseline survey data entry was completed in August 2011, and endline survey data entry was completed in May 2014.

Analysis

The baseline survey analysis was conducted using SAS for Windows, Version 9.1.3 Service Pack 4. Copyright © 2002–2003 by SAS Institute Inc., and the endline survey analysis was conducted using Stata, Release 11, Copyright © 2009 StataCorp LP. For both analyses, we used the survey commands to take into account stratification and clustering, and data were weighted using the inverse of the probability of selection. Regression analyses using the survey commands were conducted on a merged baseline-endline database to determine significant differences between baseline and endline values for key indicators. Certain weighted analyses are not possible using SAS or Stata; therefore some estimates (e.g., median age at first sex) were produced using un-weighted data and do not take into account the clustered nature of the data. Since the survey was not designed to produce provincial estimates, the provincial data included in this report are not precise estimates for each province but do allow for a relative comparison of the findings.

Sources of error

The survey questionnaires were printed in Portuguese because most of the local languages are not written languages. Although translation into the local languages was addressed during the training, with interviewers discussing the correct translation of questions and responses, it was not possible to ensure the consistency of the translations across interviewers. This may have led to some bias if particular interviewers used translations that were markedly different. Household listings were not available for the enumeration areas, so the listings were done by the study teams. Interviewers were trained to include all households in the listing, regardless of how distant they were and of their socioeconomic status. However, it is possible that some households were excluded from the listing because interview teams were not comfortable accessing them. In order to avoid selection bias in the field, a list of replacement households was provided to the supervisors to be used in case one of the original sampled households could not be interviewed. The supervisor first made a strong effort to complete the interview for the original sampled household before deciding to replace it.

Section 2: Results

Characteristics of Respondents

Table 2-1 summarizes the demographic characteristics of women interviewed in the baseline and endline surveys (see Annex B for response rates and household characteristics). Respondents were similar in the two surveys. Their mean ages were 29.9 years (95% CI: 29.0, 30.8) at baseline and 28.5 years (95% CI: 27.7, 29.3) at endline. The majority of women were married or living with a non-marital partner (65.4% at baseline, 68.1% at endline); the percent living with a partner was higher at endline ($p < 0.05$). One third of women were Catholic and the remains were predominantly Protestant, Zionist or Muslim. The majority of women (nearly 60%) had primary schooling only; a greater proportion of women at endline had secondary education or higher ($p < 0.05$).

Table 2-1: Background characteristics of respondents

Percent distribution of women age 15–49 by background characteristics, ESD-FPI baseline survey (2011) and endline survey (2014)

Background characteristic	Baseline % (weighted)	Baseline # (weighted)	Endline % (weighted)	Endline # (weighted)
Age				
15–19	19.2	272	23.6	301
20–24	16.0	226	17.9	270
25–29	16.5	235	14.7	247
30–34	14.3	204	15.4	264
35–39	12.6	178	11.2	207
40–44	10.8	153	9.1	144
45–49	10.6	152	8.2	142
Marital status				
Never married	16.5	234	17.0	252
Married	16.8	238	13.1	177
Living together	48.6	689	55.0*	891
Divorced/ Separated/ Widowed	18.1	257	14.9	255
Religion				
Catholic	29.1	413	29.8	449
Protestant	23.7	338	23.3	341
Zionist	18.4	260	19.8	384
Muslim	15.6	222	15.5	195
Other	8.4	119	6.2	127
None	4.7	67	5.2	74
Education Level				
No education	28.3	402	21.0	345
Primary	56.6	804	56.3	863
Secondary or higher	15.1	214	22.7*	366
Native Language				
Portuguese	5.0	71	4.6	85
Emakhuwa	32.6	463	34.6	409
Xichangana	42.3	601	41.4	592
Other/ Missing	20.0	286	19.4	489
Province				
Cabo Delgado	32.6	463	31.7	499
Inhambane	12.2	173	13.9	219
Gaza	34.8	494	36.2	570
Maputo Province	20.4	289	18.2	287
Total	100.0	1,419	100.0	1,575

P values from regression using survey commands to account for clustered nature of data; significance levels denoted by * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

In a generalized HIV epidemic such as that in Mozambique, women who are in marital union (married or living with a partner) are the most in need of family planning and HIV services. Table 2-2 shows women’s relationship status and living arrangements. The majority of women (58.0% at baseline and 53.1% at endline) were currently in union – either married or living with their partner. At endline, the proportion of women in union but not living with their partner was twice as high.

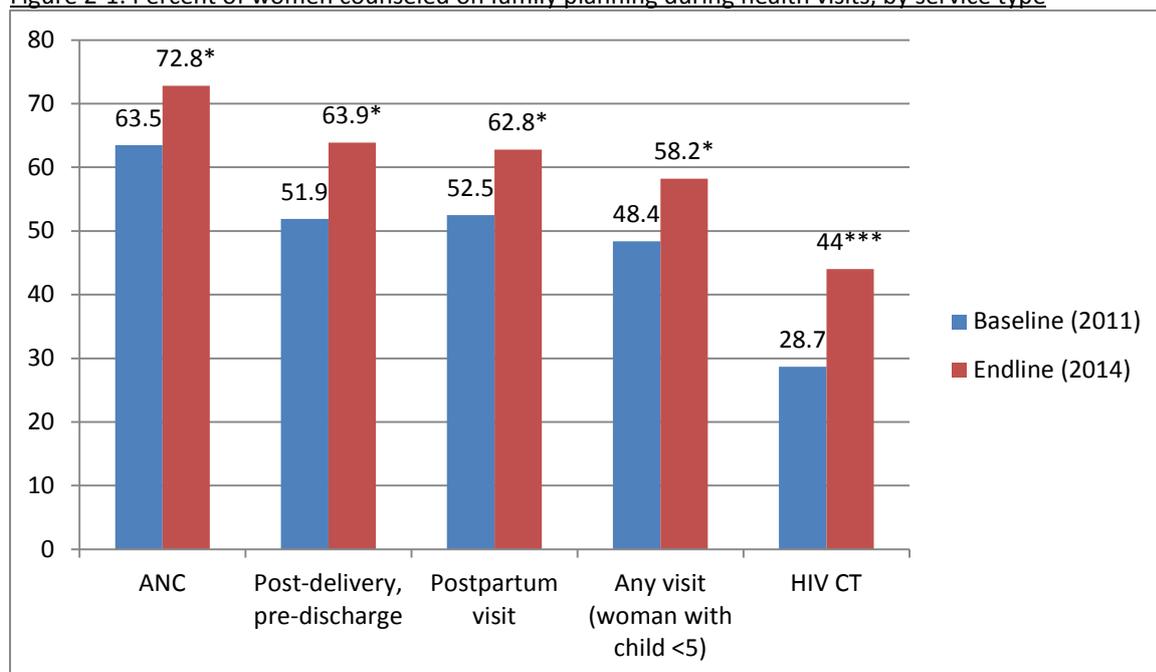
	Baseline % of women 15-49	Endline % of women 15–49
In Union		
Married or living with partner	58.0	53.1
Not living with partner	7.2	14.9
Not in union	34.6	31.9
Missing	0.2	0.1
Number of women 15–49	1,419	1,575

The following tables present results from the endline survey, with comparison to baseline values in the text. The full baseline survey tables are available in the ESD-FPI baseline survey report (<http://www.pathfinder.org/publications-tools/extending-service-delivery-family-planning-initiative-baseline-report.html>).

Integration of Family Planning with General Health, Maternal Health, and HIV Counseling & Testing Services

The survey findings indicate that ESD-FPI has helped improve integration of family planning counseling/services in ANC, delivery, postpartum and HIV services (Figure 2-1), highlighting to the potential for integration as a way to increase use of contraception.

Figure 2-1: Percent of women counseled on family planning during health visits, by service type



* p<0.05, ** p<0.01, ***p<0.001

Exposure to family planning messages in general health service visits

Table 2-3 summarizes whether women aged 15–49 who gave birth in the last 5 years had health appointments for themselves or for their child in the last 12 months, and if so, whether they had family planning consultations during the visit. There were 853 survey respondents with a birth in the past 5 years, the large majority (84.5%) of whom had health appointments for themselves or their child. Almost three-fifths (58.2%) discussed family planning during their visit (compared to 48.4% at baseline, $p=0.013$), indicating that family planning counseling was increasingly available across a range of services. Women aged 25–34 were most likely to have had an appointment in the past 12 months (>80%). Women who live in Maputo Province (Matola) had fewer health appointments and lower rates of family planning consultations when they did have appointments.

Background characteristic	Had health appointments in the last 12 months who:		% who did not have health appointments in the last 12 months	Number of women who gave birth in last 5 years
	% counseled on FP	% not counseled on FP		
Age				
15–19	37.9	36.8	25.4	110
20–24	56.7	28.2	15.2	206
25–29	67.5	22.4	10.1	184
30–34	63.5	25.1	11.4	190
35–39	64	18	18.0	104
40–44	68.1	18.4	13.5	50
45–49	*	*	*	9
Marital status				
Never married	62.2	22.2	15.6	71
Married	71.4	15.5	13.1	103
Living together	56.3	29.7	14	561
Divorced/ Separated/ Widowed	49.2	24	26.9	118
Education Level				
No education	61.2	24	14.8	173
Primary	58.3	27.3	14.4	505
Secondary or higher	54.5	25.3	20.2	175
Province				
Cabo Delgado	46	31.9	22	219
Inhambane	68.1	18	13.9	186
Gaza	73	18.7	8.3	349
Maputo Province	33.1	42.9	24	99
Total	58.2	26.3	15.5	853

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed.

Antenatal care

There are several points of contact that health facilities have with women before, during, and after pregnancy during which family planning and HIV counseling can take place. As Table 2-4 shows, the vast majority (97.7%) of women who gave birth in the last 5 years received ANC care, and approximately two-thirds (68.6%) had four or more ANC consultations as commensurate with WHO standards, compared to 61.4% at baseline ($p=0.048$).

Table 2-4: Number of ANC visits

Percent distribution of women age 15–49 who had given birth in the last 5 years by number of ANC visits for the most recent live birth, according to background characteristics

Background characteristic	# ANC consultations					Don't know/ Missing	Number of women age 15–49 who had a birth in the last 5 years
	None	1	2–3	4+			
Age							
15–19	6.0	1.3	24.2	68.1	0.4	110	
20–24	1.3	0.2	26.3	69.2	3.0	206	
25–29	1.6	1.5	30.3	62.5	4.2	184	
30–34	0.0	0.8	19.2	78.6	1.5	190	
35–39	3.0	0.0	28.4	64.7	3.9	104	
40–44	4.5	0.0	33.9	56.3	5.4	50	
45–49	*	*	*	*	*	9	
Marital status							
Never married	0.0	0.0	22.4	77.6	0.0	71	
Married	1.8	1.8	24.3	70.7	1.5	103	
Living together	2.0	0.4	27.4	67.3	2.9	561	
Divorced/ Separated/ Widowed	5.7	1.9	20.6	67.0	4.9	118	
Education Level							
No education	3.1	2.5	29.3	61.4	3.7	173	
Primary	2.0	0.3	27.2	68.6	2.0	505	
Secondary or higher	2.4	0.5	17.0	76.1	4.0	175	
Province							
Cabo Delgado	5.4	1.2	40.7	52.8	0.0	219	
Inhambane	0.4	2.4	11.8	74.4	11.2	186	
Gaza	0.0	0.2	21.1	78.2	0.5	349	
Maputo Province	3.3	0.0	13.4	72.6	10.6	99	
Total	2.3	0.7	25.7	68.6	2.7	853	

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed.

ANC is an opportune time for counseling on HIV and family planning, as women seeking ANC are clearly sexually active and will be at risk for pregnancy again. Of the women who had given birth in the last 5 years and had ANC visits during that pregnancy, nearly all (95.3%) were counseled on HIV and offered HIV testing at that time (Table 2-5), compared to 82.1% at baseline ($p < 0.001$).

Table 2-5: HIV testing and counseling during ANC visits

Percent distribution of women age 15–49 who had given birth in the last 5 years and had ANC visits by whether they were counseled about HIV and offered HIV testing, according to background characteristics

Background characteristic	% who were counseled on HIV and:		% who were not counseled on HIV during last pregnancy	Number of women who gave birth in the last 5 years and had ANC visits
	were offered HIV testing	were not offered HIV testing		
Age				
15–19	94.0	3.9	1.8	106
20–24	97.2	0.2	2.6	204
25–29	94.8	2.0	3.2	181
30–34	95.0	1.3	3.7	190
35–39	97.0	0.0	2.3	101
40–44	(90.7)	(6.4)	(2.9)	48
45–49	*	*	*	9

Marital status					
Never married	99.6	0.0	0.4		71
Married	94.2	1.9	3.9		101
Living together	94.9	1.9	3.0		552
Divorced/ Separated/ Widowed	95.5	2.0	2.1		115
Education Level					
No education	92.0	2.1	5.7		167
Primary	95.0	2.1	2.7		498
Secondary or higher	99.6	0.4	0.0		174
Province					
Cabo Delgado	90.3	4.9	4.7		207
Inhambane	93.9	0.7	4.9		185
Gaza	98.2	0.0	1.7		349
Maputo Province	99.1	0.9	0.0		98
Total	95.3	1.8	2.8		839

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

Table 2-6 describes family planning consultations during antenatal care (ANC) visits, including the methods recommended to women. Of the 839 women who gave birth in the last 5 years and had ANC visits, the majority (72.8%) received family planning counseling during their ANC visits, a significant increase from 63.5% at baseline ($p=0.016$). This indicates that family planning is increasingly integrated in ANC consultations, a result to which the project contributed through training on integration of FP services in MCH, supporting necessary reorganization of services, and mentoring and supervision. Women who were living with their partner were least likely to have received family planning counseling during their ANC visit (49.3%). A specific method was recommended to 51.0% of all women seen for ANC. The pill was the most commonly recommended method (44.6%); no information was available on the type of pill recommended (i.e. progestin-only vs. combined oral contraceptives).

