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USAID/Mozambique: Family Planning Assessment

NOVEMBER 2012

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Cover Photo by Leslie B. Curtin.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
APE	*Agente Polivalente Elementar (*Portuguese for Community Health Worker)
APS	Annual Program Statement
C-Section	Caesarian section
CDC	United States Center for Disease Control and Prevention
CDCS	Country Development Coordination Strategy, USAID
CHASS	Clinical HIV/AIDS Services Strengthening Project
CHW	Community health worker
CIDA	Canadian International Development Agency
CPR	Contraceptive prevalence rate
CSR	Corporate social responsibility
CYP	Couple years of protection
ESD-FPI	Extended Service Delivery–Family Planning Initiative
DFID	Department for International Development, United Kingdom
DHD	District Health Directorate
DHS	Demographic and Health Survey
DKT	DKT International, a social marketing company
ESD	Extending Service Delivery
FP	Family planning
FP/RH	Family planning/reproductive health
GOM	Government of Mozambique
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
IHSMP	Integrated Health Social Marketing Program
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine device
JSI	John Snow, Inc.
LAPM	Long acting and permanent methods
LAM	Lactation amenorrhea method
M&E	Monitoring and evaluation
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program

MNCH	Maternal and newborn child health
MOF	Ministry of Finance
MOH	Ministry of Health
NGO	Nongovernmental organization
OBGYN	Obstetrician/gynecologist
OC	Oral contraceptive
PEPFAR	President's Emergency Plan for AIDS Relief
PHD	Provincial Health Directorate
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission (of HIV)
PPC	Postpartum care
PPP	Public-private partnership
PSI	Population Services International
RAPID	Resources for the Awareness of Population Impacts on Development
SBCC	Social and behavior change communications
SCIP	Strengthening Communities through Integrated Programming
SCMS	Supply chain management system
SDM	Standard days method
SEED	Supply, enabling environment, demand
SWAP	Sector-wide approach to health
TB	Tuberculosis
TBA	Traditional birth attendant
TFR	Total fertility rate
TOT	Training of trainers
TWG	Technical working group
UN	United Nations
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

INTRODUCTION

Mozambique has been making major efforts to build up its health system and provide a broad array of services to its widely dispersed population. Family planning (FP) has been slow to gain traction in Mozambique, but the government is committed to improving the performance of the national program. The Government of Mozambique (GOM) affirmed the importance of FP for reducing infant and maternal mortality when it endorsed the Millennium Development Goals (MDGs) in 2000. Mozambique's First Lady has made statements in support of FP, and the Deputy Minister of Health affirmed the country's commitment to FP at the London Summit on Family Planning held in July 2012.

USAID/Mozambique believes this is an opportune time to build on current momentum. This Family Planning Assessment is intended to help inform USAID's new Country Development Coordination Strategy (CDCS); identify gaps and opportunities in Mozambique's FP program; and specify short- and longer-term priorities for future USAID support. The objectives for the FP Assessment are to (1) review the national demographic situation and trends and describe the structure and functioning of the national FP/reproductive health (FP/RH) program that USAID currently supports; (2) determine the extent to which that program is achieving the planned results; (3) outline recommendations for refocusing and strengthening the national FP/RH strategy and program and building high-level GOM commitment to it; and (4) make recommendations to guide the reshaping and strengthening of USAID/Mozambique strategy and support to the program over the next five to seven years.

ASSESSMENT METHODOLOGY

The FP Assessment team conducted qualitative interviews and informal discussions with key informants from USAID and other U.S. Government agencies and with Mozambique Ministry of Health (MOH) central, provincial, and district officials. The team also met with providers in health centers and maternity hospitals; community groups; USAID implementing partners (Pathfinder, JHPIEGO, John Snow, Inc. [JSI], and Population Services International [PSI]); and representatives from international donor agencies, including the United Nations Population Fund (UNFPA), the United Kingdom Department for International Development (DFID), the World Health Organization (WHO), the World Bank, and the Canadian International Development Agency (CIDA). The team was in Mozambique from September 8 through October 3, 2012. USAID and its partners organized site visits in the provinces of Nampula, Maputo, and Gaza. The FP Assessment team organized technical issues conceptually in terms of enabling environment, supply issues, and demand generation as constituent components of a health service delivery system.

MAIN CONCLUSIONS OF THE ASSESSMENT

Demographic Levels and Trends and FP Program Performance

Mozambique has one of the highest fertility rates in sub-Saharan Africa; unlike some neighboring countries, it has not seen fertility decline. According to the Mozambique Demographic and Health Survey (DHS), the total fertility rate (TFR: the average number of children a woman will

have by the end of her reproductive years) has in fact risen slightly, from 5.5 births per woman in 2003 to 5.9 by 2011. The high fertility can be partly attributed to low ages at marriage, sexual debut, and first birth. It also reflects traditional cultural sensibilities that value large families and many children. The ideal number of children reported by married women in the 2003 DHS was 5.7, while married men reported that 7.1 children were ideal.

Mozambique's slight fertility rise from 5.5 in 2003 to 5.9 in 2011 could be partly attributable to declines in FP. The contraceptive prevalence rate (CPR: the percentage of married women using contraception) fell from 16.5% in 2003 to 11.6% in 2011, mainly because of declines in the use of traditional methods. In 2011, only 22.3% of married women who were not currently using an FP method said they had an unmet need for spacing or limiting methods of contraception. However, total unmet need rose slightly between 2003 and 2011, suggesting that slightly more women may be acquiring greater interest in using an FP method.

Enabling Environment

The commitments and recommendations the GOM made at the July 2012 London FP Summit offer a good opportunity to build momentum for more visible, multisectoral leadership for FP at the central and provincial levels of Mozambique's health system. The government does have a *Family Planning and Contraception Strategy 2010–2015 (2020),* but currently FP visibility within the MOH is limited to the Maternal and Child Health (MCH) Department; as yet there are no technical links and coordination with other MOH directorates.

The Operational Plan outlined in the FP and Contraception Strategy is a good beginning, but the plan also needs a clear plan of action, a budget review, and assistance to implement and monitor program priorities at the national, provincial, and district levels. Among the operational gaps are a lack of innovative and segmented approaches for reaching priority subpopulations such as youth, people living with HIV/AIDS (PLWHA), and men as supportive partners and agents of change. More effective convergence with other health and development activities (e.g., with the Ministry of Youth and Sports) would help expedite FP implementation.

Supply of Family Planning Services

One of the main objectives of the Strategy is to improve access to and availability of services by increasing the use of health facilities for MCH services, including FP. However, there are as yet not enough well-equipped, fully-staffed health facilities to meet the demand that is being created for facility-based care. There is a serious shortage of MCH nurses in district and subdistrict health facilities. Human resources limitations will inhibit the expansion of the FP program and its ability to achieve higher CPRs.

The current method mix, which is dominated by pills and injectables, may not be meeting the needs of clients who wish to extend birth intervals. The reported increase in the use of intra-uterine devices (IUDs) as part of postpartum care (PPC) is encouraging, but if this method is to be scaled up, MCH nurses will require refresher training in IUD insertion and removal, and special attention to improve counseling about the IUD will be needed.

Implants are reportedly in high demand among women who are aware that they are available. Donors have made commodity commitments for 2013 and the MOH is planning to introduce the method more widely in health centers. However, the MOH would be well advised not to move too quickly—it will be essential to put into place effective training plans (particularly at the

provincial and district levels), and to ensure that guidelines and protocols are in place for counseling, insertion, follow-up, and removal.

The MOH, USAID, and other donors are supporting a variety of approaches to extend the reach of FP information and services into underserved rural communities where access problems are particularly acute. Continued support for community health workers (CHWs) will be necessary to improve FP knowledge and attitudes and to extend provision of pills and injectables in these widely dispersed areas.

One of the most significant imperatives is to strengthen the system for delivering contraceptive commodities to the districts. Also, linking consumption data from subdistrict facilities up the reporting chain to national officials and the country's three central warehouses is needed to improve the reliability of commodity logistics reporting and efficient provision of FP commodities.

Very few FP commodities are supplied through the private sector. Condoms to slow the transmission of HIV constitute the main social marketing activity in Mozambique. Pharmacies still rarely carry a full range of contraceptives. Ensuring that FP methods such as pills, Depo-Provera, and implants can be procured through commercial outlets would give beneficiaries more choice about where to obtain contraceptives. Workplace settings, especially in Mozambique's rapidly expanding mining sector, may also offer attractive new opportunities for social marketing.

Demand Generation

Mozambique does not yet have a strong program of social behavior change communication/information, education, communication (SBCC/IEC) for promoting FP and RH. There is little advertising or broadcast media attention given to reducing family size norms or to the benefits of FP for reducing maternal and infant mortality. Although the MOH has identified youth, men, and PLWHA as target populations, IEC and demand-generation activities are not tailoring messages or activities to these groups.

The social and cultural contexts in which FP and other RH services are situated in Mozambique need to be considered in formulating new SBCC/IEC strategies. Pregnant unmarried young women lacking access to health services and options in life are most vulnerable and need care and support. Women's reproductive rights emphasizing the promotion of more autonomy for them in choosing the number and spacing of their children seem to be neglected in current SBCC/IEC work.

The strategy for generating demand for FP at the community level in the USAID Strengthening Communities through Integrated Programming (SCIP) and Extended Service Delivery (ESD) projects depends on volunteer community health workers who receive no compensation. This model may prove difficult to sustain without providing some form of incentives for them.

RECOMMENDATIONS TO STRENGTHEN USAID PROGRAMMING IN SUPPORT OF THE NATIONAL FAMILY PLANNING AND CONTRACEPTION STRATEGY

Short-term Recommendations (2 Years or Less)

1. MOH and other political leadership must guarantee effective oversight, regulation, and accountability for implementation of the *Family Planning and Contraception Strategy 2010–*

2015, including systems to monitor and evaluate progress. USAID and other donors should help the GOM to mobilize leaders within the MOH and other ministries to build management support structures and systems, as recommended at the FP London Summit.

2. The roles of the FP and the Contraceptives Technical Working Groups (TWGs) in building up FP governance efforts need greater clarity. The FP TWG should be encouraged to add members from local civil society organizations and representatives from other ministries with related technical priorities, such as Women and Social Action, Youth and Sports, and the Population Directorate.

3. USAID should support the FP TWG in drawing up a plan of action for operationalizing the *FP and Contraception Strategy 2010–2015 (2020)* at the provincial level, which would offer considerable opportunity to explore multisectoral planning and budgeting opportunities.

4. Within the United States Government (USG), identify opportunities to highlight FP priorities with other health programs, including the Prevention of Mother to Child HIV Transmission Acceleration Plan, and the gender programming of the President's Emergency Plan for AIDS Relief (PEPFAR). Internal communication and coordination mechanisms should be organized to ensure that FP progress is monitored across the USG portfolio and FP technical expertise is offered. Consideration should be given to incorporating FP into broader USG assistance to build provincial and district planning and budgeting capacities.

5. Central to the *Strategy* is the introduction of more long-acting and permanent methods (LAPMs), which must be delivered by skilled personnel in hospitals and health centers. To significantly expand the FP program the MOH will have to increase the number of MCH nurses and make the requisite investments in pre-service and in-service training. As part of the workforce planning efforts underway for the five-year Health Sector Strategic Plan, USAID should help the MOH to plan for the projected demand for MCH nurses, particularly at local and district health facilities.