Table 2-6: Family planning counseling during ANC

Percent distribution of women aged 15–49 who had given birth in the last 5 years who made at least one ANC visits by whether they received FP counseling, and if so whether a method was recommended, by type of method, according to background characteristics

Background characteristics	% who received FP consultation during ANC visit and was recommended...*					% who received FP consult during ANC visit but were not recommended specific method	% who did not receive FP consult during ANC visit	Number of women who gave birth in last 5 years and had ANC visits
	Any Method	LAPM**	Pills	Injectables	Male condoms			
Age								
15–19	39.5	14.8	35.5	29.9	12.5	21.7	37.7	106
20–24	48.0	9.6	39.0	35.1	15.2	23.3	28.6	204
25–29	57.7	14.0	49.2	43.9	13.0	15.5	25.8	181
30–34	54.8	16.9	48.2	40.8	14.0	20.3	24.3	190
35–39	61.0	20.0	44.9	43.9	16.7	26.3	11.7	101
40–44	(60.2)	(13.1)	(51.4)	(53.4)	(13.9)	(20.1)	(19.8)	48
45–49	*	*	*	*	*	*	*	9
Marital status								
Never married	54.0	20.6	47.0	39.9	12.2	23.0	23.0	71
Married	54.8	11.2	34.5	26.2	6.1	19.0	26.1	101
Living together	51.0	15.2	45.3	41.9	10.0	20.6	27.5	552
Divorced/ Separated/ Widowed	50.1	9.0	39.9	38.6	6.8	25.2	24.6	115
Education Level								
No education	54.8	11.0	47.1	40.5	8.7	21.8	22.9	167
Primary	49.6	13.1	40.7	38.6	7.8	21.0	28.6	498
Secondary or higher	55.8	22.1	47.7	38.8	14.5	20.8	23.4	174
Province								
Cabo Delgado	37.1	10.7	25.8	21.9	8.1	17.7	44.7	207
Inhambane	61.8	30.4	57.1	55.4	23.3	32.1	6.1	185
Gaza	58.4	10.4	53.3	48.7	4.9	23.6	18.0	349
Maputo Province	57.7	24.3	41.6	36.1	15.8	12.7	26.2	98
Total	51.7	14.3	43.2	39.0	9.2	21.1	26.6	839

*These do not total to 100% because some women had more than one method recommended to them ** Long acting and permanent methods (LAPM)

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

Place of delivery

Among women who gave birth in the past 5 years, the majority (75.7%) had done so at a public or private health facility (Table 2-7), compared 67.1% at baseline ($p=0.195$). One quarter of women had given birth at home. Notably, almost half of women who had no education and half of those living in Cabo Delgado had given birth at home.

Table 2-7: Place of delivery

Among women age 15–49 with a birth in the five years preceding the survey, the percent distribution by place of delivery, according to background characteristics

Background characteristic	Public facility	Private facility	Home	Number of women with a birth in the past 5 years
Age				
15–19	75.2	0.0	24.8	110
20–24	82.7	1.4	15.9	206
25–29	79.4	0.0	20.6	184
30–34	71.9	1.5	26.7	190
35–39	61.6	0.0	38.4	104
40–44	62.5	0.0	37.5	50
45–49	*	*	*	9
Marital status				
Never married	95.8	0.0	4.2	71
Married	51.4	0.0	48.6	103
Living together	78.4	1.0	20.6	561
Divorced/ Separated/ Widowed	72.2	0.0	27.8	118
Education Level				
No education	54.7	0.0	45.3	173
Primary	76.6	1.0	22.5	505
Secondary or higher	90.9	0.2	8.8	175
Province				
Cabo Delgado	48.3	0.0	51.7	219
Inhambane	83.2	0.9	15.9	186
Gaza	89.0	0.0	11.0	349
Maputo Province	91.1	4.1	4.8	99
Total	75.0	0.6	24.3	853

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed.

Skilled birth attendance

Table 2-8 shows the person providing assistance during delivery for women who had given birth in the last 5 years. Three-quarters (78.2%) of women who had given birth in the last 5 years had skilled birth attendants (doctor/nurse or auxiliary midwife) assist with their most recent delivery, compared to 65.3% at baseline ($p=0.045$). The remainder of women (20.5%) had other attendants including family members and/or traditional birth attendants. This finding may reflect efforts from the government to reduce maternal mortality through a strategy of increasing institutional deliveries, which included increasing availability of trained providers, maternal waiting houses, and bike ambulances, among others.

Table 2-8: Assistance during delivery

Among women age 15–49 with a birth in the five years preceding the survey, the percent distribution by persons providing assistance during last delivery and percentage delivered by a skilled provider, according to background characteristics

	Person providing assistance during delivery	Percentage	Number of
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Background characteristic	Doctor/ Nurse	Auxiliary Midwife	Other (Family/Friends, TBA)	No one	delivered by a skilled provider	women with a birth in the past 5 years
Age						
15–19	51.4	27.3	21.2	0.2	78.6	110
20–24	56.9	28.7	13.6	0.8	85.6	206
25–29	57.0	24.0	17.3	1.7	81	184
30–34	42.5	32.5	22.7	2.4	75	190
35–39	42.5	25.4	31.0	1.1	67.9	104
40–44	38.0	26.8	35.2	0.0	64.8	50
45–49	*	*	*	*	*	9
Marital status						
Never married	62.6	33.1	3.4	0.9	95.8	71
Married	40.5	14.0	44.9	0.6	54.5	103
Living together	51.7	29.5	17.0	1.8	81.1	561
Divorced/ Separated/ Widowed	46.0	33.8	20.2	0.0	79.8	118
Education Level						
No education	34.8	26.8	36.4	2.1	61.5	173
Primary	51.3	27.5	20.0	1.2	78.8	505
Secondary or higher	62.4	30.9	5.7	1.1	93.2	175
Province						
Cabo Delgado	28.9	24.4	45.7	1.0	53.2	219
Inhambane	41.2	44.3	13.6	0.9	85.5	186
Gaza	65.7	26.7	5.6	2.0	92.4	349
Maputo Province	60.0	29.2	10.2	0.5	89.2	99
Total	50.2	28.0	20.5	1.4	78.2	853

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed.

Among women with a birth in the past 5 years, 673 (75.0%) delivered in a health facility. These women were asked whether they received family planning counseling after delivery but before discharge, and if so, who did the counseling (Table 2-9). 63.9% of women who gave birth at a health facility in the past 5 years were counseled on family planning before discharge, compared to 51.9% at baseline ($p=0.017$). Most were counseled by a doctor or nurse (56.3%).

Table 2-9: Family planning counseling after delivery in healthcare facilities
Percent distribution of women aged 15–49 who had given birth in the last 5 years at a health facility by whether they received FP counseling, and type of counselor, according to background characteristics

Background characteristics	Received FP counseling after delivery by:			Did not receive FP counseling after delivery	Number of women who gave birth in last 5 years at a health facility
	Doctor/ Nurse	Auxiliary Midwife	Other		
Age					
15–19	30.7	7.4	0.0	61.9	81
20–24	59.4	5.5	0.2	34.9	177
25–29	64.9	4.2	1.4	29.5	151
30–34	60.3	11.4	0.0	28.4	148
35–39	60.4	7.2	0.0	32.4	76
40–44	(71.7)	(10.5)	(0.0)	(17.8)	35
45–49	*	*	*	*	5
Marital status					
Never married	51.3	10.0	0.0	38.7	67
Married	46.5	10.3	0.0	43.1	61
Living together	59.3	6.6	0.5	33.6	456
Divorced/ Separated/ Widowed	51.7	6.5	0.0	41.8	89
Education Level					

No education	60.7	16.3	1.8	21.2	109
Primary	56.2	5.1	0.1	38.5	403
Secondary or higher	53.8	8	0.0	38.1	161
Province					
Cabo Delgado	29.6	10.6	0.0	59.8	117
Inhambane	36.5	23.8	3.2	36.5	152
Gaza	79.8	1.9	0.0	18.3	308
Maputo	32.0	8.9	0.0	59.1	96
Total	56.3	7.3	0.3	36.1	673

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

Slightly less than half of women (46.8%) who had a delivery at a health facility received a FP consultation and were recommended a specific contraceptive method (Table 2-10), compared to 40.2% at baseline. The pill was the most commonly recommended method, at 38.2%. Overall, 6.2% of women who had a birth in the past five years at a health facility left the health facility with a contraceptive method (Table 2-11), compared to 18.0% at baseline ($p < 0.001$). Pills were the most commonly received method, followed by injectables. The proportion of women who received a method was lowest among women with no education.

Table 2-10: Contraceptive methods recommended after delivery at health facilities

Percent distribution of women age 15–49 who had given birth in the last 5 years at a health facility, by whether a contraceptive method was recommended, by method, according to background characteristics

Background characteristics	Had FP consult and was specifically recommended:*					Had FP consult but was not recommended specific FP method	Did not receive FP consult after delivery	Number of women who gave birth in last 5 years at a health facility
	Any Method	LAPM	Pill	Inject-ables	Male condom			
Age								
15–19	26.1	3	17.8	15.9	2.5	12	61.9	81
20–24	45.1	8.5	35.6	36.7	3.6	20	34.9	177
25–29	52.8	12.7	44.4	37.8	6.1	17.7	29.5	151
30–34	55.7	14.9	51.5	47.8	10.1	15.6	28.4	148
35–39	49.5	13.5	30.5	41.7	9.4	18.1	32.4	76
40–44	(66.4)	(9.7)	(60.7)	(48.4)	(3.9)	(15.9)	(17.8)	35
45–49	*	*	*	*	*	*	*	5
Marital status								
Never married	41.5	9.7	34.5	28.4	5.9	19.8	38.7	67
Married	41.4	6.5	15.6	25.2	0.6	15.4	43.1	61
Living together	49.7	11.5	42.8	39.5	6.9	16.6	33.6	456
Divorced/ Separated/ Widowed	39.2	5.9	34.9	33.1	3.8	19	41.8	89
Education Level								
No education	58.5	7.7	50.7	50.0	6.2	19.7	21.2	109
Primary	45.1	8.6	37.5	34.1	3.9	16.3	38.5	403
Secondary or higher	44.3	16.2	32.8	33.7	10.9	17.6	38.1	161
Province								
Cabo Delgado	27.3	3.6	15.3	17.2	2.4	12.9	59.8	117
Inhambane	45.4	24.5	42.6	39.6	19.7	18	36.5	152
Gaza	59.8	8.8	52.6	48.9	2.9	21.9	18.3	308
Maputo Province	33.1	13.2	21.1	19.5	9.7	7.2	59.1	96
Total	46.8	10.2	38.3	36.2	5.8	17.1	36.1	673

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

Table 2-11: Contraceptive methods used following delivery at a health facility

Percent distribution of women age 15–49 who had given birth in the last 5 years at a health facility, by type of contraceptive they left with, according to background characteristics

Background characteristics	% who left with following contraceptive methods:					Counseled but did not leave with FP method	Did not receive FP counseling	Number of women who gave birth in last 5 years at a health facility
	Any Modern Method	LAPM	Pill	Injectables	Male condom			
Age								
15–19	3.1	0.0	1.8	0.7	0.5	35.0	61.9	81
20–24	4.3	1.1	1.2	0.8	1.2	60.8	34.9	177
25–29	9.0	1.2	2.2	3.8	1.7	61.5	29.5	151
30–34	2.5	0.9	1.1	0.5	0.0	69.2	28.4	148
35–39	21.1	1.3	12.9	0.5	3.4	46.5	32.4	76
40–44	(7.6)	(2.6)	(5.0)	(0.0)	(0.0)	(74.6)	(17.8)	35
45–49	*	*	*	*	*	*	*	5
Marital status								
Never married	2.7	0.0	1.0	1.6	0.0	58.7	38.7	67
Married	9.3	0.0	2.5	1.0	3.3	47.6	43.1	61
Living together	7.1	1.4	3.3	1.3	1.1	59.3	33.6	456
Divorced/ Separated/ Widowed	1.5	0.0	0.0	1.5	0.0	56.8	41.8	89
Education Level								
No education	3.6	0.0	2.7	0.9	0.0	75.2	21.2	109
Primary	5.4	1.2	2.1	1.2	0.6	56.1	38.5	403
Secondary or higher	10.2	1.0	4.2	1.8	3.2	51.7	38.1	161
Province								
Cabo Delgado	3.7	0.0	2.8	0.8	0.0	36.5	59.8	117
Inhambane	12.0	5.7	5.1	1.2	0.0	51.5	36.5	152
Gaza	5.8	0.7	2.9	1.6	0.2	75.8	18.3	308
Maputo Province	6.9	0.0	0.0	1.0	5.9	33.9	59.1	96
Total	6.2	1.0	2.6	1.3	1.1	57.7	36.1	673

* These do not total to 100% because some women had more than one method recommended to them

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

Postpartum care

Of the 853 women who gave birth in the last 5 years, nearly all (93.4%) had a postpartum visit, increasing from 86.7% at baseline ($p=0.018$). Table 2-12 shows that the majority (84.7%) of postpartum visits occurred 3 or more days after delivery.