6. To make contraceptives more readily available in local communities, USAID projects (ESD and SCIP) should help the MOH to build up referral systems and increase the frequency and reach of mobile brigades, since many women cannot get to a health facility regularly.

7. The MOH should be commended for its efforts to increase community participation in the FP program, and particularly for increasing the number of *Agente Polivanente Elementar* (APE) community health workers. USAID should help the MOH to modify FP norms and guidelines for allowing APEs to provide an initial offering of pills and injectables.

8. To improve the method mix, particularly IUD utilization, USAID should provide assistance to the MOH for IUD refresher training for MCH nurses. MOH and USAID should consider expanding the Maternal and Child Health Integrated Program (MCHIP) postpartum IUD insertion program to additional model maternity wards. The SCIP project should communicate and disseminate the results of its IUD study in Nampula and scale up the program in districts that demonstrate interest and readiness. ESD should select several districts in Gaza and Maputo where the SCIP IUD model could be replicated. Rumors, myths, and misinformation continue to affect knowledge and attitudes toward the IUD. USAID projects (ESD and SCIP) should review the curricula for training project-supported community volunteers to ensure that IUD information is accurate and current.

9. Implants are reportedly in high demand among women who are aware that they are available. USAID should help the MOH to cautiously scale up the implant program over the

next two years. USAID projects should provide technical assistance to the MOH to draft training norms and guidelines for implant insertion, removal, and follow-up.

10. USAID projects should inventory contraceptive supplies in district warehouses and ensure that buffer stocks are available. In each warehouse a buffer stock of three months is recommended for oral contraceptives (OCs) and injectables and two months for IUDs. In addition, quantities and budget levels for contraceptive commodities should be estimated to ensure that buffer stocks are available. Monthly logistics data should include the important indicators of "stock on hand" and "consumption."

11. Several changes could be made to USAID's integrated social marketing program to strengthen the role of the private sector in delivering contraceptives. Preliminary recommendations from this assessment are to (a) include OCs and implants in the social marketing program; (b) increase the number of private clinics that can provide OCs, injectables, and implants by providing financial support to DKT International; and (c) increase the utilization of private clinics and enhance their impact on the use of OCs, injectables, and implants by having community volunteers provide outreach within communities and, where feasible, make referrals to private clinics.

Long-term Recommendations (More than 2 Years)

1. Help the MOH to operationalize the FP/RH communication strategy to build up the enabling environment for FP and stimulate demand for services. Assistance to the MOH should center on plans to segment and address communications messages and channels to the key populations of youth, PLWHA, and men. To accomplish this, the roles and responsibilities of the GOM and various partners should be clearly articulated.

2. Financing systems must raise adequate funds for health to ensure that services are affordable, especially to those in the lowest socioeconomic strata. They must also raise adequate funds to ensure that the GOM is successful in increasing cost-sharing from its national budget for procuring contraceptives from current allocations of 5% of the total cost to 10% by 2015 and 15% by 2020.

3. To help ensure that IUD and implant providers are available and sustainably skilled, USAID should support the MOH in conducting a financial and technical needs assessment of pre-service and in-service MCH nurse training institutions in provinces that will receive USAID assistance. USAID should consider developing a performance-based budgeting grant mechanism to improve training for the MCH provincial cadre.

4. As part of an expanded private sector strategy, USAID should assess opportunities for delivering FP services in Mozambique's rapidly expanding resource extraction industries. Expansion of FP in industrial workplace settings may offer attractive new opportunities.

5. The SCIP and ESD projects depend heavily on volunteer community workers to mobilize local communities and generate demand for FP services. However, the volunteers receive no compensation. It is unclear whether they will be motivated to continue to do their jobs well or to do them at all without some form of compensation. USAID and representatives from the SCIP and ESD projects need to consider options for providing subsidies to community volunteers (as PEPFAR is doing). Also the capacity of volunteer CHWs to organize into associations needs to be encouraged so that they can submit proposals and possibly receive local funding from the 7 million *meticaish* fund.

6. Demand for FP services should also be generated by addressing social and cultural norms that inhibit FP use. Priorities for attention would be to

- Delay the age of marriage
- Delay the age of sexual debut and first birth
- Encourage female educational attainment
- Create more employment and career opportunities for women

7. Additional efforts are needed to strengthen the reproductive rights of women so that they have more autonomy in terms of engaging in sexual activity and initiating child-bearing. A rights-based approach to generating FP demand should emphasize women's ability to employ contraception before and within marriage, determine the timing and number of their offspring, and be able to access high-quality obstetric services and emergency contraception in cases of sexual abuse and rape.

I. INTRODUCTION

In recent decades Mozambique has been making major efforts to build up its health system and provide an array of services to its widely dispersed population. The country has made advances in developing the health system infrastructure; training new doctors, maternal and child health (MCH) nurses, and other health staff; and improving the flow of essential drugs and equipment to a far-flung network of provincial, district, and subdistrict health facilities. Yet Mozambique still suffers from very high infant, child, and maternal mortality; one of the highest HIV infection rates in the world; a high incidence of malaria, especially among children; and poor water, sanitation, and waste disposal infrastructure. The country also has one of the highest fertility rates and the lowest rates of family planning (FP) use in sub-Saharan Africa.

Mozambique has begun to give more attention to FP and reproductive health (RH) services in order to reduce morbidity and mortality among pregnant women. Priority is being given to younger women, since 20% of all births in 2005–10 were to women younger than 20.[1] The Mozambique FP program has been slow to gain traction, but the Government of Mozambique (GOM) is committed to doing better. It affirmed the importance of FP in reducing infant and maternal mortality when it endorsed the Millennium Development Goals in the 2000 Millennium Summit.[2] More recently, Mozambique's First Lady has made statements in support of FP, and the Deputy Minister of Health attended the Summit on Family Planning in London in July 2012.

OBJECTIVES OF THE ASSESSMENT

USAID/Mozambique believes this is an opportune time to build on the country's current momentum by conducting an FP assessment. This report explores why FP has been slow to gain traction in Mozambique and what steps might be taken to accelerate progress in reducing unintended pregnancies and the infant and maternal mortality resulting from high-risk first births among very young women; births that are spaced too closely together; and high-parity births to older women. The assessment is intended to help inform USAID's new Country Development Coordination Strategy (CDCS), identify gaps and opportunities in Mozambique's FP program, and specify short- and longer-term priorities for future USAID support.

The objectives of the assessment as stated in the scope of work (Annex A) are to

1. Review the national demographic situation and trends and describe the current structure and functioning of the national FP/RH program that USAID currently supports.
2. Determine the extent to which USAID's FP/RH support program is achieving the expected results.

[1] United Nations Population Division. 2012. *Mozambique Population Data – Online*. New York: UNPD/DESA, September, 2012, http://esa.un.org/unpd/wpp/unpp/panel_population.htm.

[2] Ministry of Health, Government of Mozambique. 2012. *Family Planning and Contraception Strategy, 2010–2015 (2020)*. Maputo, Mozambique, MOH National Directorate of Public Health, August 2010, p. 7.

3. Outline recommendations for refocusing and strengthening the national FP/RH strategy and program and building high level GOM commitment to it.
4. Make recommendations for reshaping and strengthening the USAID/Mozambique strategy and its support to the program over the next five to seven years.

ASSESSMENT METHODOLOGY

The assessment team used a range of methods and approaches to collect and analyze information relevant to the assessment objectives. This consolidated information served as the basis for formulating findings and recommendations. The team reviewed numerous background documents, including USAID strategies and project reports; the Preliminary Results Summary from the 2011 Mozambique Demographic and Health Survey; the GOM *Family Planning and Contraception Strategy 2010–2015 (2020)*; its *Preventing Mother to Child HIV Transmission Acceleration Plan FY 2012;* and numerous other documents (see Annex B for a bibliography).

During the site visit to Mozambique September 8–October 3, 2012,[3] the team conducted qualitative interviews and informal discussions with key informants, among them USAID officials; representatives of the U.S. Centers for Disease Control and Prevention (CDC) and the President's Emergency Plan for AIDS Relief (PEPFAR); central, provincial, and district Ministry of Health (MOH) officials; providers in health centers and maternity hospitals; and community groups. The team also met with USAID implementing partners Pathfinder, JHPIEGO, John Snow, Inc. (JSI), and Population Services International (PSI); and with representatives of international donors the United Nations Population Fund (UNFPA), the United Kingdom Department for International Development (DFID), the World Health Organization (WHO), the World Bank, and the Canadian International Development Agency (CIDA). (See Annex C for the interview guides and Annex D for a list of those interviewed and sites visited.)

USAID and partners organized site visits to officials and facilities in the provinces of Nampula, Maputo, and Gaza. These areas were selected because they are the sites of different types of program activities and facilities, serve different segments of the population, and represent different geographic areas of Mozambique.

The scope of work set out a broad range of technical issues that the assessment should address. The assessment team organized technical issues conceptually around three main themes: the enabling environment, supply issues, and demand generation (see Table I).

[3] One team member was in Mozambique for the two weeks of September 8–21, the other for the two weeks of September 16– October 3.

Table 1. Technical Issues Mapped	
Major Themes of Assessment Report	**Technical Issues**
Enabling environment	• National strategies • National policy • Governance • Advocacy • Finance • Donor support
Supply of family planning	• Family planning service delivery system • Human resources • Method mix • Integration of family planning with other health services • Contraceptive procurement and logistics • Role of the private sector
Demand generation	• Community mobilization • Behavior change communications • Social and cultural determinants of FP use

II. DEMOGRAPHIC LEVELS AND TRENDS AND FP PROGRAM PERFORMANCE

According to the United Nations Population Division, as of mid-2012 Mozambique's population was 24.4 million. Between 2010 and 2015, its annual population growth rate is 2.24%; continuation at that rate would double the population in 30.9 years, placing far heavier demands on educational facilities, food supplies, employment generation, housing, and transportation infrastructure.

Mozambique is almost unique in showing no evidence of fertility decline for the past 10–15 years, during which several neighboring countries experienced modest downward trends. According to the Mozambique Demographic and Health Survey (DHS), the total fertility rate (TFR: the average number of children a woman will have by the end of her reproductive years) appears to have even risen slightly, from 5.5 births per woman in 2003 to 5.9 in 2011[4] (see Annex E, Figure E.7). Fertility in urban centers was essentially unchanged between 2003 and 2011, moving from 4.4 births per woman in 2003 to 4.5 in 2011, but rural fertility rates rose from 6.1 births per woman in 2003 to 6.6 in 2011.[5]

One element in Mozambique's fertility is the low average age at first marriage. According to the 2003 DHS, the median age at first marriage for women aged 25–49 was 17.5 and the age at first sexual intercourse among women was 16.1.[6] Many couples in Mozambique have multiple partners, which may also be increasing the number of births. Mozambique's fertility also reflects traditional cultural sensibilities that value large families and many children. In the 2003 DHS the ideal number of children reported by married women was 5.7 and by married men was 7.1.

Mozambique's slight fertility rise from 5.5 in 2003 to 5.9 in 2011 could also be partly attributable to a decline in FP use. The contraceptive prevalence rate (CPR: the percent of currently married women using contraception) fell from 16.5% in 2003 to 11.6% in 2011 (see Figure E-9, Annex E). Much of the decline resulted from reductions in the use of traditional methods, since modern method use was essentially unchanged, falling only slightly from 11.7% to 11.3%. Sexually active unmarried women reported far higher levels of use (30.3%).