Table 2-12: Timing of postpartum visit

Among women age 15–49 with a birth in the five years preceding the survey, the percent distribution by timing of first postnatal checkup for the last birth, according to background characteristics

Background characteristic	Received postpartum visit on:				Did not receive postpartum care	Number of women with a birth in the past 5 years
	First day	1–2 days	3+ days	Don't know/missing		
Age						
15–19	0.9	4.7	82.8	1.6	10.0	110
20–24	0.0	10.3	83.4	1.1	5.3	206
25–29	0.0	5.4	86.6	1.3	6.7	184
30–34	0.3	7.1	91.5	0.2	0.9	190

35–39	0.0	12.9	81.0	1.1	5.0	104
40–44	0.0	16.6	74.2	2.9	6.3	50
45–49	*	*	*	*	*	9
Marital status						
Never married	2.8	6.2	86.1	0.5	4.4	71
Married	0.0	5.2	86.7	0.0	8.1	103
Living together	0.0	8.1	85.3	1.7	5.0	561
Divorced/ Separated/Widowed	0.0	15.8	78.4	0.0	5.8	118
Education Level						
No education	0.0	11.2	83.0	0.8	5.0	173
Primary	0.1	8.0	85.5	0.8	5.6	505
Secondary or higher	0.9	7.1	83.9	2.5	5.6	175
Province						
Cabo Delgado	0.0	5.1	84.5	0.6	9.8	219
Inhambane	0.0	10.7	85.0	1.2	3.1	186
Gaza	0.5	11.7	82.7	1.7	3.4	349
Maputo Province	0.0	4.4	91.9	0.3	3.3	99
Total	0.2	8.4	84.7	1.1	5.5	853

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed.

Of the 803 women who gave birth in the last 5 years and had at least one postpartum (PP) visit, almost two-thirds (62.8%) received family planning counseling during that postpartum visit (Table 2-13), compared to 52.5% at baseline ($p=0.016$). The majority of the family planning counseling sessions during postpartum visits were conducted by doctors and nurses (58.7%)

Table 2-13: Family planning counseling during postpartum visits

Percent distribution of women age 15–49 who had given birth in the past 5 years and had a postpartum visit, by whether they received family planning counseling and type of counselor, according to background characteristics

Background characteristics	Received FP counseling during PP visit by:			Did not receive FP counseling during PP visit	Number of women who gave birth in last 5 years and had PP visit
	Any Provider	Doctor/ Nurse	Auxiliary Midwife		
Age					
15–19	43.7	40.4	2.9	56.3	98
20–24	63.9	61.7	1.9	36.1	194
25–29	63.6	60.3	1.2	36.4	173
30–34	75.3	69.2	6.1	24.7	186
35–39	61.7	55.0	6.7	38.3	98
40–44	(65.9)	(59.9)	(6.0)	(34.1)	45
45–49	*	*	*	*	9
Marital status					
Never married	72.8	68.0	4.9	27.2	66
Married	62.5	60.7	1.2	37.5	94
Living together	61.7	57.2	3.7	38.3	530
Divorced/ Separated/Widowed	62.2	57.8	4.5	37.8	113
Education Level					
No education	62.0	56.6	5.4	38.0	163
Primary	62.8	59.2	2.9	37.2	476
Secondary or higher	63.4	59.1	3.8	36.6	164
Province					
Cabo Delgado	43.6	39.4	4.2	56.4	193
Inhambane	71.8	50.8	20.1	28.2	179
Gaza	83.8	82.7	0.0	16.2	335

Maputo Province	33.7	32.5	1.2	66.3	96
Total	62.8	58.7	3.5	37.2	803

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

Among women who had postpartum visits, 45.0% were recommended a specific contraceptive method (Table 2-14). Similar to consultations after delivery, the pill was the most commonly recommended (31.2%) method, followed by injectables (29.6%). Of the women who had a postpartum visit, 5.1% left the visit with a contraceptive method, compared to 13.8% at baseline ($p < 0.001$) (Table 2-15). Most of these women received pills or injectables. There is clearly still opportunity to improve integration of family planning in postpartum services, as this group of women is at risk for pregnancy.

Table 2-14: Contraceptive methods recommended during postpartum visits
Percent distribution of women age 15–49 who had given birth in the last 5 years and had a postpartum visit, by whether a specific method was recommended, by method, according to background characteristics

Background characteristics	Had FP consult and was specifically recommended:					Had FP consult but no specific FP method was recommended	Not counseled on FP	Number of women who gave birth in last 5 years and had PP visit
	Any Method	LAPM	Pill	Injectables	Male condom			
Age								
15–19	31.5	3.3	14.7	13.4	3.0	12.3	56.3	98
20–24	43.8	7.2	31.4	31.7	3.2	19.8	36.1	194
25–29	43.1	11.2	38.6	33.4	5.5	18.0	36.4	173
30–34	58.2	12.3	39.9	36.8	8.7	16.7	24.7	186
35–39	42.6	8.8	23.7	31.0	6.5	19.1	38.3	98
40–44	(53.8)	(6.7)	(34.0)	(29.6)	(2.7)	(12.1)	(34.1)	45
45–49	*	*	*	*	*	*	*	9
Marital status								
Never married	48.0	11.4	35.3	29.2	7.6	24.8	27.2	66
Married	41.1	3.6	8.8	14.1	0.3	21.4	37.5	94
Living together	46.1	10.2	36.4	33.8	6.5	14.8	38.3	530
Divorced/ Separated/ Widowed	41.8	4.1	27.7	26.4	2.4	19.4	37.8	113
Education Level								
No education	45.1	6.1	31.3	31.1	5.3	16.9	38.0	163
Primary	46.4	7.1	30.9	28.4	3.3	16.0	37.2	476
Secondary or higher	39.7	16.3	32.1	32.3	11.6	21.3	36.6	164
Province								
Cabo Delgado	30.1	2.3	8.9	10.2	2.0	13.2	56.4	193
Inhambane	42.5	22.4	36.6	34.9	18.7	26.8	28.2	179
Gaza	61.8	8.3	49.1	45.5	2.7	22.0	16.2	335
Maputo Province	27.7	14.0	21.8	20.3	10.6	3.6	66.3	96
Total	45.0	8.6	31.2	29.6	5.2	17.1	37.2	803

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

Table 2-15: Contraceptive methods used following postpartum visits

Percent distribution of women age 15–49 who had given birth in the last 5 years and had a postpartum visit, by type of contraceptive they left the visit with, according to background characteristics

Background characteristics	% who left with following FP method:					Counseled but did not leave with FP method	Not counseled on FP	Number of women who gave birth in last 5 years and had PP visit
	Any Method	LAPM	Pill	Inject-ables	Male condom			
Age								
15–19	2.0	0.0	0.5	1.6	0.0	38.0	56.3	98
20–24	3.4	0.4	1.2	1.7	0.0	56.5	36.1	194
25–29	7.0	0.1	4.2	2.3	0.3	51.4	36.4	173
30–34	8.0	0.0	4.6	3.4	0.0	61.1	24.7	186
35–39	7.1	0.1	1.5	2.8	0.7	49.5	38.3	98
40–44	(0.9)	(0.9)	(0.0)	(0.0)	(0.0)	(58.7)	(34.1)	45
45–49	*	*	*	*	*	*	*	9
Marital status								
Never married	1.1	0.0	0.0	1.1	0.0	61.7	27.2	66
Married	4.9	0.1	1.7	1.6	0.0	55.4	37.5	94
Living together	6.3	0.2	3.1	2.8	0.2	49.9	38.3	530
Divorced/ Separated/ Widowed	1.2	0.0	0.8	0.3	0.0	59.1	37.8	113
Education Level								
No education	7.0	0.0	5.3	1.7	0.0	52.5	38.0	163
Primary	4.6	0.2	2.1	1.9	0.1	54.1	37.2	476
Secondary or higher	4.5	0.1	0.2	3.8	0.4	48.8	36.6	164
Province								
Cabo Delgado	4.2	0.0	3.5	0.7	0.0	37.9	56.4	193
Inhambane	10.8	1.6	3.1	6.0	0.0	46.9	28.2	179
Gaza	5.6	0.0	2.1	2.8	0.3	77.3	16.2	335
Maputo Province	1.0	0.0	0.0	1.0	0.0	13.3	66.3	96
Total	5.1	0.2	2.4	2.2	0.1	52.8	37.2	803

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

HIV/AIDS Counseling and Testing

HIV counseling and testing is an important reproductive health service. It allows women to better understand their personal risks of HIV, empower themselves with knowledge of how to prevent sexually transmitted diseases like HIV, and to get immediate care when they are infected. It also provides another opportunity for integrating family planning services. Knowledge of where to access HIV/AIDS counseling and testing services is the first step in accessing these services. Table 2-16 shows that the vast majority of women know where to access HIV/AIDS testing services. Among all women, 92.3% identified hospitals as a place to get HIV tests (compared to 84.4% at baseline) and 25.8% mentioned one or more non-hospital locations (compared to only 1.0% at baseline). Women with more education had higher rates of knowledge about availability of HIV testing services. Knowledge varied by province; a larger proportion of women in Cabo Delgado were not able to name a source for testing.

Table 2-16: Knowledge of HIV testing sites

Percent distribution of women age 15–49 who know where they can get HIV tests, by location, according to background characteristics

	% of women who know these		Number of
	Hospitals	Other locations	

Background characteristic	locations are sites to get HIV test		where to get HIV test	Women age 15–49
	Hospital	Other		
Age				
15–19	88.4	22.3	11.0	301
20–24	97.1	35.7	2.1	270
25–29	93.5	27.9	4.9	247
30–34	96.7	21.6	0.6	264
35–39	90.6	29.1	6.5	207
40–44	92.3	28.4	7.7	144
45–49	84.4	11.2	14.9	142
Marital status				
Never married	88.1	30.4	11.5	252
Married	89.5	52.1	4.4	177
Living together	93.5	18.2	6.0	891
Divorced/ Separated/ Widowed	94.9	25.6	4.0	255
Education Level				
No education	86.4	19.2	10.2	345
Primary	92.3	22.4	6.9	863
Secondary or higher	97.6	40.4	1.7	366
Province				
Cabo Delgado	84.0	30.4	12.3	365
Inhambane	91.5	17.7	8.1	428
Gaza	97.1	20.9	2.8	538
Maputo Province	97.7	33.9	2.1	244
Total	92.3	25.8	6.4	1,575

The ESD – FPI aimed to integrate HIV/AIDS counseling and testing services with already established healthcare services, such as family planning services. Thus, it is important to assess baseline-endline changes in coverage of HIV/AIDS counseling and testing services in the provinces where the project works. As Table 2-17 shows, almost three-quarters (72.2%) of women had taken an HIV test at least once in their lives and received the result, compared to 56.6% at baseline ($p < 0.001$). More than half (57.1%) of young women age 15–19 had tested for HIV compared to 40.4% at baseline, which indicates a promising increase and highlights the ongoing need for HIV/AIDS testing services within this age group that is going through sexual debut. Nearly half of women (44.1%) at endline had tested for HIV within the past 12 months, compared to only one third (34.5%) at baseline.

During HIV/AIDS testing, 67.9% of women were counseled on HIV prevention (compared to 50.4% at baseline, $p < 0.001$) and 44.0% were counseled on family planning (compared to 28.7% at baseline, $p < 0.001$), indicating the growing potential for integrating family planning in a variety of HIV/AIDS services. The ESD-FPI contributed to this by piloting the provision of FP counselling followed by method provision in HIV services such as counselling and testing, PMTCT and ARV treatment.

Table 2-17: Coverage of HIV testing

Percent distribution of women age 15–49 by timing of last test, whether they were counseled on HIV prevention and family planning, and whether they received their test results, according to background characteristics

Background characteristic	Have tested for HIV at least once and						Received results		Ever tested	Number of women
	Last test was:			During testing, was counseled on...		Yes	No			
	< 12 months	1–2 years	> 2 years	HIV prevention	Family planning					
Age										
15–19	39.3	15.1	2.7	48.3	30.5	54.1	3.0	57.1	301	
20–24	60.2	12.1	16.7	85.8	57.8	87.0	2.0	89.0	270	

25–29	50.7	21.2	14.5	77.8	53.9	83.1	3.2	86.3	247
30–34	50.1	20.1	18.9	83.9	53.3	85.4	3.7	89.0	264
35–39	33.9	11.1	25.9	65.3	42.0	69.4	1.4	70.9	207
40–44	41.3	15.5	18.0	66.0	43.4	74.1	0.7	74.8	144
45–49	16.6	7.9	26.0	42.9	21.6	49.0	1.5	50.5	142
Marital status									
Never married	36.0	8.9	6.6	46.4	29.9	51.6	0.0	51.6	252
Married	43.7	14.4	14.2	67.8	56.4	69.3	3.1	72.4	177
Living together	47.1	17.5	16.8	74.1	45.7	78.2	3.3	81.4	891
Divorced/ Separated/ Widowed	42.3	14.8	20.5	69.6	43.0	76.0	1.6	77.7	255
Education Level									
No education	32.8	12.9	17.2	59.4	35.4	60.6	2.3	62.9	345
Primary	45.9	15.7	15.4	70.8	46.7	73.7	3.2	76.9	863
Secondary or higher	50.0	16.2	13.4	68.6	45.5	79.1	0.6	79.7	366
Province									
Cabo Delgado	35.8	10.6	9.5	50.0	36.2	49.4	6.6	56.0	365
Inhambane	27.5	16.6	27.9	64.4	56.4	71.5	0.4	72.0	428
Gaza	58.9	16.7	12.5	85.9	49.1	87.6	0.5	88.1	538
Maputo Province	41.8	19.2	21.3	65.8	38.3	81.8	0.6	82.3	244
Total	44.1	15.2	15.3	67.9	44.0	72.2	2.4	74.6	1,575

Partner and Household Attitudes Regarding Family Planning

Partner approval of health services

Women’s perception of whether their partners approve of accessing reproductive healthcare services can influence their healthcare decisions. Among women who currently have a partner, 63.0% reported that they believed their partners approved of using contraceptive methods (Table 2-18), compared to 52.3% at baseline ($p=0.009$). Perceived approval varied by province; only half (51.0%) of women in Cabo Delgado said that their partners approved of contraceptive methods, compared to more than two-thirds in other provinces.

Background characteristic	Partner approves of contraceptive methods			Number of women currently in union
	Yes	No	Do not know/missing	
Age				
15–19	48.1	31.3	20.6	138
20–24	72.8	18.7	8.6	176
25–29	63.9	22.2	13.9	197
30–34	72.4	17.2	10.4	208
35–39	62.5	16.8	20.7	161
40–44	70.9	10.8	18.4	102
45–49	41.7	19.9	38.4	86
Marital status				
Married	72.6	16.3	11.1	177
Living together	60.8	21.2	18.1	891
Education Level				
No education	54.3	25.1	20.5	251
Primary	63.5	20.6	15.9	635
Secondary or higher	74.5	11.2	14.3	181

Province				
Cabo Delgado	51.0	31.6	17.4	283
Inhambane	70.1	7.4	22.5	269
Gaza	71.3	15.7	13.0	367
Maputo Province	66.2	13.8	20.0	149
Total	63.0	20.3	16.8	1,068

As Table 2-19 shows, almost all women (96.4%) who gave birth in the last 5 years and had ANC visits felt that they had their partners' approval in accessing ANC care. This percentage increased significantly from baseline value of 93.0% ($p=0.029$).

Table 2-19: Partner approval of ANC visits

Among women age 15–49 with a birth in the five years preceding the survey, the percent distribution by whether their partner approved of ANC visits, according to background characteristics

Background characteristic	Partner approves of ANC use				Number of women who gave birth in the last 5 years and had ANC visits
	Yes	No	Do not have partner	Do not know/missing	
Age					
15–19	92.5	5.6	0.3	1.7	106
20–24	97.2	0.3	2.0	0.5	204
25–29	97.4	2.0	0.0	0.7	181
30–34	97.1	0.5	1.7	0.6	190
35–39	97.1	0.4	1.1	1.3	101
40–44	(97.3)	(0.0)	(2.7)	(0.0)	48
45–49	*	*	*	*	9
Marital status					
Never married	94.7	0.0	3.3	2.0	71
Married	99.7	0.3	0.0	0.0	101
Living together	97.1	2.0	0.0	0.8	552
Divorced/ Separated/Widowed	89.6	1.7	7.7	1.1	115
Education Level					
No education	98.6	0.0	0.3	1.1	167
Primary	96.0	2.4	1.0	0.6	498
Secondary or higher	95.6	0.5	2.7	1.3	174
Province					
Cabo Delgado	95.0	3.8	1.2	0.0	207
Inhambane	94.4	2.7	1.3	1.6	185
Gaza	98.6	0.2	1.1	0.2	349
Maputo Province	94.3	0.0	1.3	4.4	98
Total	96.4	1.6	1.2	0.8	839

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed. Values based on samples of 25-49 cases are shown in parentheses.

Household head attitudes toward family planning

Household heads' acceptance of contraception as a method to avoid pregnancy can influence women's willingness to use such methods. In general, roughly four-fifths (79.3%) of household heads surveyed were accepting of contraception (Table 2-20), compared to 64.8% at baseline ($p<0.001$). A larger proportion of female household heads (82.9%) were accepting of contraception than were than male household heads (77.3%). Support for contraception increased with increasing levels of education. These findings indicate that in general, household heads have had some exposure to the concept of family planning and support it as a way to avoid pregnancy.

Table 2-20: Acceptance of family planning methods by household heads

Percent distribution of household heads who accept family planning as a method to avoid pregnancy, according to background characteristics

Background characteristic	% who accept FP method to avoid pregnancy	Number of household heads
Age		
<25	71.9	174
25–34	84.2	379
35–44	81.0	457
45–54	77.4	343
55–64	77.2	169
65+	73.6	99
Gender		
Male	77.3	1004
Female	82.9	617
Education Level		
No education	71.2	424
Primary	80.0	884
Secondary or higher	88.2	254
Other	*	18
Total	79.3	1,621

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed.

Slightly more than a third (34.3%) of household heads ever had a family planning consultation with a health provider (Table 2-21), similar to the baseline value of 34.4%. A higher percentage of female household heads ever had a consultation (39.5%) than male heads (31.6%).

Table 2-21: Family planning consultation by health provider to household heads

Percent distribution of household heads who have spoken with a health provider about family planning, by background characteristic

Background characteristic	% who have spoken about FP with health provider	Number of household heads
Age		
<25	30.4	174
25–34	39.8	379
35–44	36.0	457
45–54	32.3	343
55–64	27.8	169
65+	26.5	99
Gender		
Male	31.6	1004
Female	39.5	617
Education Level		
No education	29.5	424
Primary	36.4	884
Secondary or higher	33.7	254
Other	*	18
Total (Household Heads)	34.3	1,621

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed.

Less than one quarter (22.4%) of household heads had discussed family planning with someone in the last 6 months (Table 2-22), similar to the baseline value of 21.5%. Those who discussed family planning primarily spoke with family members (12.7%), friends (9.1%), or health professionals (4.2%).

Table 2-22: Discussion of family planning by household heads

Percent distribution of household heads who discussed family planning in the last 6 months, by discussion partner, according to background characteristics

Background characteristic	Anyone	Discussed FP in the last 6 months with:				Did not Discuss FP	Number of household heads
		Family	Health Professional	Friends	Other		
Age							
<25	15.9	8.3	3.8	7.7	0.0	84.1	174
25–29	27.1	15.8	4.8	11.8	2.2	72.9	379
30–34	22.4	14.1	3.1	7.3	2.2	77.6	457
35–39	20.8	11.2	6.1	8.2	3.1	79.2	343
40–44	23.2	12.6	2.2	11.1	3.5	76.8	169
45–49	19.9	6.4	4.7	9.7	4.3	80.1	99
Gender							
Male	19.0	10.7	3.4	7.6	2.4	81.0	1004
Female	28.7	16.4	5.8	12.0	2.3	71.3	617
Education Level							
No education	16.0	7.9	4.6	7.2	0.1	84.0	424
Primary	22.5	13.1	3.2	8.1	2.5	77.5	884
Secondary or higher	33.3	20.9	6.6	15.0	4.0	66.7	254
Other	*	*	*	*	*	*	18
Total	22.4	12.7	4.2	9.1	2.3	77.6	1,621

Note: An asterisk indicates that a value is based on a sample of less than 25 cases and has been suppressed.

Exposure to Community-Level Family Planning Interventions and Youth-Friendly Services

The ESD – FPI trained Community Health Workers (CHWs) to convey family planning information and refer people for services and to provide pill refill in selected communities. Table 2-23 shows that 14.7% of women were visited by a CHW who discussed family planning in the past 12 months, the same as the baseline value of 14.7%. It is possible that CHWs helped stimulate demand for contraception by referring women for national health weeks/mobile brigades, but women did not interpret these referrals as ‘discussing family planning.’ Women who were married or had higher levels of education were more likely to receive family planning advice from a CHW. Only 3.9% of women in Inhambane and 7.2% in Maputo received family planning advice from a CHW, as compared to 20.1% in Cabo Delgado and 17.8% in Gaza province.

Table 2-23: Exposure to family planning messages by a CHW

Percent distribution of women aged 15–49 who were visited by a CHW who told her about family planning in the last 12 months, according to background characteristics

Background characteristic	% of women 15–49	Number of Women 15–49
Age		
15–19	5.5	301
20–24	19.5	270
25–29	12.9	247
30–34	22.9	264
35–39	19.7	207

40–44	13.1	144
45–49	13.1	142
Marital status		
Never married	5.7	252
Married	29.8	177
Living together	13.7	891
Divorced/ Separated/ Widowed	15.4	255
Education Level		
No education	17.1	345
Primary	16.5	863
Secondary or higher	8.0	366
Province		
Cabo Delgado	20.1	365
Inhambane	3.9	428
Gaza	17.8	538
Maputo Province	7.2	244
Total	14.7	1,575

Community events are also a useful venue for conveying family planning messages. One-fifth (18.9%) of women reported participating in a community event in the past 12 months where family planning was discussed (Table 2-24). Participation was higher among women in their 30s and early 40s (nearly 30%), as well as women living with a partner (24%) and women with no education (24%).

Table 2-24: Exposure to family planning messages at community events
Percent distribution of women aged 15–49 who participated in a community event at which FP was discussed, according to background characteristics

Background characteristic	% of women 15–49	Number of Women 15–49
Age		
15–19	8.7	301
20–24	19.6	270
25–29	17.2	247
30–34	29.4	264
35–39	25.2	207
40–44	27.1	144
45–49	12.2	142
Marital status		
Never married	5.7	252
Married	16.3	177
Living together	23.5	891
Divorced/ Separated/ Widowed	19.3	255
Education Level		
No education	24.0	345
Primary	20.1	863
Secondary or higher	11.2	366
Province		
Cabo Delgado	20.6	365
Inhambane	8.7	428
Gaza	28.4	538
Maputo Province	4.9	244
Total	18.9	1,575

In the past 6 months, 10.8% of women reported having participated in a mobile brigade (where facility-based providers offer family planning services via outreach services in the community), as

shown in Table 2-25. Participation in mobile brigades was relatively consistent across age groups and education levels, and was noticeably higher in Cabo Delgado (19.1%).

Background characteristic	% of women 15–49	Number of Women 15–49
Age		
15–19	8.4	301
20–24	12.2	270
25–29	10.8	247
30–34	12.1	264
35–39	11.9	207
40–44	10.9	144
45–49	10.4	142
Marital status		
Never married	3.0	252
Married	13.8	177
Living together	12.5	891
Divorced/ Separated/ Widowed	10.6	255
Education Level		
No education	11.2	345
Primary	12.1	863
Secondary or higher	7.0	366
Province		
Cabo Delgado	19.1	365
Inhambane	5.7	428
Gaza	9.2	538
Maputo Province	3.2	244
Total	10.8	1,575

Considering the large population of adolescents and youth in Mozambique, there is a clear need to increase young people’s access to contraception and increase their ability to demand services that are respectful of their rights and unique needs. The ESD-FPI adolescent and youth strategy – geared towards young people 10-24 – was nested within the larger strategy of the project. The strategy aimed to strengthen high-quality integrated contraceptive and other SRH services for young people, increase demand for those services through community empowerment and mobilization, and foster linkages between the community system and the health system. At endline, young women aged 15-24 were asked about their uptake of youth-friendly services (YFS). In the last 12 months, 6.2% (n=37) of young women aged <25 went to a youth-friendly services center. This may reflect the national government’s strategy to integrate youth-tailored services into existing health facilities (which are not specifically designated as YFS), while continuing to invest in a limited number of stand-alone YFS centers (especially those that were functioning). ESD-FPI supported 1-2 standalone YFS per province to serve as a center of excellence and a reference point for young people within that province; Inhambane received the most support in this regard, which may have contributed to the higher uptake of YFS in that province (20.4%).