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[4] The United Nations Population Division is reporting a TFR of 5.1 for the period from 2005 to 2010. This considerable discordance with the 2011 DHS deserves further investigation. The disagreement is not insubstantial—a TFR of 5.9, if valid, would suggest that Mozambique's population is growing faster than the 2.24 annual rate reported by the UN. Unfortunately, DHS birth history diagnostic tables will only become available with the release of the final country report for the 2011 DHS. The team was therefore not able to pursue this matter further at the time of preparing this report.

[5] Given the size and sampling design for the 2003 DHS, there is a 95% certainty that the 2003 TFR ranged between 5.3 and 5.7 live births (the 2003 confidence interval is + or – 0.204 births). Since the 2011 DHS sample was similar to that of the 2003 survey, the TFR confidence intervals for the 2011 DHS likely range between 5.7 and 6.1 live births. The mid-points for these TFR confidence intervals indicate that there was likely an increase of 0.4 births per woman between 2003 and 2011, with much of the gain occurring in rural areas. Further analysis of the birth histories for the 2003 and 2011 surveys (e.g., contrasting possible patterns of omission and temporal displacement) could provide insight into the validity of TFR trends in the two surveys. This information will become available with the release of the final country report for the 2011 DHS.

[6] 2011 DHS data for age at first intercourse is not yet available so the data from 2003 DHS are presented.

According to the 2011 DHS, the most popular methods reported (Figure E-12, Annex E) were injectables (5.1%) and pills (4.5%). Most women who are not currently using contraceptives but want to adopt a method in the future say they intend to use pills or injectables. Only 1.1% of married women reported the use of condoms, a low figure given Mozambique's 2009 HIV prevalence rate of 11.5% (9.2% for men and 13.1% for women).[7] Less than 1% of married women use IUDs, implants, the lactation amenorrhea method (LAM), or tubal ligation.

The demand for FP services in Mozambique seems low given the levels of contraceptive use reported in the 2011 DHS. Only 22.3% of married women who were not currently using contraceptives said they had an unmet need for spacing or limiting methods. More women said they wanted to use contraception to delay the timing of their next birth (13.8%) than those (8.4%) who expressed an interest in methods that would permanently protect against unwanted pregnancies (see Figure E-6, Annex E). However, it is notable that total unmet need rose from 18.4% in 2003 to 22.3% in 2011. This suggests that slightly more women may be becoming interested in using an FP method.

[7] HIV prevalence rates are reported in Instituto Nacional de Estatistica and Demographic and Health Surveys, Macro International, Inc. *National Survey on Prevalence, Behavioral Risks, and Information about HIV and AIDS: Key Findings*, Maputo, Mozambique, and Calverton, Maryland: Ministry of Health and Macro International, September 2009.

III. NATIONAL HEALTH SYSTEM STRUCTURE AND FAMILY PLANNING

The National Health System, which is heavily dominated by the public sector, is the major service provider in Mozambique. Results from the 2011 DHS show that the public sector supplies 76.5% of all contraceptives: 54.1% from health centers, 8% from public pharmacies, and 7.1% from rural hospitals.

The MOH at the central level has responsibility for creating and applying health care policy. It retains control over the distribution of resources to provinces; formulates standards; defines targets and objectives; and provides medicines and contraceptives to provincial and district warehouses. Responsibility for the national FP program is assigned to the National Health Directorate Office for Maternal and Child Health, where a single officer is responsible for FP.

In each province there is a Provincial Health Directorate (PHD) organized like the central MOH. PHDs have considerable autonomy within the province in such areas as distributing resources, managing personnel, and monitoring activities. Within the PHD, FP is again assigned to the MCH Office, which is one of seven offices within the Provincial Health Inspector Office. There is also one provincial FP officer.

District Health Directorates (DHDs) and City Health Directorates are in charge of health services provided at the district and community levels. The DHD manages recurrent expenditures and salaries, maintenance operations, small investment projects, and planning and budgeting. Each DHD serves an average of 100,000 inhabitants, but the range is from 10,000 to 400,000. The City Health Directorate, the lowest level of the national system, has the most direct role in providing primary health care.

Most FP services are provided at lower levels of the health system. Health *posts* provide the most basic primary preventive and curative care, and may be staffed with one MCH nurse or a clinical officer. Health *centers* provide a more comprehensive range of MCH services, including antenatal care (ANC), labor and delivery services, postpartum care (PPC); FP counseling and services; HIV/AIDS prevention and treatment; tuberculosis and malaria treatment; healthy child and child-at-risk consultations; immunizations; and treatment for injuries and diseases. MOH policy calls for two MCH nurses to be assigned to each health center. The larger centers also have at least one medical technician and a medical doctor who is a general practitioner.

District general hospitals and rural hospitals provide obstetric and surgical services. Provincial hospitals offer more diagnostic and curative services and have training centers for provincial health care staff. The highest level of care is provided in the three referral hospitals, in Maputo, Beira, and Nampula.

The FP program has the following components: training of MCH nurses to provide FP services; counseling and information on FP for women, men, and youth; FP information and counseling during ANC visits; and counseling on FP postpartum, with contraceptives provided if requested. Services include provision of modern contraceptives: male and female condoms, oral contraceptives (OCs), injectables, and IUDs. Postabortion care is also provided. Implants became available in some public maternity facilities in 2012, but they are not common. Tubal ligation, though rare, is performed occasionally in general, rural, and provincial hospitals.

The GOM is now building a cadre of community health workers (CHW), known in Portuguese as the *Agente Polivalente Elementar (APE).* A major responsibility of these CHWs is to mobilize communities to attend mobile brigades. They are also supposed to provide information on malaria prevention and treatment, do rapid diagnosis for malaria, and treat severe cases with artesimin suppositories (although stock-outs are not uncommon).

IV. USAID/MOZAMBIQUE ASSISTANCE TO THE HEALTH PROGRAM

The United States Government (USG) has a wide-ranging program of support for improving the health status of the people of Mozambique. The USG health portfolio is targeted to prevention of HIV infection and treatment of HIV-positive clients; prevention and treatment of malaria and tuberculosis; FP and RH; maternal, neonatal, and child health (MNCH); and safe water, improved sanitation, and better personal hygiene.[8]

USAID/Mozambique's support for the country's FP program aims to provide all women of reproductive age with a full range of contraceptive methods. In addition to short-term reversible methods, such as OCs, injectables, and condoms, attention is given to increasing the availability and use of long-acting and permanent methods (LAPMs), such as IUDs and implants. At present, USAID provides no support for vasectomies and tubal ligations.

The Ministry of Health and USAID/Mozambique are working together to improve FP use through a strategy that integrates FP with other primary health care entry points, such as HIV, ANC, cervical cancer screening, PPC, post-abortion care, and child immunizations. These efforts are supported by the strengthening of FP services at health facilities; building capacity for providing services in local communities through mobile brigades and CHWs, paid and voluntary; and providing better FP information and counseling in local communities. Other U.S. government agencies and donors have also developed ambitious community mobilization programs that rely on community members to increase civil society participation in the national FP program.

USAID/Mozambique currently provides population (POP) funding for the following projects designed to expand the availability, quality, and use of FP services:

- *Maternal and Child Health Integrated Program (MCHIP)*, implemented by JHPIEGO and Save the Children (April 2011 to March 2015). The MCCHIP objective is to increase the use of MNCH interventions to minimize deaths among mothers, newborns, and children under 5.
- *Strengthening Community through Integrated Program (SCIP),* implemented by Pathfinder International in Nampula Province and World Vision in Zambezia Province (SCIP Nampula: August 2009–July 2014; SCIP Zambezia: July 2009–June 2014). The objectives of SCIP are to increase district, subdistrict, and community accessibility and use of health services (including FP) and tighten linkages between health providers and other community-based development activities (e.g., water and sanitation for health, environmental health infrastructure development, and community social mobilization).
- *Extending Service Delivery (ESD),* implemented by Pathfinder International in Gaza and Maputo Provinces (2010–2014). The objectives are to promote greater FP use by integrating FP into primary care and HIV services; enhance knowledge and use of FP and other RH services for

[8] In 2012, by far the majority of funds were from PEPFAR; Population funds constituted about $12 million out of $350 million (3%).

students, faculty, and staff in pre-service institutions; increase community knowledge and access to FP services; and strengthen youth-friendly FP counseling and care.

- *DELIVER (Task Order 1 and 5) and DELIVER II (Task Order 4),* implemented by JSI (DELIVER: 2004– 2014; DELIVER II, Sept. 2010–Sept. 2014). The objective of both programs is to help Mozambique to build up its logistics system for procuring and distributing essential drugs and equipment (including contraceptives) from the central down to the subdistrict levels of the health system.

- *Integrated Health Social Marketing Program (IHSMP) for Mozambique,* implemented by PSI (Sept. 2011–Sept. 2014). The objective is to build the capacity of local private and civil society organizations to procure, distribute, and advertise essential health commodities. The project focused on condom distribution during its first year but plans to expand into the social marketing of OCs and other contraceptive methods during the rest of the project life.

- *Clinical HIV/AIDS Services Strengthening Project (CHASS),* implemented by Family Health International and Abt Associates, Inc. (2010–2015). The project goal is to build up the health systems in Sofala, Manica, Tete, and Niassa provinces by maximizing access, quality, and sustainability in the delivery of comprehensive HIV/AIDS and related primary health services.

- *Strengthening Civil Society Participation in Health and Primary Education,* a Program Statement issued by USAID/Mozambique on March 27, 2012. Multiple awards are planned for 2012 through 2017. The purpose is to strengthen civil society engagement in delivery of health and education services. Gender and governance are cross-cutting themes for all program activities.