Contraceptive Knowledge and Use

Collectively, ESD-FPI's interventions to integrate family planning into other health services were intended to contribute to increased use of contraception among women in project areas. The following section summarizes findings related to knowledge and use of contraception among survey respondents.

Knowledge of contraception

Table 2-26 shows that 96.8% of all women interviewed at endline had heard of at least one contraceptive method (compared to 95.5% at baseline) and 96.6% knew of at least one modern method (compared to 94.0% at baseline). The most commonly known methods were pills (92.4%), male condoms (92.0%), and injectables (89.2%). Over 99% of women with secondary or higher education knew of at least one modern contraceptive method. The province with the lowest level of knowledge of contraceptive methods shifted from Inhambane at baseline (82.0%) to Cabo Delgado at endline (92.1%).

Ever use of contraception

Nearly two-thirds (66.4%) of women reported that they had ever used a contraceptive method (Table 2-27), similar to baseline (64.0%). More than half of women had ever used a modern contraceptive method (59.2%), and one fifth had ever used a traditional method (18.9%).¹³ Pills were the most common method ever used (35.9%), followed by injectables (26.2%), male condoms (25.7%) and periodic abstinence (14.4%). Women with at least secondary education had the highest rates of ever using contraception (80.8%), and women who had never married almost exclusively used modern methods (mostly male condoms). Women with no education had most commonly used the pill (29.1%), compared with baseline where periodic abstinence was the most common method ever used among this group (25.4%). Women in Cabo Delgado had the lowest rate of ever using a contraceptive method (42.5%) compared to over 60% in all other provinces. Less than half (45.8%) of 15–19 year old women had ever used a modern contraceptive method, yet the median age of first sexual intercourse among this age group was 14.6, and nearly all women reported having had sex by age 20 (see Annex C for full table on age at first sexual intercourse). This indicates the need to increase access to family planning services among young adolescents, many of whom are at risk of pregnancy.

¹³ Respondents could report more than one method that they had used in the past.

Table 2-26: Knowledge of contraceptive methods

Percentage of all respondents age 15–49 who know any contraceptive method and specific methods, by background characteristics

Background characteristic	Any Method	Any Modern Method	Modern Methods										Traditional Methods		Number of women	
			Female Sterilization	Male Sterilization	Pill	IUD*	Injectables	Implant	Male Condom	Female Condom	LAM**	Emergency Contraception	Any Traditional Method	Periodic Abstinence		Withdrawal
Age																
15–19	93.6	28.8	10.3	84.6	54.9	79.6	45.9	88.9	63.6	11.7	8.0	34.7	28.8	21.2	93.6	301
20–24	99.6	52.7	15.9	98.6	72.9	94.5	71.0	97.7	82.7	31.2	19.6	57.4	43.0	48.0	99.6	270
25–29	97.7	56.8	22.2	94.6	70.0	90.6	59.8	94.9	85.0	38.4	17.1	59.6	44.0	43.4	97.7	247
30–34	98.7	62.9	23.6	97.2	71.6	96.0	64.0	94.0	79.2	44.9	14.0	62.4	41.2	49.8	98.7	264
35–39	96.9	54.8	23.4	95.4	69.1	91.8	60.5	89.5	77.5	37.5	17.5	62.4	49.8	43.3	96.9	207
40–44	98.2	73.0	26.8	92.9	72.0	93.2	59.0	93.5	75.1	48.1	16.1	62.6	46.9	45.0	98.2	144
45–49	90.4	58.2	18.5	83.1	56.4	81.8	44.2	81.4	63.2	31.5	13.7	54.7	41.8	35.9	90.4	142
Marital Status																
Never married	93.7	36.7	16.6	89.0	65.4	84.6	56.1	91.8	77.4	13.8	12.6	39.2	31.5	30.7	93.7	252
Married	97.9	64.6	40.4	94.1	75.6	90.9	71.8	93.2	87.4	35.8	24.4	74.1	69.4	37.0	97.9	177
Living together	96.7	50.5	13.2	91.9	62.0	89.0	53.9	91.4	71.1	34.3	12.4	52.8	35.5	42.2	96.7	891
Divorced/Separated/ Widowed	98.3	62.4	22.8	96.2	74.1	93.7	62.7	93.6	76.6	41.2	16.7	57.2	44.2	41.7	98.3	255
Education Level																
No education	93.9	44.5	15.7	87.6	49.5	86.1	42.4	83.4	65.0	30.8	10.4	51.5	37.4	35.9	93.9	345
Primary	96.5	51.7	17.0	92.3	65.9	88.8	57.1	93.1	73.8	35.7	13.8	52.9	38.8	37.6	96.5	863
Secondary or higher	99.4	58.5	26.0	96.8	82.2	93.0	74.2	97.2	87.7	24.2	20.5	58.8	47.6	47.6	99.4	366
Province																
Cabo Delgado	91.7	32.8	23.6	83.0	41.4	76.6	47.7	82.4	59.2	17.8	11.3	43.5	40.8	15.6	91.7	365
Inhambane	95.6	35.7	20.4	92.0	55.5	87.9	57.2	88.4	76.2	20.9	20.6	74.1	66.8	66.9	95.6	428
Gaza	99.7	73.0	13.6	98.8	82.0	98.3	57.0	98.5	84.5	52.8	14.5	62.5	35.9	57.8	99.7	538
Maputo Province	99.7	54.7	19.2	96.2	86.0	94.1	78.2	98.5	83.4	24.0	16.2	39.5	29.4	24.0	99.7	244
Total	96.6	32.8	18.8	92.4	66.2	89.2	57.9	92.0	75.1	32.0	14.6	53.9	40.5	39.5	96.6	1,575

* Intrauterine device (IUD) **Lactational amenorrhoea method (LAM)

Table 2-27: Ever use of contraception

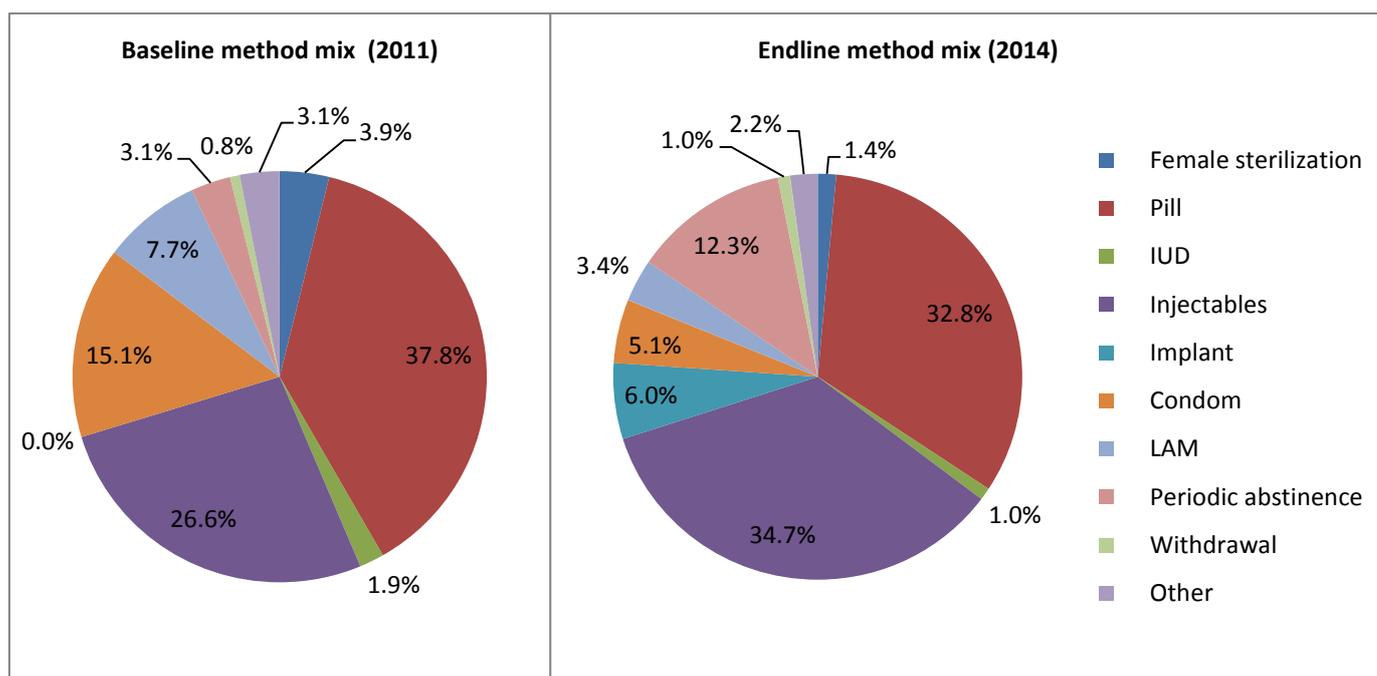
Percentage of all women 15–49 who have ever used any contraceptive method, by method, according to background characteristics

Background characteristic	Any Method	Any Modern Method	Modern Methods										Traditional Methods			Number of women		
			Female Sterilization	Male Sterilization	Pill	IUD	Injectables	Implant	Male Condom	Female Condom	LAM	Emergency Contraception	Any Traditional Method	Periodic Abstinence	Withdrawal		Other	
Age																		
15–19	50.2	45.8	0.0	0.4	16.9	0.6	10.0	1.9	31.9	3.3	2.1	0.3	9.3	7.3	3.9	1.1	301	
20–24	70.3	64.4	0.1	0.0	38.7	2.1	25.4	1.6	36.9	4.6	4.2	2.2	17.5	12.2	8.6	3.8	270	
25–29	82.8	72.9	0.1	0.6	51.0	5.5	30.2	3.4	30.4	4.3	10.9	1.6	26.8	21.4	8.6	0.4	247	
30–34	81.2	75.5	2.6	1.8	51.2	2.1	42.8	3.8	23.2	3.4	14.6	1.5	24.1	16.5	9.6	0.8	264	
35–39	65.0	52.9	2.8	0.0	37.2	3.6	24.2	2.3	17.4	3.3	4.7	0.0	23.4	21.3	3.1	0.3	207	
40–44	68.0	60.6	0.9	0.0	36.5	1.4	37.8	2.7	10.8	1.2	5.5	0.0	21.1	14.5	8.4	1.5	144	
45–49	47.4	38.1	1.4	0.0	26.0	6.6	26.0	2.8	7.1	1.0	6.1	0.0	17.3	13.4	4.8	2.3	142	
Marital status																		
Never married	56.6	55.5	0.0	0.0	17.8	2.0	11.5	3.0	41.1	5.6	2.3	1.8	11.1	7.8	7.1	2.2	252	
Married	67.9	38.2	0.5	0.0	25.2	3.7	19.8	1.4	9.6	3.2	6.6	0.7	42.0	39.4	6.2	1.8	177	
Living together	69.2	65.8	1.1	0.8	42.7	2.3	31.7	2.8	24.8	2.0	8.3	0.6	15.2	10.1	6.6	1.5	891	
Divorced/Separated/ Widowed	66.0	57.5	1.8	0.0	40.5	4.1	28.0	2.3	25.4	5.8	5.2	1.5	21.1	16.0	7.1	0.3	255	
Education Level																		
No education	54.2	45.8	1.1	1.1	29.1	1.5	22.5	0.4	8.9	2.8	7.1	0.3	19.0	15.3	4.2	1.2	345	
Primary	65.1	56.2	0.9	0.4	34.4	2.3	29.5	2.6	19.1	1.4	7.7	0.4	19.1	15.1	5.4	1.6	863	
Secondary or higher	80.8	79.0	0.9	0.0	45.8	5.0	21.2	4.5	57.3	8.5	3.6	2.9	18.3	11.8	12.2	1.2	366	
Province																		
Cabo Delgado	42.5	23.5	1.3	1.0	10.5	1.6	10.2	1.5	6.1	1.4	2.9	0.5	27.0	25.5	2.1	1.1	365	
Inhambane	61.9	56.5	0.9	1.0	28.5	3.3	27.5	2.8	23.0	7.2	2.6	1.2	23.5	20.7	11.8	2.3	428	
Gaza	81.0	79.8	0.1	0.0	54.2	2.7	35.1	1.0	27.9	1.8	12.1	0.8	14.7	7.6	8.3	1.2	538	
Maputo Province	82.4	82.4	2.0	0.0	49.3	4.2	35.3	7.4	57.5	6.6	5.4	1.9	9.6	3.8	7.5	2.1	244	
Total	66.4	59.2	0.9	0.5	35.9	2.7	26.2	2.6	25.7	3.3	6.6	0.9	18.9	14.4	6.7	1.5	1,575	

Current use of contraception

Among the 1,068 women currently in marital union (married or living with a partner), the percent who reported currently using a contraceptive method increased from 25.9% at baseline to 41.5% at endline ($p < 0.001$), and the percent using a modern contraceptive method increased from 24.1% at baseline to 35.1% at endline ($p = 0.004$) (Table 2-28). Overall, the greatest increase was seen in injectable use (from 6.9% at baseline to 14.4% at endline, $p = 0.002$). Pill use increased slightly from 9.8% at baseline to 13.6% at endline, IUD use remained relatively constant at less than 1%, and condom use decreased from 3.9% at baseline to 2.1% at endline. An encouraging finding is the 2.5% prevalence of implant use at endline, since implants were only recently introduced in Mozambique (mid-2012) and stock outs have been reported. No women reported that their partner had a vasectomy. Traditional method increased significantly among women in union from 1.8% at baseline to 6.4% at endline ($p = 0.001$), largely driven by an increase in periodic abstinence. This may include use of other fertility awareness methods like the Standard Days Method, as the survey question on periodic abstinence used the standard DHS wording of “avoiding sexual intercourse on certain days of the month that have greatest risk for pregnancy.” **Figure** shows the method mix among current contraceptive users at baseline and endline.

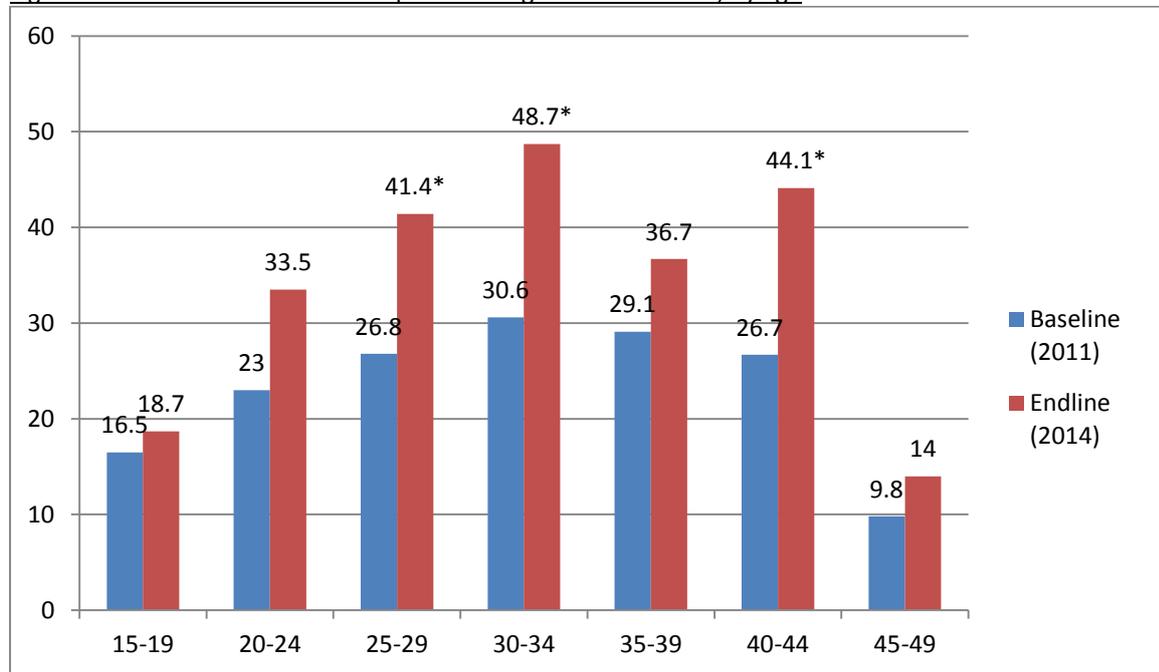
Figure 2-2: Contraceptive method mix among women in union who are current contraceptive users



Current use of modern contraceptive methods among women in union increased from baseline among all age groups, including young women (see Figure 2-3). Contraceptive use remained highest among married women in their twenties and thirties, with lower rates of use among adolescents and women in their mid-to-late 40s. With the exception of women in their late 20s (who preferred pills), all other age groups were relatively equally split between using pills and injectables. Increases in modern contraceptive use were most notable among women in union with no education (from 11.5% at baseline to 27.8% at endline, $p < 0.001$) or primary education (from 27.0% at baseline to 35.4% at endline, $p = 0.073$), indicating that the project may have helped to increase access among women who are more socioeconomically vulnerable. Approximately half of women reported using

contraception in Gaza, Inhambane and Maputo Provinces, while Cabo Delgado remained lower at 26%. When comparing each province with the baseline results, contraceptive use increased from 11.5% to 26.0% in Cabo Delgado, 27.5% to 50.3% in Inhambane, 32.2% to 51.4% in Gaza, and 47.4% to 47.8% in Maputo Province.

Figure 2-3: Use of modern contraception among women in union, by age



Significance levels denoted by * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Findings were similar among all 1,575 women interviewed: as shown in Table 2-29, 39.5% reported currently using any contraceptive method and 34.5% were using a modern method, compared to 28% and 26% at baseline, respectively. Method use varied by age group: adolescent women primarily used male condoms or pills, while women in other age groups primarily used pills or injectables. Method use also varied by province, with nearly half of women in Gaza, Inhambane and Maputo provinces using contraception compared to only one-quarter of women in Cabo Delgado.

Table 2-28: Current contraceptive use by women currently in union, by background characteristics
Percent distribution of all women currently in union age 15–49 by contraceptive method currently used, according to background characteristics

Background characteristic	Modern Method									Traditional Method				Number of women in union	
	Any Method	Any Modern Method	Fem Sterilization	Pill	IUD	Injectables	Implant	Condom	LAM	Any Traditional Method	Periodic Abstinence	Withdrawal	Other		Not using a method
Age															
15–19	21.6	18.7	0.0	4.0	0.0	11.1	1.2	2.3	0.0	3.0	3.0	0.0	0.0	78.4	138
20–24	41.7	33.5	0.0	10.6	1.2	13.1	0.7	2.7	5.3	8.2	7.5	0.0	0.7	58.3	176
25–29	52.2	41.4	0.2	22.1	0.7	11.5	3.2	3.7	0.0	10.7	8.6	2.1	0.1	47.8	197
30–34	55.2	48.7	1.5	18.3	0.2	20.9	4.0	1.0	2.9	6.4	4.3	0.4	1.8	44.8	208
35–39	43.0	36.7	1.8	16.6	0.3	14.2	2.3	1.6	0.0	6.2	4.0	0.0	2.2	57.0	161
40–44	49.5	44.1	0.4	14.8	0.4	22.9	3.9	1.7	0.0	5.5	4.8	0.0	0.6	50.5	102
45–49	15.5	14.0	1.2	4.1	0.0	5.6	2.7	0.4	0.0	1.6	0.5	0.0	1.1	84.5	86
Education Level															
No education	36.0	27.8	0.0	11.3	0.2	12.5	2.8	1.0	0.0	8.3	6.5	0.0	1.8	64.0	251
Primary	41.6	35.4	1.0	13.7	0.3	13.6	2.6	1.9	2.3	6.2	5.4	0.0	0.8	58.4	635
Secondary or higher	49.5	45.1	0.2	17.0	1.2	20.5	1.4	4.8	0.0	4.4	1.4	3.0	0.0	50.5	181
Province															
Cabo Delgado	26.0	14.0	0.6	3.0	0.0	5.3	2.6	0.0	2.4	12.1	11.2	0.0	0.9	74.0	283
Inhambane	50.3	43.6	1.2	17.0	1.3	18.9	3.0	2.0	0.2	6.7	3.0	3.1	0.7	49.7	269
Gaza	51.4	49.8	0.1	23.3	0.4	21.0	2.2	1.2	1.4	1.7	1.4	0.0	0.3	48.6	367
Maputo Province	47.8	43.7	1.6	12.4	0.8	16.5	2.5	9.9	0.0	4.1	0.9	0.5	2.7	52.2	149
Total	41.5	35.1	0.6	13.6	0.4	14.4	2.5	2.1	1.4	6.4	5.1	0.4	0.9	58.5	1,068

Table 2-29: Current contraceptive use by all women aged 15–49

Percent distribution of all women age 15–49 by contraceptive method currently used, according to background characteristics

Background characteristic	Modern Method									Traditional Method				Number of women	
	Any Method	Any Modern Method	Fem Sterilization	Pill	IUD	Injectables	Implant	Condom	LAM	Any Traditional Method	Periodic Abstinence	Withdrawal	Other		Not using a method
Age															
15–19	29.1	26.8	0.0	6.1	0.4	7.8	2.1	10.2	0.0	2.3	1.9	0.4	0.0	70.9	301
20–24	42.6	36.3	0.0	10.5	1.2	11.2	0.6	9.3	3.5	6.2	5.1	0.6	0.5	57.4	270
25–29	51.7	42.7	0.1	22.3	0.6	12.5	2.9	4.2	0.0	9.0	7.2	1.7	0.1	48.3	247
30–34	52.2	47.1	1.2	18.3	0.6	20.0	3.6	1.0	2.3	5.1	3.4	0.3	1.4	47.8	264
35–39	41.6	35.1	3.0	14.9	0.8	12.0	2.0	2.4	0.0	6.5	4.6	0.2	1.7	58.4	207
40–44	41.2	36.5	0.9	12.8	0.3	17.8	3.5	1.2	0.0	4.7	3.8	0.0	0.9	58.8	144
45–49	12.3	11.1	1.6	2.7	0.0	4.7	1.8	0.3	0.0	1.3	0.5	0.0	0.7	87.7	142
Education Level															
No education	31.1	24.6	0.1	10.0	0.4	11.0	2.3	0.8	0.0	6.4	4.9	0.0	1.5	68.9	345
Primary	39.1	33.9	0.9	13.0	0.4	13.0	2.2	2.6	1.7	5.3	4.5	0.1	0.6	60.9	863
Secondary or higher	48.4	45.3	0.9	13.4	1.3	10.9	2.6	16.1	0.1	3.1	1.1	2.0	0.0	51.6	366
Province															
Cabo Delgado	23.1	12.6	0.6	2.9	0.0	4.7	2.5	0.0	1.9	10.6	9.6	0.2	0.7	76.9	365
Inhambane	45.3	39.4	1.0	14.0	1.2	13.7	2.0	7.4	0.2	5.9	2.5	3.0	0.4	54.7	428
Gaza	50.4	49.1	0.1	21.0	1.1	18.9	2.0	5.0	1.0	1.3	1.0	0.0	0.3	49.6	538
Maputo Province	42.0	39.9	2.0	11.1	0.4	10.2	2.7	13.4	0.0	2.1	0.4	0.3	1.4	58.0	244
Total	39.5	34.5	0.7	12.5	0.6	12.1	2.3	5.3	1.0	5.0	3.8	0.5	0.6	60.5	1,575

Source of contraceptive method

As shown in Table 2-30, of the women who currently use pills, injectables, or male condoms (the most popular contraceptive methods that require acquisition of medicine or health products), the vast majority (84.1%) acquired their method from a public sector medical facility like a district hospital or a health facility (compared to 73.7% at baseline). Women sought pills and injectables almost exclusively through the public sector (90.6% and 97.4%, respectively), while male condoms were acquired through multiple sources with the public sector representing 38.2% (compared to 31.0% at baseline). This may reflect the diverse sources in which women can acquire condoms for free or for very minimal price, including in the private sector.

Table 2-30: Source of modern contraceptive methods

Percent distribution of users of modern contraceptive methods age 15–49 by most recent source of method, according to method

Source of contraceptive method	Male			Total
	Pill	Injectable	Condom	
Public Sector	90.6	97.4	38.2	84.1
Private Sector	6.8	1.3	40.0	10.4
Other source	2.1	1.3	18.9	4.7
Missing	0.6	0.0	3.0	0.8
Total	100.0	100.0	100.0	100.0

Discussion of contraception with others

Overall, 35.6% of women reported that they have talked with someone else about how to prevent pregnancy (Table 2-31). The majority talked with someone in their family (11.1%) or a friend (12.4%). Women aged 20-29 had the highest rates of talking with their spouse about family planning, compared to the other age groups.