V. ENABLING ENVIRONMENT: FINDINGS AND CONCLUSIONS

FAMILY PLANNING COMMITMENT: LEADERSHIP AND POLICY

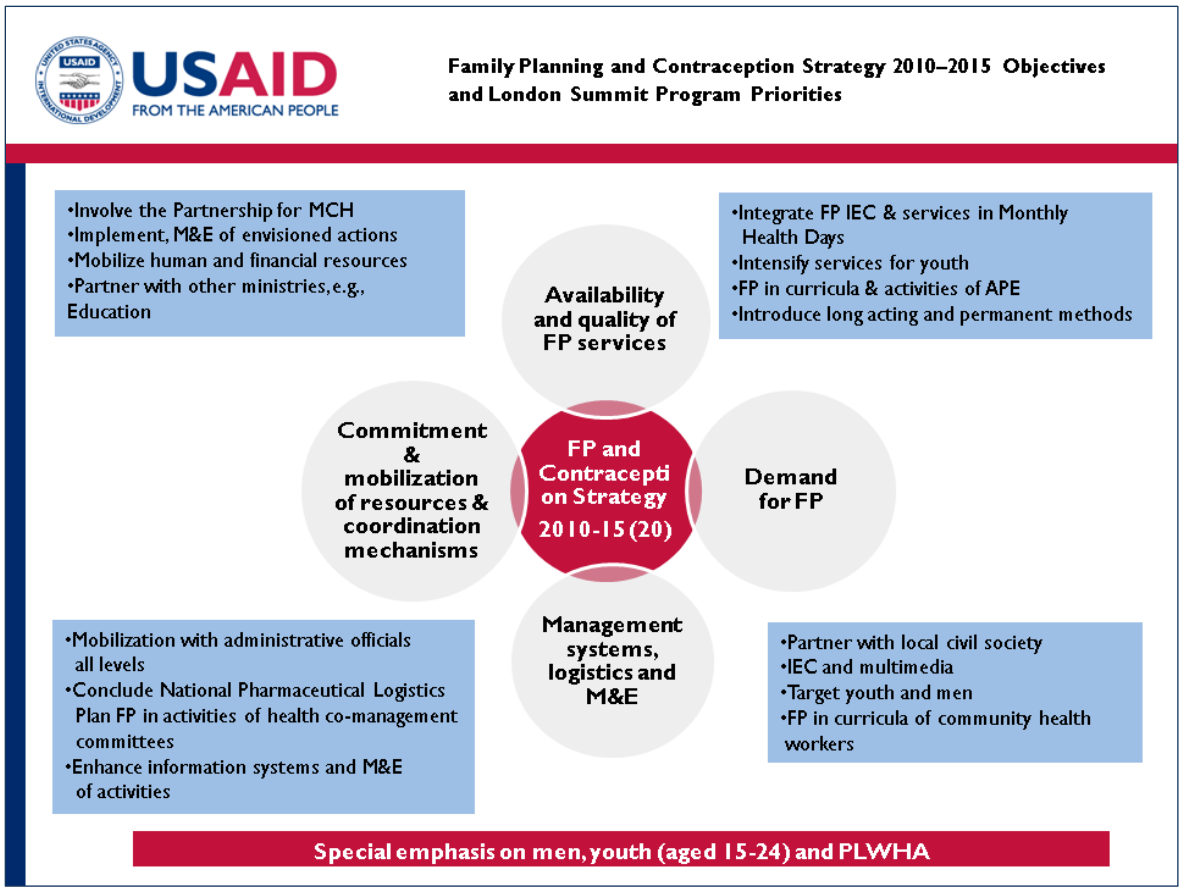
At the July 2012 London Summit on Family Planning, Dr. Nazira Abdula, Mozambique's Deputy Health Minister, announced her country's commitment to FP. She stated that Mozambique is committed to increasing women's access to modern FP methods and expanding both FP information and the delivery of contraceptives within the community. The delegation committed Mozambique to (1) continuing to provide facility and community-level information and FP services; (2) increasing the modern CPR to 34% by 2020; and (3) increasing cost-sharing from the national budget for procuring contraceptives from the current 5% of the total cost to 10% by 2015 and 15% by 2020.

Within the National Health Directorate MCH Office, a single staff position is responsible for strategic planning, implementation, and monitoring of the national FP program. The provincial level replicates the central structure but puts less emphasis on strategy formulation and policy development and more on administrative planning and budgeting. At the district level the focus is on program implementation and budgeting. Considering the leadership responsibilities of oversight, regulation, and accountability, at all levels there is limited staff and system capacity for overseeing FP activities and coordinating with partners.

FP commitment and leadership are contextualized in the GOM's *Family Planning (FP) and Contraception Strategy for 2010–2015 (2020).*[9] The Strategy has four objectives: (1) increase the availability and quality of FP services; (2) increase demand for FP services; (3) strengthen management systems, logistics, and monitoring and evaluation (M&E); and (4) increase commitment and mobilization of resources and coordination mechanisms. The Strategy (Figure 1) is concerned with all potential FP users, female and male, but with a special emphasis on men, youth aged 15–24, and people living with HIV/AIDS (PLWHA).

[9] Ministry of Health, Government of Mozambique. 2012. *Family Planning and Contraception Strategy, 2010–2015 (2020).* Maputo, Mozambique, MOH National Directorate of Public Health, August 2010.

Figure 1: Family Planning and Contraception Strategy 2010–2015 and London Summit Program Priorities.



The components of the Strategy represent the building blocks of a sound health system as recommended by the World Health Organization (WHO): leadership and governance, service delivery, financing, human resources for health, and health information and medical products. The national Strategy also emphasizes increasing demand, which is not always clearly represented in a facility-based health system model.

The text in the rectangular boxes in Figure 1 shows the program priorities the GOM identified at the London FP summit. In addition to its commitment to increasing procurement of contraceptives, the MOH's eight plans of action are to

1. Engage the MCH Partnership, led by the First Lady, in developing common advocacy messages and shared activities.
2. Conduct FP advocacy through information, education, and communication (IEC), and social mobilization, using, e.g., multimedia and partnerships with civil society groups such as community leaders, religious leaders, local administrative officials, and professional organizations.
3. Complete the National Pharmaceutical Logistics Plan.
4. Mobilize both financial and human resources to implement activities and identify funding opportunities (e.g., through donor coordination).

5. Intensify FP information and services for all women by incorporating FP into monthly health days and targeting youth and rural populations.
6. Introduce FP content into curricula and activities of the CHWs and community health committees, including information on administration of OCs and injectables.
7. Introduce LAPMs of contraception to women
8. Improve the information and M&E system.

The *FP and Contraception Strategy* has an Operational Plan attached. The Operational Plan sets out expected results, activities, responsible partners, a 2010–2011 budget, a five-year budget through 2015, and a timeline.

Objective Four of the Strategy is to increase the commitment and mobilization of resources and strengthen coordination mechanisms. The activities in this part of the Operational Plan include advocacy meetings to present and disseminate the Strategy; ensuring that funds are allocated for the Strategy; and allocation of funds from national and state budgets to purchase contraceptives. However, the budget for Objective Four is unrealistic. For example, the first-year budget for all Objective Four activities is US$500; the entire five-year budget is US$5,500. This objective is clearly underfunded. Other objectives are budgeted much higher.[10]

Furthermore, the Operational Plan does not detail how activities will be implemented. For example, the process the GOM will use to actually allocate funds to purchase contraceptives is not specified. There is also no clear plan for evaluating how the program is progressing and undertaking course corrections.

Current USAID population support to strengthen the development of MOH FP/RH policy has been extremely limited. USAID personnel have provided some direct technical assistance, and partner personnel are also providing some assistance for policy development. MCHIP's support has clearly been of value to the MOH efforts to implement MNCH interventions and train health professionals in the necessary skills, but it is unclear whether MCHIP support has been as robust for FP/RH interventions and training. ESD's Performance Monitoring Plan contains language about "relationships" with government partners at central, provincial, and district levels, but activities are not directly linked to the ESD Results Framework. There is very little evidence that these relationships have in any way built up the MOH to develop policy implementation guidelines, including strategic visioning at the provincial level. The new USAID health systems strengthening activity may offer an opportunity to expand policy development assistance, particularly for financing, budgeting, and staffing.

[10] Objective One, "increase availability and quality of contraception services," has a five-year budget of over US$67 million.

THE HEALTH AND DEVELOPMENT POLICY ENVIRONMENT

The FP and Contraception Strategy is but one of many national health strategies and policies. There is also, e.g., a National MNCH Partnership, a Community Health Strategy (2006), an Integrated Package of Services Policy, a 2009 strategy to promote gender equality in the health sector, and a National Plan for Development of Human Resources for Health (2008–15).

Since FP is programmatically positioned within the MCH office, it is referenced in many MCH documents as well as being part of the Integrated Package of Services. It is not clear, however, whether the programming priorities and activities listed in the FP Strategy are aligned with those in other health sector plans. The current Health Sector Strategic Plan (2007–12) is being revised; and completion of the new five-year plan (2012–2017) is scheduled for November 2012.

Within the broader development and social policy arena, Mozambique's Population Policy (1999) offers the most direct link to FP goals. Among the objectives it articulates are to (1) advance the systematic integration of population factors into all the other policies and programs that seek to assure improvements in the quality of life of the population, with particular stress on the country's poorest provinces; (2) promote multisector and interdisciplinary coordination in the formulation and implementation of intervention programs that respond to the main national concerns about population; and (3) provide the population with information, training, and other resources so that women, men, and adolescents can manage their reproductive and sexual lives, in accordance with their wishes, individual capacities, and civic and social responsibilities.[11]

According to documentation from the GOM and donors (UNFPA), many priorities articulated in the country's Population Policy are reflected in the *Mozambique Poverty Reduction Strategy Paper*, also referred to as the *Action Plan for the Reduction of Absolute Poverty*. However, it is unclear if detailed action plans for implementation of the Population Policy have unfolded in the last three years, particularly with regard to inter-sector government coordination, and involvement of civil society. Undoubtedly, many other social sectors have policies and strategies that are complementary to the GOM FP program priorities, including those guiding the work of the Ministry of Women and Social Action and the Ministry of Sports and Youth. The FP and RH links to these other ministries have not yet been developed.

GOVERNANCE SYSTEMS AND CIVIL SOCIETY PARTICIPATION

A Sector-Wide Approach to Health (SWAP) has been active in Mozambique for the last 12 years. The SWAP objectives are to increase coordination among health partners (government, donor, nongovernmental, and private) for improved results, effectiveness, efficiency, and quality. Within the Health SWAP there are numerous technical working groups (TWGs), with separate TWGs for family planning and for contraceptives. Informants noted that the FP TWG was one of the weakest working groups and the contraceptives TWG one of the strongest. However, the FP TWG is now drafting Terms of Reference that are being reviewed by the overarching SWAP TWG. Members of the FP TWG represent government, USAID, some multilateral organizations (e.g., UNFPA, WHO), and a few donor-funded international NGOs; local NGOs and civil society organizations are not currently represented. In addition to the SWAP there are other donor coordination groups, but it is unclear how FP is positioned within this structure.

[11] Republic of Mozambique, Council of Ministers Resolution No 5/99, April 13, 1999.

A Population Directorate outside of the MOH is also reported to be part of the GOM structure. It is unclear where the directorate is currently situated and it is not represented on the FP TWG. Several informants also mentioned an annual population conference that the prime minister attended. There is clearly little coordination between various GOM efforts.

The MOH has begun to decentralize, but there is no provincial FP and contraception policy or FP TWG. Although there are health committees in the districts, their role in planning and budgeting is unclear, and health committees do not seem to be part of the provincial structure.

Additional USAID support for FP/RH governance systems and civil society participation is being provided by the Population Reference Bureau to disseminate the final 2011 DHS results, and USAID is planning to fund a RAPID (Resources for the Awareness of Population Impacts on Development) presentation by the Health Policy Project.

FINANCING AND PROCUREMENT

Donors contribute more than 50% of the country's total budget for health. Through the SWAP, numerous donors contribute to a common fund that is available to the MOH. USAID does not contribute to pooled funding but is nevertheless a member of the SWAP. Certain donors also support the government directly or through nongovernmental organizations, private organizations, and multilaterals. For FP, this includes UNFPA, which funds DKT to train public providers on FP methods, including insertion of implants and IUDs.

UNFPA purchases about 70% of Mozambique's contraceptive supplies annually and USAID most of the other 30%. Since 2008, the GOM has allocated funds to buy contraceptives, but these funds have never been spent and are reallocated at the end of each financial year. Current USAID population funds do not seem to be directed to supporting the MOH in meeting shared financing and procurement for FP commodities or broader financing support.