Table 2-31: Talked with someone about FP

Percent distribution of women aged 15–49 who talked with someone about how to prevent pregnancy, according to background characteristics

Background characteristic	Talked with someone about FP information:					Number of women 15-49
	% who talked with spouse	% who talked with other family member	% who talked with friend	% who talked with health provider or other	% who did not talk with anyone about FP	
Age						
15–19	3.3	8.9	11.3	4.4	72.1	301
20–24	6.2	11.4	19.8	10.9	51.7	270
25–29	10.2	12.2	12.5	6.9	58.3	247
30–34	5.9	8.8	15.5	10.0	59.8	264
35–39	4.7	14.3	6.6	4.1	70.3	207
40–44	2.6	14.3	13.4	4.6	65.1	144
45–49	1.3	11.3	0.3	6.6	80.6	142

Marital status						
Never married	3.4	10.3	16.9	9.5	59.9	252
Married	5.5	15.5	6.4	4.1	68.5	177
Living together	6.9	10.3	12.2	7.0	63.6	891
Divorced/ Separated/ Widowed	0.4	11.1	13.3	6.6	68.7	255
Education Level						
No education	3.9	10.3	7.2	4.4	74.2	345
Primary	4.8	10.4	11.5	7.3	65.9	863
Secondary or higher	7.1	13.7	19.4	8.4	51.5	366
Province						
Cabo Delgado	3.4	10.3	1.6	0.8	83.9	365
Inhambane	15.6	8.3	9.5	7.7	58.9	428
Gaza	4.9	11.6	21.6	9.3	52.5	538
Maputo Province	0.6	13.5	15.2	12.4	58.3	244
Total	5.1	11.1	12.4	7.0	64.4	1,575

Condom use

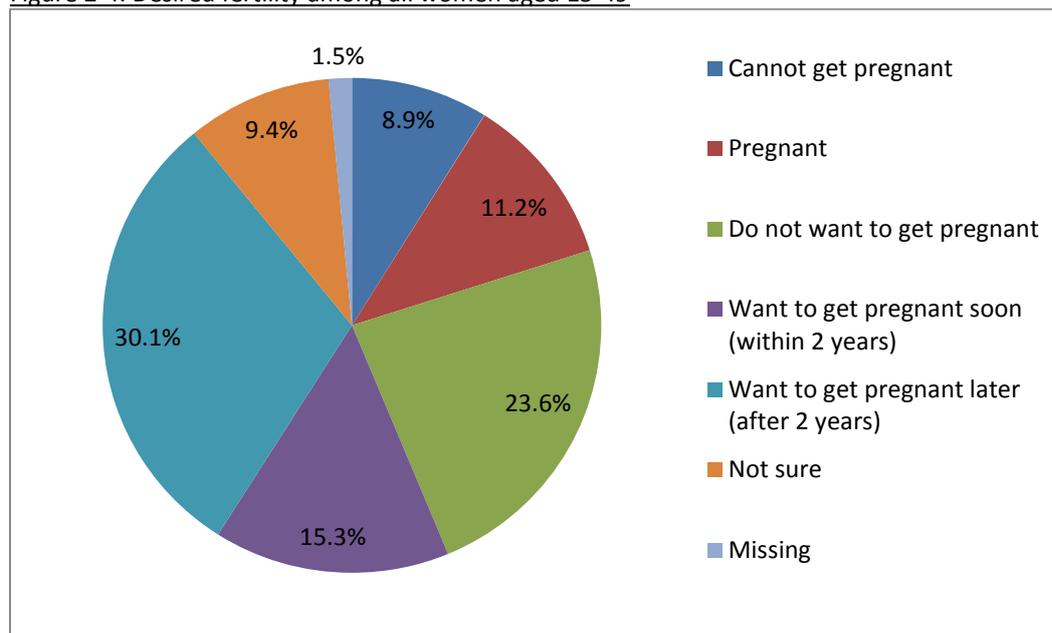
Condom use at last sex with a non-regular (non-marital, non-cohabiting) partner is an indicator of safer sexual practices as well as family planning. At baseline, of the 196 women who had sex with a non-regular partner in the past 12 months, 39.3% used a condom at last sex with that partner. At endline, of the 234 women who had sex with a non-regular in the past 12 months, 29.0% used a condom at last sex with that partner (not a statistically significant change from baseline: $p=0.154$). Condom use at last sex could not be estimated among the sub-set of women who reported multiple partners in the past year, as the sample was too small ($n=37$ at baseline, $n=45$ at endline).

Fertility Preferences and Unmet Need for Family Planning

The ESD–FPI aims to increase access to family planning services to meet the needs of women in achieving their fertility intentions. In particular, the project aims to serve women with unmet need for family planning. These are women who would like to delay a next birth for at least 2 years or do not want to have any more children, but are not currently using a contraceptive method. To determine women’s need for family planning, we asked a standard series of questions about their fertility intentions, pregnancy status, contraceptive use, and fecundity.

Nearly one quarter (23.6%) of all women interviewed did not want another child (Figure 2-4), and nearly one third (30.1%) wanted to wait at least 2 years before getting pregnant. Others wanted to get pregnant at some point in the future but were not sure when, and others were undecided about future pregnancies. These women are classified as having a need for family planning. 15.3% of women wanted to get pregnant within the next two years so they are not considered to have a need for family planning.

Figure 2-4: Desired fertility among all women aged 15-49



Unmet need for family planning was calculated for women in union, including women who were not pregnant (based on their current contraceptive use and future fertility intentions); pregnant women (based on whether they wanted their current pregnancy later or not at all); and postpartum amenorrheic women (based on whether their last birth was wanted later or not at all). Among women aged 15–49 who were currently in marital union, 24.1% had an unmet need for family planning at endline (Table 2-32) compared to 30.8% at baseline ($p=0.031$).¹⁴ Unmet need is highest among the youngest and oldest age groups. The unmet need for spacing future births (15.1%) is higher than the unmet need for limiting births (8.9%), and a greater proportion of women are using contraception to space (23.8%) than to limit (17.7%) births. This is a shift from baseline, when the unmet need for limiting (18.2%) was higher than for spacing (12.6%), and similar proportions of women were using contraception to limit (13.1%) and space (12.7%).

Overall, 63.4% of the total demand for family planning is being met in project areas (compared to 45.7% at baseline). Figure 2-5 shows the total demand for family planning (met need plus unmet need) by age group; dividing the met need by the total demand gives the percent of demand satisfied. The percent of demand satisfied for family planning is highest among women with secondary education, but is only slightly lower for women with no education or primary education. Overall, the findings indicate that demand for family planning is growing in project communities and is increasingly being met through provision of family planning services.

¹⁴ The baseline calculation of unmet need used a non-standard approach: pregnant and postpartum amenorrheic women were excluded from the calculation because the information required to assess whether their current pregnancy/last birth was wanted was not collected. Since some pregnancies and recent births may have been mistimed or unwanted, it is likely that the baseline unmet need for family planning would have been even higher if wantedness of current pregnancy/last birth had been determined and factored into the baseline unmet need calculation.

Figure 2-5: Total demand (met need plus unmet need) for family planning among women in union, by age and level of education

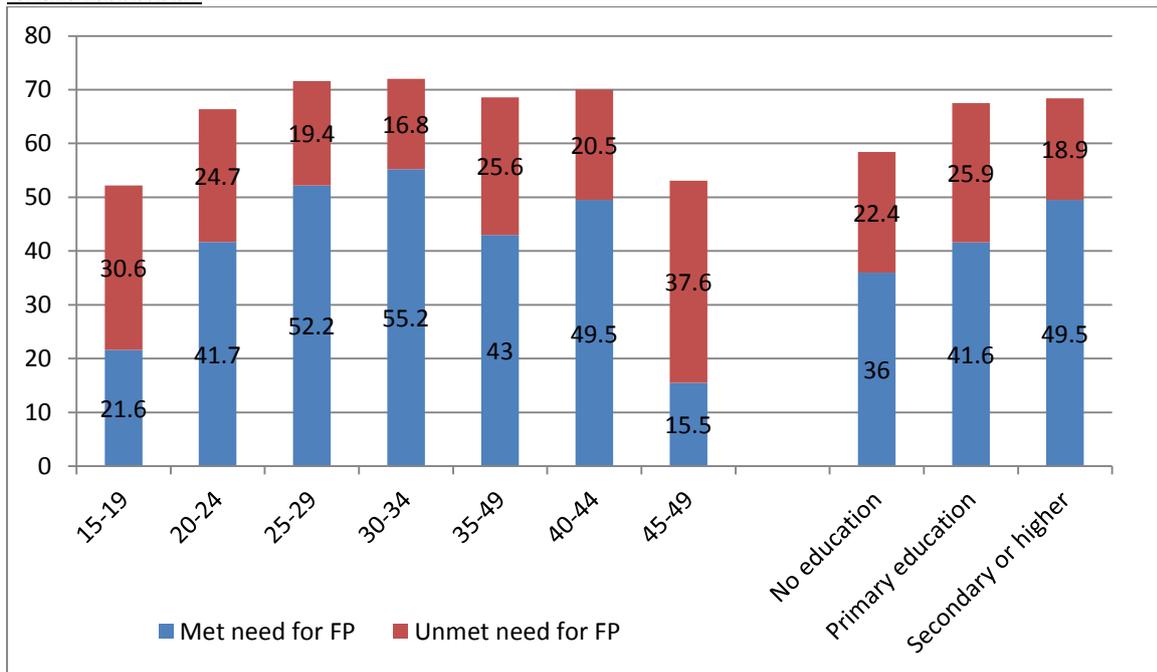


Table 2-32: Need for family planning

Percentage of women in union age 15–49 with unmet need for family planning, percentage with met need for family planning, and total demand for family planning, by background characteristic

Background characteristic	<u>Unmet need for family planning</u>			<u>Met need for family planning</u>			<u>Demand for family planning</u>			% of demand satisfied	Number of women in union
	For spacing	For limiting	Total	For spacing	For limiting	Total	For spacing	For limiting	Total		
Age											
15–19	28.5	2.2	30.6	20.6	1.0	21.6	49.1	3.2	52.3	41.3	138
20–24	24.3	0.4	24.7	39.0	2.7	41.7	63.2	3.1	66.4	62.8	176
25–29	12.5	6.9	19.4	37.2	15.0	52.2	49.8	21.8	71.6	72.9	197
30–34	9.1	7.7	16.8	25.3	29.8	55.2	34.5	37.5	72.0	76.7	208
35–39	13.1	12.5	25.6	16.8	26.1	43.0	30.0	38.7	68.6	62.7	161
40–44	7.5	13.1	20.5	3.4	46.1	49.5	10.9	59.2	70.1	70.6	102
45–49	0.0	37.6	37.6	0.0	15.5	15.5	0.0	53.1	53.1	29.2	86
Education Level											
No education	12.0	10.4	22.4	17.6	18.4	36.0	29.6	28.8	58.4	61.6	251
Primary	17.1	8.8	25.9	23.2	18.4	41.6	40.3	27.2	67.5	61.6	635
Secondary or higher	12.0	6.9	18.9	35.7	13.8	49.5	47.7	20.7	68.4	72.4	181
Province											
Cabo Delgado	20.1	6.7	26.9	19.4	6.6	26.0	39.5	13.4	52.9	49.1	283
Inhambane	10.4	9.9	20.3	17.7	32.5	50.3	28.1	42.5	70.6	71.2	269
Gaza	13.4	6.1	19.6	29.7	21.7	51.4	43.2	27.9	71.0	72.4	367
Maputo Province	10.9	21.0	31.9	24.7	23.0	47.8	35.6	44.1	79.6	60.1	149
Total	15.1	8.9	24.1	23.8	17.7	41.5	38.9	26.6	65.5	63.4	1,068

The survey asked women aged 15–49 in marital union who were not pregnant and not using contraception, if they would consider using contraception in the future and if so, what method they would prefer to use. Almost half (44.9%) of women in union not currently using contraception would consider using a method in the future (compared to 40% at baseline), with younger women more inclined to do so (Table 2-33). Among those who would use a method in the future, injectables and pills were the most commonly mentioned methods.

Table 2-33: Preferred method of contraception

Percent distribution of women in union age 15–49 who are not pregnant and not currently using a contraceptive method, by whether they would consider using contraception in the future, according to select background characteristics

Background characteristic	Women who are considering using FP in the future prefer:							Number of women	
	Any method	LAPM	Injectables	Pills	Other methods	Not considering FP	Not sure		Missing
Age									
15–19	53.3	1.6	19.8	27.8	4.2	36.4	5.7	4.6	66
20–24	77.1	2.8	23.8	42.7	7.8	10.5	5.9	6.5	67
25–29	50.8	2.4	13.5	35.0	0.0	32.1	10.3	6.8	70
30–34	55.0	4.2	33.3	16.4	1.1	26.8	8.6	9.7	67
35–39	29.5	2.0	13.6	8.6	5.3	40.7	12.2	17.7	70
40–44	(29.1)	(7.9)	(14.4)	(6.2)	(0.6)	(35.4)	(8.0)	(27.4)	48
45–49	16.3	0.0	6.2	7.0	3.1	40.3	2.8	40.7	65
Education Level									
No education	25.4	1.6	10.0	9.2	4.6	43.8	3.9	26.8	130
Primary	49.0	2.5	21.5	22.7	2.3	29.8	7.7	13.6	264
Secondary or higher	72.2	6.5	15.0	44.3	6.3	12.6	15.2	0.0	59
Province									
Cabo Delgado	29.0	3.4	15.2	7.3	3.1	44.6	4.7	21.7	161
Inhambane	37.2	0.6	19.8	12.5	4.3	27.6	5.8	29.4	122
Gaza	72.9	1.7	15.4	52.1	3.7	12.7	8.7	5.6	115
Maputo Province	51.2	4.3	28.4	15.9	2.6	29.6	16.1	3.1	55
Total	44.9	2.7	17.6	21.3	3.4	31.8	7.4	15.8	453

Note: Values based on samples of 25-49 cases are shown in parentheses.