At the central level the MOH does not use program-based budgeting. The Ministry of Finance provides funds to the MOH, which are then allocated according to the ministry's priorities. FP is listed as a top priority but is embedded in the MCH budget. FP and broader MCH program needs are thus competing with other health priorities for MOH resources.[12] SWAP fund allocations are determined at the central level, and provinces have no say in their prioritization.

There are no user fees for FP services in the public sector. It is unclear if the GOM has considered user fees for certain segments of the population as part of planning for universal coverage, especially to ensure services to the lowest socioeconomic quintiles, or has acknowledged the role of the private sector in providing health services.

[12] In Nampula, the Provincial Health Director reported that the total budget for health in 2012 was 20% of the overall budget and is projected to increase to 22% in 2013. In Gaza, the Provincial Health Director reported that the budget for health was 10% in 2012. The team did not obtain any information on budgets for health in other provinces.

CONCLUSIONS

The commitments and recommendations of the GOM at the July 2012 London FP Summit offer a real opportunity to build momentum for more visible, multisectoral leadership for FP at the central and provincial levels.

FP visibility within the MOH is limited to the MCH Department. Technical links with other departments in the National Health Directorate and in other directorates within the MOH are not yet close. However, there is an opportunity to set strategic FP priorities for short- and longer-term objectives when the 5-year Health Plan is revised at the end of 2012.

The shared technical priorities for FP as outlined in the FP and Contraception Strategy are not aligned with similar agendas in non-MOH ministries. There is a need to clearly link population policy with the FP and Contraception Strategy on the ground. Dissemination of final DHS results and the RAPID model are other opportunities to highlight the importance of FP to various other development sectors.

The Operational Plan outlined in the FP and Contraception Strategy is a good beginning, but it needs reinforcement. The MOH does not seem to have a clear plan of action with supporting documents and systems to implement and monitor programming priorities in the FP and Contraception Strategy at the national, provincial, or district levels.

There are operational policy gaps to achieving the current strategic vision for FP as outlined in the FP and Contraception Strategy. Lacking are, e.g., roadmaps for innovative and segmented approaches for reaching the diverse populations defined as "youth," PLWHA, and men as supportive partners and agents of change in their communities. Defining and developing these operational policies also offer a good opportunity for cross-health and cross-development coordination, e.g., with the Ministry of Youth and Sports.

Leaders within both the central MOH and at Nampula mentioned the need for FP advocacy and systems to support provincial and district administrators in planning and budgeting for FP priorities. Considering limited financial health resources, it is essential to ensure that FP meets the needs of the lowest socioeconomic strata without undue economic hardship.

VI. SUPPLY OF FP SERVICES: FINDINGS AND CONCLUSIONS

This section addresses issues related to the FP service delivery system that the team was asked to assess: human resources, method mix, integration of FP with other health services, management of contraceptive logistics, FP record-keeping, and the role of the private sector.

OVERVIEW

Though the MOH has worked to increase the availability of FP services through health centers, central, provincial, and district officials interviewed and MCH nurses in facilities all reported that access is still a major challenge. The Mozambican population is widely dispersed in remote areas. Low population density and the lack of facilities require patients to walk as far as 30 km in some areas to reach a health facility. One senior government health official noted that given its population Nampula Province would need twice as many fully staffed facilities to reach WHO-recommended coverage levels. To increase the number, USAID is providing support through SCIP for the construction of health centers in Nampula.

Referral mechanisms in the Mozambique health system are tenuous. The lack of adequate transportation is just one impediment to effective referral. For example, there is only one ambulance available for each district in Nampula to move patients from outlying areas to higher levels of care. This means the health system cannot adequately deal with complications of pregnancy and the need for emergency obstetric care.

The team observed many health facilities in which water was a problem; either it was available in only one room; it was available for only certain hours of the day, even when the facility provided 24-hour MCH care; or there was no running water at all. MCH nurses reported, and the team observed, that many facilities lack basic equipment, such as blood pressure machines, scales to weigh infants, obstetric specula, and human anatomical models.

The team also noted inadequate and incorrect infection control and sterilization procedures in many district health center maternity facilities and subdistrict health centers. However, the team did observe a USAID-supported model maternity facility in Xai Xai Hospital that has received three best practice awards for infection control and prevention.

Maternity waiting homes constitute an opportunity to promote health and create FP demand by e.g., providing FP postpartum. These waiting homes are being constructed and managed with partial USAID support through the SCIP projects in Nampula and Zambezia and the MCHIP project. Local communities contribute labor and construction materials. The team observed many functioning maternity waiting homes. However, the joint donor-community funding mechanism to support the construction is not working well in all areas. An administrator in a subdistrict in Nampula reported that community members could not afford to purchase the necessary construction supplies and equipment, which delayed the completion of construction.

The Mozambique FP and Contraception Strategy calls for providing youth-friendly services. Except at a large facility in Xai Xai, the team did not observe any youth coming to these facilities, which often are simply a single room in a health facility. Some nurses reported that adolescents did not like to be seen coming to health centers by others in the community. The

current service strategy does not allow for creation of separate youth facilities or special off-hour attendance hours when younger people could be served more discreetly. Also, in some health centers in Nampula, examination of service record books indicated that younger women (especially adolescent girls) were underrepresented. This suggests that youth are not being well-served by existing facilities, especially at the district and subdistrict levels.

HUMAN RESOURCES AND SERVICE DELIVERY

Facility-based Personnel

This report has already noted the lack of central and provincial program managers responsible for FP monitoring and oversight. There is also an acute shortage of OB/GYN physicians and MCH nurses in Mozambique's health system, particularly at the district and subdistrict levels.[13]

FP services within district and subdistrict health centers are provided mainly by MCH nurses, and also by a medical technician when one is assigned. The MCH nurses deployed in health centers (see Section III) are responsible for a wide range of preventive and curative integrated MCH services, of which FP is just one.[14] In addition to MCH care services, the nurses are also responsible for keeping client records and preparing commodity requisitions.

The team noted critical staffing shortages in district and subdistrict health facilities. Several health centers had only one MCH nurse even though two are mandated. In facilities with two MCH nurses, they often worked separate 12-hour shifts. The staffing shortage places unreasonable burdens on those providing services, particularly FP counseling, and compromises quality assurance. The team observed long lines of patients at district facilities, particularly hospitals; nurses reported that patients often wait up to four hours for care. Staffing shortages also compromise the ability of health center staff to organize mobile outreach.

A new FP user who wishes to receive OCs is required to obtain her first monthly packet of pills from an MCH nurse at a health center. The one-month supply at initial consultation requires a visit for re-supply after a very short interval, which heightens the chances of discontinuation.

There is FP counseling, but according to the 2011 DHS less than 65% of women reported being counseled on side effects of methods, and less than 55% of women reported being counseled on what to do if they experienced side effects. Furthermore, data from the ESD Family Planning Baseline Study indicates that only about half of married women were counseled about FP during most health facilities visits. The exception was ANC visits (63% of women were counseled; see Annex E, Figure E-15).

The availability of counseling information tools, such as flip charts, varied considerably from center to center. Posters on FP methods distributed by PSI and UNFPA some years ago were ubiquitous, but flip charts about specific methods that could be used in one-to-one counseling sessions were rare. Providers also reported that they did not use checklists for topics to cover during FP information and counseling sessions.

[13] One informant reported that there are only about 60 OB-GYNs in the country, of whom 66% work in Maputo.

[14] In addition to FP counseling and services, the MCH nurse provides pregnancy testing, ANC, labor and delivery, PPC, VCT, treatment of HIV-positive women, TB treatment, malaria treatment, child-at-risk consultations, immunization services, and treatment of diseases within the general population.

The team learned that there is a cadre of basic nurses (*infermeiras basicos)* who could possibly provide FP information and counseling to interested new acceptors. A more thorough analysis of their responsibilities is warranted to see if basic nurses could add FP information and counseling to their job descriptions. Deployment of this cadre might increase the time available for FP counseling and allow the MCH nurse to concentrate on providing the more highly skilled clinical service needed for IUD insertions and implants.

The MOH does not seem to have a separate cadre of professionally trained midwives. This is somewhat surprising given that a major objective of the FP and Contraception Strategy is to decrease maternal mortality through increased use of hospitals and health facilities for labor and delivery. A midwife cadre would alleviate some of the burden on MCH nurses.

Extending FP Services into Communities

The MOH acknowledges that a major challenge is getting FP services from district and subdistrict facilities into local communities. The MOH is working to increase FP service delivery in villages and localities through health fairs and mobile brigades. These are usually organized to provide primary child health services (e.g., immunization), but FP planning IEC, community theatre, and service provision (for condoms, OC re-supply, and injectables) are incorporated. The MCH nurses also provide referrals to health facilities for women who wish to use an IUD, for pregnant women, and for women who have recently delivered. The health fair may also include voluntary counseling and testing (VCT) on HIV.

Officials in all three provinces reported that the frequency of mobile brigades is limited by shortages of MCH nurses, lack of vehicles, and lack of local funding for fuel given the long distances to peripheral communities. The health system is very limited in its ability to mount major service delivery outreach operations. The reported frequency of health fairs and mobile brigades is highly variable—from every two weeks to every three months.

Though there is as yet no large-scale community-based FP service delivery program, the MOH is committed to building up the cadre of CHWs to expand health and FP information and services into local communities. The *APE* is the only type of CHW that is officially part of the MOH system. Plans call for training and fielding up to 2,300 CHWs nationwide by 2013; about 1,200 have already been trained. The *APEs* receive four months of training. One of the program recommendations from the Mozambique delegation to the 2012 London Summit was for FP to be fully integrated into their responsibilities, and MOH officials reported they are particularly interested in donor support to do so. This is an opportunity for USAID to review and strengthen the FP curriculum to add specific elements on FP counseling for all methods and to add OC re-supply to *APE* responsibilities.[15]

One factor that may limit rapid expansion of the *APE* cadre is the basic literacy requirement. For that reason, many *APEs* are male. This gender imbalance could limit their effectiveness in providing FP, RH, and maternal health information and counseling to individuals and families.

USAID-supported programs (primarily SCIP and ESD) are emphasizing use of volunteers to generate demand for FP services and mobilize community participation. In Portuguese, these volunteer community health workers are known as *animadoras, activistas,* and *promotores*. The *animadoras* and *activistas* cadres are exclusively supported by USAID and other donor programs;

[15] At present, malaria treatment has not been integrated into the APE training curriculum either.

they are not salaried within the MOH. They are mostly women who have been selected by community leaders and community health councils. *Animadoras* and *activistas* receive five days of general FP training. They provide information and counseling to families on the benefits of child spacing and on FP as an intervention to reduce maternal mortality. They work to improve knowledge about specific contraceptive methods and engage with community leaders to change social and cultural attitudes and norms. Traveling from house to house, they counsel husbands and wives together and also dependents of reproductive age living in the household.

Animadoras in some SCIP-supported areas provide one month re-supply of oral pills after the woman receives her initial supply from the health center. That practice, however, is not consistent in all SCIP-supported localities. In the ESD project, volunteers provide re-order or referral forms but do not re-supply OCs, so the client must still travel to the health center for refills. Thus, there appear to be policy and implementation inconsistencies between and even within USAID projects.

Traditional birth attendants (TBAs) are another volunteer cadre that is active in rural areas. They are responsible for preventing complications, ensuring clean home-based deliveries, and making referrals to hospitals when delivery complications arise. However, it is not clear how much FP counseling or contraceptive services they provide. In addition, their competency is not clear. With some additional training, TBAs might be able to play a larger role in FP and in referring clients to health centers for FP and safe delivery care.

METHOD MIX

IUDs

With the FP program dominated by pills and injectables, the IUD has a very low profile in Mozambique's mix. Few IUDs have been provided for several reasons: (a) lack of attention to this method in previous FP strategies; (b) providers insufficiently training or experienced to feel comfortable inserting IUDs; (c) insufficient counseling on this method by both MCH nurses and community volunteers; and (d) community myths and misinformation.

Although MCH nurses have been trained to insert IUDs, for many the training was long ago. After the training period, neither health facilities nor USAID partners collect data on clinical competencies for IUD insertions. Given the low frequency of IUD insertions, the skills learned may become compromised. Refresher training is particularly important to improve quality and increase IUD utilization.

Myths, rumors, and misinformation are common obstacles. The Portuguese word for the IUD is *aparelho,* which also means "machine or device." Many uneducated women do not understand how a "machine" can be inserted into the body. MOH officials and volunteer health workers in some places reported that clients believe the IUD can transmit HIV/AIDS. The team also heard (but could not substantiate) that the IUD is occasionally used as a blunt invasive instrument to abort unwanted pregnancies.

The USAID program is supporting increased attention to the IUD through the MCH postpartum program in five model maternity facilities. Providers have been trained to offer counseling during ANC visits and when a woman presents for delivery. MCH nurses have been trained to insert IUDs within the first five minutes after delivery. The team observed posters on female human reproduction and the IUD in several model maternity facilities but not in lower-level health centers. The results of the postpartum IUD program are encouraging. One model maternity

hospital reported that about 60 IUDs a month are being inserted as a result of the increased focus on this method.

The SCIP project has also reported encouraging results for the IUD. A recent study found that IUD use increased most significantly when three conditions were met: (a) providers received adequate or refresher training (for three days) and practice (for two days); (b) health center personnel made visits to the community to discuss the benefits of IUDs and to explain the procedure; and (c) community volunteers spent more time discussing the IUD during household visits.[16]

Implants

The MOH reported that implants are in high demand among women who have been informed about their availability.[17] USAID has budgeted for purchase of implants in 2013. With funding from UNFPA DKT has trained providers. USAID has also provided support to the MOH for a national training of trainers (TOT) program, and some projects have conducted regional and provincial TOT training on implants.

Given the current capacity of the health system, however, it will be a challenge for the MOH to achieve high implant use. Many additional providers will need to be trained in insertion and removal techniques. Clients need to be followed up for possible side effects, confirmation of proper retention/positioning of the implant rods, and timely replacement of the device when it expires. Many health facilities need to improve their infection control. Implants should be promoted and made widely available only when the necessary logistical support and quality assurance systems are firmly established. Mozambique is cautioned not to risk repeating the experience of Indonesia, which rushed too quickly into implant (Norplant) insertions before ensuring that clients could receive appropriate follow-up care.

Permanent Methods

Neither tubal ligation nor vasectomy, the permanent methods of contraception, is being actively promoted. There are deeply ingrained cultural barriers, particularly for vasectomy, but neither USAID nor the MOH is making any attempt to address these. Tubal ligation is available in higher-level facilities upon request, but only for women who meet three criteria: they (a) must be over 35, (b) have multiple parities, and (c) have had at least three C-sections.[18] Tubal ligation in central hospitals and model maternities does not appear to be included in postpartum services for high-parity women wishing to limit births. This may constitute a missed opportunity. Mozambique law does not prohibit sterilization, but policy restrictions, provider bias, lack of referral systems, and cultural inhibitions will present serious obstacles for both male and female sterilization for the foreseeable future.

Other

Emergency contraceptives (morning-after OCs) are available in Mozambique in pharmacies but not in public facilities. Informants reported that they are most often employed for sexual abuse victims. In Mozambique, where the average age at first sexual encounter is 16.1 (2003 DHS) and

[16] Pathfinder International. 2012. *SCIP Project: USAID/SCIP Nampula Meeting*. PowerPoint Presentation. Nampula, Mozambique: Pathfinder International, September 12, 2012.

[17] According to the 2011 DHS, 6.6% of married women and 9.5% of sexually active but unmarried women had heard of implants.

[18] Information provided by a key informant.

many unmarried young women are sexually active, emergency contraception could meet an important need.

In the country's central hospitals, nine to ten Caesarian-sections are performed every day.[19] The C-section rate is approximately 2% for all deliveries, a level below the norms in neighboring countries. Women who obtain C-sections can be given FP counseling; information on the benefits of immediate breastfeeding for mother and infants; and postpartum contraception. The extent to which this is being done, however, is not clear.

INTEGRATING FP WITH MCH AND HIV SERVICES

USAID funds are supporting the integration of FP services into MCH and HIV services. In the model maternity programs that USAID is supporting FP is being integrated with cervical cancer screening and PPC. One of the proposed model maternity interventions is to "humanize" services; e.g., husbands or partners are encouraged to be present during delivery. This would provide an excellent opportunity for FP counseling and information, but it is not clear whether this is being done.

In facilities other than the models, integration of FP into ANC and postpartum services is less systematic. In one well-equipped district maternity facility, the MCH nurse reported that she provides routine FP counseling during ANC visits, when the patient presents for delivery, and postpartum. The team then spoke with two patients who were in the recovery room (women remain at the facility for up to 24 hours if there are no complications). Neither had received FP counseling or information during the ANC visits or postpartum. One patient, 17, had just delivered her first baby and said she wanted to use FP. The other patient, who was breastfeeding her newborn, also reported she had not received any FP information during her ANC visits or postpartum.

Several subdistrict health centers the team visited reported two to three cases a month of women who presented with complications of an improperly performed abortion. While these case loads are not alarmingly high, they do suggest the need to address post-abortion care at the subdistrict level. Since abortion is illegal in Mozambique, it is likely that many abortion-related morbidities and deaths go unreported, and women often do not come to government health facilities. MCH nurses in the larger maternity facilities reported that FP counseling and services, as well as testing for sexually transmitted diseases, was being done during post-abortion care.

There is 92% BCG coverage for children younger than 2. Immunization provides an excellent opportunity for integration with FP, but it does not appear that this is being done consistently. In one large facility in Xai Xai, there were long lines of women waiting to receive immunization services but FP information and counseling were not being provided.

FP is a high priority for the PEPFAR-funded PMTCT Acceleration Plan; the objectives are consistent with the GOM's FP/RH strategy. In Nampula and Gaza, the district health directors reported that MCH nurses had received training in PMTCT. At the health facilities visited by the team, however, there was little evidence that FP counseling and services were being provided for HIV-positive pregnant women. In most facilities, PMTCT and VCT services were provided separately from FP services. Providers reported offering FP counseling when a patient presents

[19] Of these, 10% are considered to be elective and 90% are necessitated by an obstetric emergency – usually an obstructed delivery.

for VCT, but the team was not able to verify that. A continuing challenge for integration of FP into PMTCT and HIV services is that the patient still has to be referred to the MCH nurse to obtain contraceptive supplies and be recorded in the FP register.

MANAGING CONTRACEPTIVE COMMODITY LOGISTICS

USAID invests about US$30 million a year in medical commodities: approximately $2 million for treatment of opportunistic infection (OI) related to HIV infection, $6.4 million for Artemisinin-based Combination Therapies for malaria treatment (ACTs), $19 million for anti-retrovirals (ARVs) to treat HIV infection and $1.2 million for contraceptives, plus 800,000 condoms. USAID is also investing US$8 million annually to streamline the commodities supply chain through the Strengthening Commodity Management Systems (SCMS) project for HIV commodities and through DELIVER for malaria and FP commodities.

Several informants reported that MOH technical capacity to manage the international procurement process for FP commodities is limited. However, the GOM is procuring medicines on the essential drug list. The GOM has committed (see Section V) to increase its budget for contraceptive commodities over the next 10 years. Further study is needed to ascertain whether and what kind of technical assistance the GOM might need to procure contraceptive commodities.

USAID/Mozambique commissioned an Assessment of the Supply Chain of Family Planning Commodities in Mozambique in August 2012. This discussion briefly summarizes the gaps and challenges in the system found in that assessment.[20]

The FP commodity supply chain is part of the larger public health supply chain in Mozambique. The goal is to provide the desired mix of FP commodities at all service delivery points in the country. The public health supply chain consists of two central warehouses, in Maputo and Beira, eight large hospitals, 10 provincial warehouses, 150 district warehouses, and 1,400 service delivery points.

The assessment noted that several district warehouses appeared to be rationing contraceptive commodities: at one, a team member observed rationing in 66% of the FP orders placed by health facility patients; in another, there was rationing in 45% of the orders. This suggests that safety stocks are insufficient; apparently the commodity logistics system is incapable of building adequate buffer stocks for FP commodities.

Stock-outs of condoms, OCs, and injectables have been a problem in the past, but the situation has been improving. According to a UNFPA survey, the percentage of facilities reporting no stock-outs in the six months before the survey had increased for all methods.[21] The FP assessment team attempted to validate this finding, but when asked if stock-outs were a problem, the MCH nurses interviewed by the team simply said no.

The commodity assessment reported significant human resources challenges top performers leave for better opportunities, managers have little logistics training, and there is limited training in standard operating procedures and limited supervision for lower levels of the supply chain.

[20] Manuel, Coite. "Assessment of the Supply Chain of Family Planning Commodities in Mozambique." Unpublished USAID presentation August 2012 and report September 11, 2012.

[21] UNFPA. 2011. *Mozambique Progress Profile – Global Program to Enhance Reproductive Health Commodity Security*. September.

The GOM does not appear to be doing audits, and there appear to be no accountability procedures to prevent theft. Deliver and SCIP have been working to address the training issues.

The data generated at district and facility levels on consumption of FP commodities are inadequate. Facility-based service statistics are not bubbling up to higher levels of the supply chain, which frustrates efforts to use consumption data to estimate levels and duration of use for individual methods and projected need. The ability to link subdistrict and district consumption data to provincial facilities and report this information up to the center (and the three central warehouses) is necessary to improve the reliability of commodity logistics reporting and efficient provision of FP commodities.

FP RECORD-KEEPING AND REPORTING

FP service statistics are collected in health centers. FP registers have columns for pills, injectables, and IUDs. There is also a column for Other Methods that could be used to report implants once that method becomes more widely available.

There is no column in the FP registers to indicate how many children a woman has had and when her deliveries occurred. Having more complete information on the birth histories of clients would be useful in providing information on such methods as IUDs, implants, and tubal ligation that are particularly relevant for multiparous women who would like to limit future childbearing.

In the current FP registers, it is not possible to track individuals, since clients do not have unique identifiers. As patients come to the clinic, their names are written in the register, but there is no way to tell how often they have been there before. Though there is a column for the first FP visit, for returning patients, the column used is titled *Seguinte*, which does not clarify whether the visit is the second or the tenth. This confusion could make it difficult to distinguish between new acceptors and continuing users and to track the FP/RH health needs of individual patients.[22]

The FP registers also have a section for HIV status with columns for positive, negative, and unknown. Whether VCT testing kits are available impacts how the data are reported. For example, one clinic checked unknown for the entire time it experienced VCT equipment stock-outs. Thus, HIV-positive women were almost certainly underrepresented and not adequately linked to FP status.