Section 3: Conclusion

The results of the ESD-FPI baseline and endline surveys indicate that the project has helped improve integration of family planning counseling/services in ANC, delivery, postpartum and HIV counseling and testing services, highlighting the potential for integration as a means to increase use of contraception. A small proportion of women at endline reported receiving a contraceptive method within delivery or postpartum services, which represents a missed opportunity to improve immediate postpartum contraceptive uptake. These findings are consistent with the project's strategic focus on integrating family planning counseling in maternal health care, with method provision (i.e. postpartum IUD) only introduced in the last year of project implementation, targeting a limited number of providers. It is possible that early effects of method introduction may be masked by the analysis of all births in the past 5 years, since several of these births occurred before the project began doing work on postpartum method provision.

The survey findings also suggest that ESD-FPI has successfully contributed to increasing use of modern contraception and decreasing unmet need for family planning among women of reproductive age in project areas. Contraceptive increases were most notable among women in union with no education or primary education. As the ESD-FPI supported increased access to family planning services in public health facilities, the project may have contributed to increasing access among women who are more socioeconomically vulnerable. Contraceptive uptake increased among youth but remains low, indicating that further work is needed to reach young women who have just begun their sexual lives but are not being reached by existing services. The high approval of family planning among household heads at endline suggests that the project has made progress in influencing attitudes toward contraception, particularly among male household heads. The endline survey results indicated some exposure to project interventions at the community level, including contact with CHWs who discussed family planning, and participation in mobile brigades and community events (exposure to these interventions was not assessed at baseline). The results also indicate that women have talked with someone else about how to prevent pregnancy, an important step toward changing behaviors.

Because the surveys were not designed to produce provincial estimates, the provincial data included in this report are not precise estimates for each province but do allow for a relative comparison. The endline findings indicate that Cabo Delgado continues to lag behind other provinces, with the lowest rates of contraceptive use (only a quarter of women using a contraceptive method compared to nearly half of women in the other provinces) and the highest unmet need for family planning. These findings are consistent with the Mozambique 2011 DHS, in which Cabo Delgado had the lowest rate of contraceptive use. It is possible that differing demographic characteristics may have contributed to these findings: endline survey respondents from Cabo Delgado were younger, had higher rates of formal marriage (vs. living together), had lower levels of education, and were more likely to report religious affiliation (Catholic or Muslim) than respondents in the other provinces.

Annex A: Sampling Strategy

The baseline and endline household survey samples were calculated to be able to detect a baseline-endline change of 10% in key indicators (contraceptive prevalence, partner approval of RH practices, etc.), using the standard sample size calculation formula to detect the difference in two proportions:

$$n = D [(Z\alpha + Z\beta)^2 * (P1 (1 - P1) + P2 (1 - P2)) / (P2 - P1)^2]$$

We assumed alpha = 0.05, Beta = 0.8 and a design effect of 2. We assumed a refusal rate of 10%, and used 2007 census data to estimate the proportion of the population represented by women of reproductive age as well as average household size. Estimates for key indicators were taken from the 2008 MICS and other sources available at the time of the sample calculations.

The baseline and endline surveys used multi-stage stratified samples selected from the III database developed by the Instituto Nacional de Estatísticas (INE) for the Third General Census of Population and Housing which was conducted in August 2007. The sample design took into account the urban and rural strata so the samples are representative of these strata in each province, and the endline sample was designed to be comparable with the baseline sample. The sample was selected in three stages, including selection of a representative sample of Primary Sampling Units from the 2010 Master Sample of Mozambique (based on the data from the Third Census of Population and Housing in 2007), followed by selection of households and women.

- Stage 1: A random sample of enumeration areas (73 at baseline, 79 at endline) were selected in each stratum (urban/rural) using Probability Proportional to Size (PPS), in which the measure of size was the total number of households within each stratum. A sample of enumeration areas (primary sampling units) was allocated proportionally in each stratum.
- Stage 2: an exhaustive list of households was compiled in each sample enumeration area prior to selection of households. From this list of households, 22 households were randomly selected in each sample enumeration area in rural areas and 18 households were randomly sampled from households in urban areas, with equal probability of selection. The number of households selected varied by rural and urban areas due to a difference in the mean number of women of reproductive age per household (per 2007 census).

Stage 3: one woman was selected from each sampled household. After listing all members of the sampled household, if more than one eligible woman (woman aged 15–49 years) lived in the household, one 15–49 year old was selected with equal probability using a Kish Table.

Annex B: Response Rates and Household Characteristics

Table B-1 shows response rates for the ESD – FPI baseline and endline surveys. At baseline, a total of 1,586 households were selected in the sample, of which 1,519 households (95.8%) completed the survey. At endline, a total of 1,657 households were selected in the sample, of which 1,621 households completed the survey, yielding a household response rate of 97.8%. Primary reasons for non-response within selected households were because all occupants were away for long periods of time, or there were no competent individuals to respond to the survey.

Within the households selected for the survey, one woman aged 15–49 was asked to participate in the women’s questionnaire. At baseline, a total of 1,429 women were eligible, of which 1,419 (99.3%) completed the survey. At endline, a total of 1,588 women were eligible, of which 1,578 (99.4%) completed the survey and 1,575 women were included in the endline analysis (three women who completed the survey were excluded because they were outside the 15-49 age range).

	Baseline	Endline
Household interviews		
Households selected	1,586	1,657
Households completed interview	1,519	1,621
Household response rate	95.8%	97.8%
Interviews with women age 15–49		
Number of eligible women	1,429	1,588
Number of women interviewed	1,419	1,578
Eligible women response rate	99.3%	99.4%

Figure B-1 shows the reported endline distribution of the household population in 5-year age groups, by sex. A household is defined as a person or a group of persons, related or unrelated, who live together in the same house or compound, share the same housekeeping arrangements, and eat together as a unit. The population under age 20 constitutes 58.5% of the total population, reflecting the young age structure. There is a significant drop in population above this age; none of the 5-year age groups (both sexes combined) above 20 years make up more than 10% of the total population. Of the 8,335 household members, 4,561 (54.2%) are women. The household population structure was similar in the baseline survey (data not shown).

Figure B-1: Population Pyramid

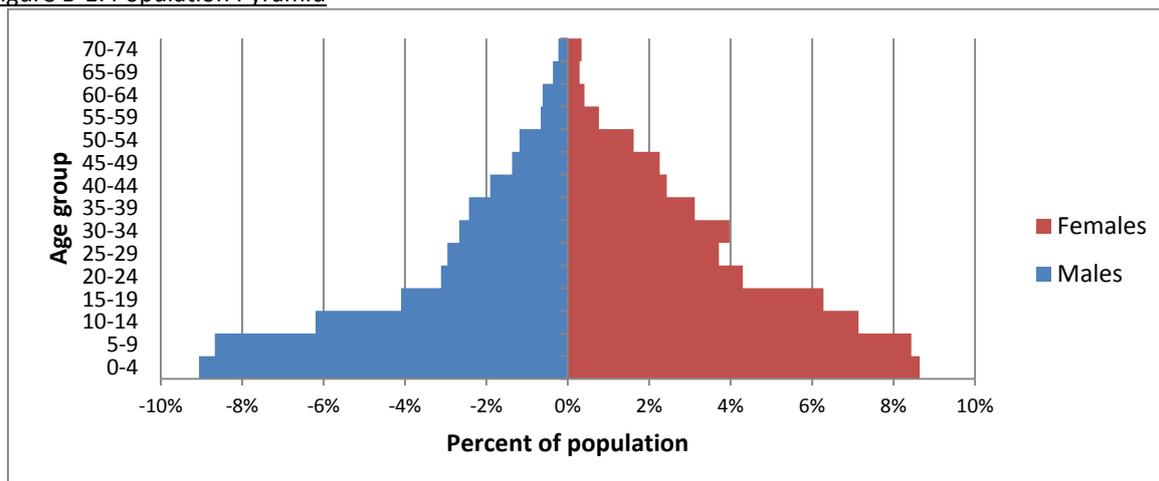


Table B-2 shows the composition of the households included in the baseline and endline surveys. The majority of households (64.9% at baseline, 65.3% at endline) were headed by males. The average household had about 5 members, but nearly 35% of households had 6 or more members.

Characteristic	Baseline % of households	Endline % of households
Household headship		
Male	64.9	65.3
Female	35.1	34.7
Total	100.0	100.0
Number of usual members		
1	4.4	2.7
2	14.1	11.4
3	14.9	17.4
4	14.8	16.0
5	16.9	15.7
6+	34.8	36.8
Total	100.0	100.0
Mean size of households	4.8 (4.6, 5.1)	5.0 (4.8, 5.2)
Number of households	1,519	1,621

Table B-3 provides information on characteristics of the houses in which the baseline and endline survey participants live. In all, the endline survey participants were slightly better off with a higher proportion of households having electricity and modern housing features (i.e. floor, roof and walls made of more refined materials such as cement). On average, 2.7 people at baseline and 2.5 people at endline sleep in a room.

Housing characteristic	Baseline % of households	Endline % of households
Electricity		
Yes	19.5	33.8
No	80.2	66.2

Floor		
Natural	60.6	49.4
Other more refined materials	39.4	50.6
Roof		
Natural	52.2	42.3
Other more refined materials	47.8	57.7
Walls		
Natural	43.4	37.3
Rudimentary	26.7	22.5
Finished	28.6	39.0
Other	1.1	1.2
Mean number of rooms for sleeping	2.0 (1.9, 2.1)	2.3 (2.2, 2.4)
Mean number of people per room for sleeping	2.7 (2.6, 2.8)	2.5 (2.3, 2.6)
Number of households	1,519	1,621

Table B-4 shows ownership of household goods, which was slightly higher among the endline sample than the baseline sample for most items. Several households (44.4% at baseline, 67.3% at endline) had access to telecommunication through mobile phones. Most households lacked means of transportation, with only 30% having access to a bicycle and less than 10% having access to other means of transportation such as animal drawn carts and motorbikes (results not shown).

<u>Table B-4: Household durable goods</u>		
Percentage of households possessing various household effects and means of transportation		
Possession	Baseline % of households	Endline % of households
Radio	42.9	52.2
Television	25.6	37.3
Mobile phone	44.4	67.3
Refrigerator	14.2	20.5
Candles/ lanterns	62.9	54.6
Clock	18.6	22.6
Bicycle	29.9	28.7
Number of households	1,519	1,621

Annex C: Age of First Sexual Intercourse

In countries like Mozambique where women are likely to experience first sexual intercourse prior to marriage, age at first sexual intercourse is an important indicator of a woman's exposure to the risk of pregnancy. In this survey, women were asked about their age at first intercourse. Roughly three percent of respondents did not report their age at first sex and were excluded from the analysis. As shown in Table C-1, 51.9% of women experienced sexual intercourse by age 15 and 88.5% by age 18. Median age at first sexual intercourse was 14.9 years. Women who had never married and women who had attended at least secondary school were more likely to have delayed sexual intercourse.

Table C-1: Age at first sexual intercourse

Percentage of women age 15–49 who had first sexual intercourse by specific exact ages, percentage who never had intercourse, and median age at first intercourse, according to background characteristics

Background characteristic	Percentage who had first sexual intercourse by exact age					Percentage who never had intercourse	Number of women age 15–49	Median age at first intercourse
	15	18	20	22	25			
Age								
15–19	61.6	N/A	N/A	N/A	N/A	15.8	298	14.6
20–24	48.3	89.1	97.8	N/A	N/A	0.4	267	15.1
25–29	48.4	86.6	95.9	98.4	99.6	0.0	246	15.1
30–34	48.1	88.5	95.4	96.2	98.5	0.0	260	15.1
35–39	53.0	87.5	96.5	97.5	99.5	0.0	200	14.9
40–44	51.1	82.0	94.0	98.5	99.3	0.0	133	14.9
45–49	50.8	83.3	96.0	97.6	97.6	0.0	126	14.9
Marital status								
Never married	45.6	89.2	98.5	98.5	100.0	19.1	251	15.3
Married	65.9	90.9	96.0	97.7	98.3	0.0	176	14.3
Living together	52.4	88.3	96.3	98.3	99.3	0.0	855	14.9
Divorced/ Separated/ Widowed	46.4	87.5	97.2	98.4	99.6	0.0	248	15.2
Education Level								
No education	61.0	89.6	97.8	99.1	100.0	0.0	318	14.5
Primary	53.6	88.8	96.2	98.0	99.0	3.2	849	14.8
Secondary or higher	39.7	86.9	96.4	98.0	99.3	5.8	362	15.6
Province								
Cabo Delgado	87.0	98.2	99.1	99.6	99.6	1.1	362	13.5
Inhambane	62.2	93.1	98.0	99.7	99.7	4.1	393	14.5
Gaza	30.9	80.4	93.3	96.5	98.6	2.4	533	16.0
Maputo Province	28.6	84.7	98.0	98.0	99.5	6.2	242	16.2
Total	51.9	88.5	96.6	98.3	99.3	3.1	1,530	14.9

Annex D: List of People Involved in the ESD—FPI Endline Survey

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