MCH nurses reported that record-keeping books for FP and other services are longer and wider than those previously used and are harder to photocopy. This makes it challenging to transmit monthly performance reports to higher levels of the health system.

Implementing partners report data on couple years of protection (CYP) but that indicator is more a measure of contraceptives distributed rather than an actual use. The MOH is planning to report the number of new and of continuing users rather than CYP. Presumably USAID's three main service delivery projects (SCIP, ESD, and MCHIP) will be transitioning to these new MOH indicators. However, there will also be some need to retain the CYP measures that the projects are currently reporting in order to ensure continuity with earlier project reporting periods.

[22] During the visit to Nampula, the team learned of a *Ficheiro* model, a mobile file designed to track individuals and provide rapid identification to patients lost to follow-up. This system, while purportedly introduced in many health facilities, was not functioning in any sites the team visited.

Role of the Private Sector

According to the 2011 DHS, 16.1% of all users accessed contraceptive supplies through the private sector, primarily private pharmacies (7.3%) and grocery stores (4.1%). Another 6.8% of women accessed supplies through "other sources," primarily friends and relatives. The for-profit private sector is largely confined to major cities.

Condoms are the main family planning method currently supplied through the private sector, which in 2011 provided 41.3% of all male and 35.1% of all female condoms. Some pills and IUDs were distributed through pharmacies and private clinics, but nearly 90% of all women still obtained these methods from public facilities.

These results are not surprising given that much private sector distribution of FP commodities has focused on condoms to combat the spread of HIV. Until now, there has been little progress in supplying other family FP through private outlets. This may be due in part to policy constraints that have limited the ability to sell a broad range of contraceptive methods through commercial channels. Only pharmacies are currently allowed to sell OCs; injectables and IUDs are only available in private clinics. In Mozambique the provision of medicines and health supplies and equipment is dominated by four major pharmaceutical companies, and commercial FP supplies can only be imported through one of them, which recently has not been giving much priority to importing contraceptives, which tend to have low profit-margins.

Social marketing of FP commodities is being promoted by two donor-funded organizations, PSI and DKT. The former is largely funded by USAID and DKT by UNFPA, the Netherlands, and Norway. Both have already achieved considerable success in getting social-marketed condom brands distributed through private channels. The 2011 DHS reports that the Jeito (PSI) and Prudence (DKT) condoms are the dominant brands purchased, and 82.3% of the private market for condoms is controlled by these two brands, with Prudence having the slightly larger market share. PSI has recently unveiled three new condom products as part of its "1+1=2" campaign to reposition the Jeito brand: the original Jeito product, a new red strawberry-flavored condom, and a yellow lemon-scented studded condom.

PSI and DKT are now partnering to provide a greater array of contraceptive methods in private clinics. DKT has about 20 franchised clinics providing subsidized IUD and implants, mostly in Maputo and Beira. In August 2011 the franchised clinics provided 1,300 implants and 100 IUDs. DKT also promotes condom sales (6.5 to 7.0 million so far in 2012) via street vendors and other delivery mechanisms in urban areas. They are interested in expanding their network of clinics if additional funding can be obtained.

With funding support from UNFPA, DKT also imports Sino II implants (using two rods). These will be pilot-tested in order to assess client satisfaction and the clinical feasibility of delivering the method. DKT has started five-day TOT sessions for providers. However, the MOH closed down DKT's television advertising campaign for Sino II implants on the ground that they were promoting a specific contraceptive and creating demand when Sino II were not yet widely available in private clinics.

PSI is also working to see how condoms and other FP services might be provided more widely through private pharmacies. One suggestion has been to place a public health worker in every pharmacy to counsel and test for HIV and refer HIV+ customers to HIV/AIDS treatment facilities. There could also be opportunities to integrate VCT and FP in pharmacies. For

example, pregnant women who test positive at pharmacies could be counseled to visit a fully equipped PMTCT health facility.

Mozambique is experiencing rapid economic growth due in part to foreign investment in extractive industries, particularly in Tete, Cabo Delgado, and Nampula. The existence of large industries may provide an opportunity for targeted expansion of public-private FP partnerships. The DELIVER Project and PSI have been looking into partnerships in the workplace, rather than relying only on private clinics or pharmacies. PSI already has partnerships with a major sand removal company in southern Nampula and local banks and telecommunication companies. The best opportunities for expanding PPPs for FP would likely be with companies that have many employees and already provide basic health services (e.g., in mining, construction, and port facility management).

PSI hopes to concentrate the social marketing of FP commodities in communities surrounding the companies it partners with. Attention will be given to reaching commercial sex workers that often frequent towns that have sprung-up to house employees of large enterprises—industries that often attract women from Zimbabwe and Malawi for income. But as PSI has noted, large companies tend to more interested in controlling malaria and reducing the transmission of HIV since they more directly affect the health (and absenteeism) of their employees. Sexual and reproductive health (including FP) tends to be a more challenging proposition.

The assessment team heard numerous comments about the advisability of promoting more PPPs and corporate social responsibility (CSR) initiatives for FP and RH. PPP and CSR opportunities often take considerable time to negotiate and make operative. It was not possible to identify a clear pathway for pursuing these opportunities, but they should be explored.

CONCLUSIONS

One of the main objectives of the MOH FP and Contraception Strategy is to improve access to and the availability of services by increasing use of health facilities for all MCH services, including FP. However, as yet there are not enough well-equipped, fully staffed health facilities to meet the demand that is being created for facility-based care. Donor investments will be needed to help the MOH to continue to build up infrastructure and strengthen the functionality of the health system.

There is a serious shortage of MCH nurses in district and subdistrict health facilities. Human resources limitations therefore inhibit the expansion of the FP program and its ability to achieve higher CPRs.

The quality of counseling and informed choice for FP is questionable. MCH nurses have so many other responsibilities that they are unable to spend much time with each patient. Counseling materials, such as pamphlets, flip charts, and checklists, were not available in many of the facilities the team visited.

The MOH is moving to improve reporting on the FP program. Data will be collected on new acceptors, current users, and continuing users to eventually replace data on CYP. This is a step forward, but the indicators will only be robust if the quality of facility-based reporting can be assured and estimates of eligible provincial and district populations are valid.

The current method mix, which is dominated by pills and injectables, may not be meeting the needs of all clients—particularly those who wish to have longer intervals between births and those who wish to limit family size permanently.

The increases reported in IUD use as part of PPC are encouraging. To scale up this method more widely, however, MCH nurses will require refresher training in IUD insertion and removal, and special attention should be given to improving counseling about the IUD.

Implants are reportedly in high demand among women who are aware of them. Donors have made commodity commitments for 2013 and the MOH is planning to introduce the method more widely. The MOH is cautioned not to move too quickly, however. It will be essential to put into place effective provincial and district training plans and to ensure that guidelines and protocols are in place for counseling, insertion, follow-up, and removal.

The large cadre of community volunteers, particularly those supported by USAID programs, are working to improve information on specific methods and to change community attitudes, but they are not yet able to provide OC resupply or injectables. There are also inconsistencies by project related to the role and responsibilities of community volunteer workers.

The MOH and USAID systems for integrating FP into other health service entry points are encouraging but not yet fully developed. Data are being collected for each vertical service (e.g., FP, MCH, HIV, immunizations, child-at-risk); patients have to be referred to different parts of the facility for FP; and there appears to be little coordination between the FP program and the PEPFAR program for collecting FP data.

With regard to managing commodity logistics, one of the most significant needs is to strengthen the delivery system from the central to district levels. In addition, better transmission of consumption data from subdistrict facilities up the reporting chain to national officials and the central warehouses is needed for more efficient provision of FP commodities.

The proposed plans of the DELIVER Project to provide three regional commodities advisers fill a serious logistics management gap. SCIP has made a good start on training additional logistics managers and MCH nurses.

Supply of FP commodities through the private sector is very limited. Condoms procured to slow the transmission of HIV constitute the main social marketing activity in Mozambique. A full range of contraceptives is still not readily available through pharmacies there. A major effort to ensure that OCs, emergency contraception, Depo-Provera, and condoms can be procured through commercial outlets would make contraceptive supplies more accessible. Workplace settings, especially in the rapidly expanding mining sector, may offer attractive new opportunities for social marketing.

VII. GENERATING DEMAND FOR FP: FINDINGS AND CONCLUSIONS

Results from the 2011 DHS suggest that the current demand for FP is not very high in Mozambique. Only 22.3% of women not using an FP method said they would like to use contraception to space or limit births. With a CPR of only 11.6% for married women, it might not be unreasonable to assume that more women in Mozambique would be interested in FP. The fact that unmet need is relatively low suggests that the demand is weak. This in turn suggests that more effort will be needed to communicate with women about their sexual and RH options, including the importance of FP to determining the number and timing of their offspring.

The generation of demand for FP and other RH services is typically addressed through social and behavior change communication (SBCC) and information, education, and communication (IEC) strategies using national and regional media channels (e.g., radio, television, and more recently various forms of social media), billboards and strategically delivered pamphlets, educational facilities, and regional and community health facilities. In countries with successful FP programs (e.g., Bangladesh, Brazil, Egypt, and Indonesia), such efforts have typified early efforts to mobilize support for FP and have often been seen as essential to rapidly increase the visibility and use of FP services.

These efforts are most effective when correct information is conveyed and the messaging is well-targeted. Some FP materials being distributed in some USAID project sites had information only about condoms. There also did not appear to be any targeted FP messages for the three priority groups the MOH identified in its Family Planning Strategy: youth, men, and PLWHAs.

At present USAID's FP demand generation efforts are focused on improving the availability of community information on FP and other RH issues and increasing the use of services at local health facilities. This strategy is attempting to mobilize local communities to become better-informed about health issues (including FP) and make greater use of the health facilities and services available in their areas.

BUILDING DEMAND THROUGH COMMUNITY OUTREACH

The SCIP and ESD projects are working with community leaders and volunteer community health workers (*animadoras* and *activistas*) to better inform community residents about FP and its importance to maternal and child health. This ground-up approach attempts to generate demand for FP and other health services through greater community participation in social development activities. The approach also emphasizes the integration of health information and service provision with other development sectors, such as agriculture, education, and water and sanitation activities.

These projects have helped to strengthen community health committees in the districts where they are working. Represented on these committees are teachers, religious leaders, traditional healers, TBAs, and other influential community leaders. The committees work to inform and educate their communities about health concerns and encourage greater use of the health services available. Health committees also observe conditions at local health centers to address deficiencies (e.g., hygienic conditions) and the quality of services provided. They hold monthly

meetings on health and community needs topics that are well attended. The volunteer members of the committees currently receive no compensation for their efforts.

In addition to the committees, the SCIP and ESD projects rely heavily on *animadoras* and *activistas* to convey FP information. Some volunteers also provide information about safe motherhood and the importance of registering for ANC, delivering at health facilities, and obtaining PPC, but it is not clear if this messaging is delivered consistently in all project areas. Volunteers also accompany clients to health facilities for services and coordinate with health facilities in organizing outreach, such as health fairs and other special activities. These voluntary workers are selected from within the community and, like those on the community health committees, are not compensated for their efforts.

Community health fairs, which appear to be well-attended, offer a wide range of FP and other health information in addition to some basic services. One fair the assessment team visited was providing Expanded Program for Immunization (EPI) for children, voluntary HIV testing and counseling, ANC counseling, and information on FP and maternal health.

The SCIP Project currently depends on over 32,000 volunteers and the ESD project on 3,500. These community-based workers are outside the formal health structure and work independently of the *APEs* (where they exist) and TBAs. In most of the project sites visited, these volunteers seemed highly motivated and enthusiastic about the work they were doing. The SCIP and ESD projects were providing caps, T-shirts, and backpacks to help give visibility to their presence in their assigned work areas. Some *animadoras* and *activistas* told the team that they hope their work as voluntary community health workers will open up opportunities for further training and employment in public health.

However, the fact that the *animadoras* and *activistas* receive no compensation raises concerns about their long-term dedication to their work and the sustainability of a voluntary system to generate meaningful FP demand. These volunteer workers often asked why they did not qualify for some form of remuneration. A previous JHPIEGO project had paid community workers a stipend for $50 a month. Several respondents said they did not see why a similar payment could not be made by the SCIP and ESD projects. It is unclear whether these volunteers will be motivated to do their jobs well or continue working without some compensation, and if that is not possible at least some other acknowledgment of their work

The team also observed that *animadoras* and *activistas* have few materials to assist them. They also get no incentives to do their work, such as transportation allowances or cell phone airtime. Voluntary community workers reported that transportation is their greatest challenge. They reported having to walk long distances to the health facility, 15-30 km in many instances, to pick up supplies and bring them to the community. Many do not have substantial footwear or flashlights and there is a concern for volunteers who live in rural areas where there are snakes. Neither MOH nor USAID-supported programs provide food or water at meetings and events that volunteer community workers and community leaders are expected to attend.

An additional concern is that SCIP and ESD voluntary community health workers received only five days of training before starting work in their communities. It is unclear whether this is sufficient for them to be fully conversant with the range of FP and other RH issues they may

encounter and whether ESD's follow-up technical assistance for CHWs is adequate.[23] Another concern is the fact that some voluntary community health workers only visit households and convey information for a few hours each week. This level of effort is not likely to generate much additional interest in FP. However, the actual number of hours worked by CHWs seems to vary by project site.

The team also noted that voluntary health workers were not giving much emphasis to the special needs of young adults aged 15–24 or to male involvement in FP. Youth services in most health facilities the team visited were not well-established and appeared to have low client use. The voluntary workers do not appear to be making special efforts during their rounds to reach youth (most notably sexually active unmarried adolescents). The voluntary workers occasionally talk with men, but there did not appear to be a systematic strategy for engaging men on FP/RH topics.

COMMUNICATIONS ACTIVITIES TO ENCOURAGE GREATER FP DEMAND

Mozambique's current Family Planning Strategy gives considerable emphasis to the importance of providing more FP information and education and generating demand for services. Despite this official support, the country currently does not have a strong SBCC/IEC program for promoting FP/RH. There is little advertising or radio and television attention given to these topics. According to the 2011 DHS, only 44.8% of women had heard messages about FP on radio, 18.2% on television, and 8.7% from newspapers. A recent effort to produce television spots for IUDs and injectables was canceled owing to disagreements about how contraceptive commodities should be branded. A stronger effort to generate demand that stresses the health benefits of FP, delaying the birth of a first child, and accessing facility-based maternity services will be needed if the country's FP efforts are to gain traction. Numerous myths and misconceptions also need to be addressed through better information and education initiatives.

Entry points for promoting FP integration with other development sectors should be encouraged to stimulate greater interest in FP. An important linkage would be to enhance instruction on sexual and reproductive health (including FP) and reproductive rights in schools and pre-service training facilities for educators. The ESP teacher training program in Xai Xai might be expanded to other provinces where USAID is making substantial FP investments. Mama Biz cards and role-playing (activities supported through SCIP and ESD) are inexpensive and useful ways to convey information about FP and other sexual and FH issues.

Future SBCC/IEC efforts to build up FP demand will need to address social and cultural norms that inhibit FP use. In Mozambique women marry and have their first child at very young ages and do not always appreciate the advantages of remaining in school and delaying child bearing. The importance of educating girls in promoting self-awareness, behavior change, and opportunities in life cannot be over-emphasized. Knowing more about sexual and reproductive health, including contraceptive methods, is an important way for women to gain independence and greater control over their options and prospects in life.

More attention to the sexual and reproductive rights of women should inform future SBCC/IEC programming. Women's autonomy with respect to choosing sexual partners, whom to marry,

[23] One CHW stated that she did not know whether Depo-Provera could be used by young acceptors. Youth were not sure if getting Depo-Provera would make them infertile. Good quality training could have given this CHW the information necessary to address community's misunderstandings about the method.

and the timing and number of children they will bear are essential human rights that have been embraced by international agreements among nation states. The sexual and reproductive rights of women should form the centerpiece of efforts to build demand for sexual and reproductive health services, including FP methods that meet the reproductive needs of women at different points in their reproductive life course.

In Mozambique women often do not have the power to make decisions about whether to adopt an FP method. The husband and resident mother-in-law often decide whether the wife should use FP. Family imperatives also put pressure on younger women to find a financially supportive partner (often an older man) rather than remain at home and in school. Gender relations that are poverty-driven are compromising the roles and status of Mozambican women.

An important aspect of the sexual and reproductive rights of women relates to sexual exploitation and gender-based violence against them. Greater sensitization to these issues needs to be incorporated into SBCC/IEC initiatives focusing on sexual health. The importance of integrating contraceptive services (especially emergency contraception) into programs dealing with rape and sexual abuse requires far greater attention. The One UN Project in Zambezia, funded by CIDA, is making a major effort to integrate gender-based violence and gender equity issues into a broader health project. This project may produce useful guidance on how to operationalize these interventions within Mozambique's unique cultural environment.

CONCLUSIONS

Mozambique currently does not have a strong SBCC/IEC program for promoting FP/RH. There is little advertising or broadcast media attention given to these topics.

The social and cultural contexts in which FP and other RH services are situated in Mozambique need to be considered in formulating new SBCC/IEC strategies. Pregnant unmarried young women lacking access to health services and options in life are most vulnerable and in need of care and support.

Women's reproductive rights emphasizing the promotion of women's autonomy for choosing the number and spacing of their children seems to have been somewhat neglected in current SBCC/IEC work.

The strategy for generating community FP demand in SCIP and ESD is dependent on volunteer community health workers who receive no compensation. This model may prove difficult to sustain without providing some form of incentives for them.

Demand generation needs to be better directed to the target populations. The MOH has identified youth, men, and PLWHA as target populations yet the same messages are being used for all groups. Birth spacing might be more applicable for women and families with preferences for large families. Men may be more interested in condom use, and the diagnosis and treatment of sexually transmitted diseases and HIV, while Information on nonhormonal methods may be more applicable for PLWHAs (who are sometimes reluctant to take other medications along with ARVs).

VIII. RECOMMENDATIONS FOR STRENGTHENING USAID PROGRAMMING IN SUPPORT OF THE NATIONAL FAMILY PLANNING AND CONTRACEPTION STRATEGY

ENABLING ENVIRONMENT

Short-term (2 Years or Less)

1. MOH leadership must guarantee effective oversight, regulation, and accountability for implementing the FP and Contraception Strategy, including systems to monitor and evaluate progress. In the immediate short-term, the FP TWG needs to collaborate in sharing its programmatic priorities with the working group that is drafting the 2012–2017 Health Sector Plan. Steps should be taken to ensure that FP issues are highlighted in dissemination of the 2011 DHS results.

2. Leaders within the MCH Department and at the political level (e.g., First Lady) need to be mobilized and directed to take action on the London Summit recommendations.

3. The FP TWG needs support to explore emerging opportunities, such as follow-up to the Child Survival Summit and the Partnership for Mother and Child Health (this was a specific GOM recommendation at the London Summit).

4. The MOH does not have enough current staff focused on FP at all levels to adequately fill their governing role. Building management support and systems for FP within the MOH is a clear priority that the GOM outlined in its London commitments. Direct technical assistance from international donors (e.g., donors providing seconded part-time or full-time staff) and their partners needs to be identified to meet specific gaps. For USAID, the roles and responsibilities of MCHIP, ESD and mission technical staff need to be clearly mapped out, and advocacy with other donors to support the efforts should be pursued.

5. The roles of and support to the FP TWG and the Contraceptives TWG to strengthen GOM FP governance efforts need to be clarified. The FP TWG should also be encouraged to include local civil society groups and representation from other ministries with related technical priorities, such as Women and Social Action, Youth and Sports, and the Population Directorate.[24]

6. FP must be viewed as a priority beyond the MCH department of the MOH. It needs to be closely linked to other health and development sectors. In the short term, support should be given via the FP TWG to explore options to collaborate with the GOM Population Division, e.g., on the annual Population Conference. The planned RAPID activity will also allow an opportunity for multisectoral coordination and agreement on a FP advocacy agenda.

[24] Two civil groups to consider are *Forum Mujer* and the IPPF affiliate in Mozambique, *Associacao Mocambicana par Desenvolvimento da Familia (AMODEFA*).

7. USAID should support the FP TWG in drawing up a plan of action for operationalizing the FP and Contraception Strategy at the provincial level. Provincial strategy development offers considerable opportunity to explore multisectoral planning and budgeting opportunities.

8. There is a need to involve civil society at the national, provincial and district levels in FP planning, budgeting, and monitoring, as well as advocacy. At the central level this includes the Mozambique IPPF affiliate, who attended the London FP Summit, and *Forum Muher.* At the provincial and district levels it certainly includes the community health committees. In the short term, USAID's new Civil Society Strengthening Program could be instrumental for promoting local civil society involvement in FP and RH.

9. Within the USG, it would be useful to identify opportunities to highlight FP priorities with other programming, such as the PMTCT and HIV Acceleration Plans, and PEPFAR gender programming. Internal communication systems should be organized to ensure that progress on FP programming is monitored across the USG portfolio, and to offer needed FP technical expertise.

10. Incorporating FP into broader USG support for building up provincial and district planning and budgeting offers an opportunity to ensure that FP programming priorities are highlighted. USAID should explore this. If it is not immediately feasible, it might be feasible to explore the possibility of enhancing FP provincial advocacy, planning, and budgeting in the longer term with new awards. This programming should also consider the role of the community health committees.

Longer-term (More than 2 years)

1. It will be important to support the MOH in operationalizing the FP/RH communication strategy to enhance the enabling environment for FP and further promote demand for services. This assistance should focus on communication efforts that specifically address youth, PLWHA, and men; and clearly articulate the roles and responsibilities of the GOM and various partners. Intensifying efforts with youth is a clear priority as outlined in the GOM London FP Summit recommendations. A multisectoral FP Strategy might be pursued with other ministries, such as Youth and Sports and Women and Social Action.

2. The operational plan for the FP and Contraception Strategy needs to incorporate opportunities for intersectoral linkages within the MOH and collaboration with other development and social sectors. Additionally, clear and direct advocacy messaging and materials linking health and development priorities are needed.

3. USAID should look into government-to-government funding arrangements to support the national FP portfolio, particularly if matched funding can be leveraged from the MOH.

4. Health financing systems must raise adequate funds to ensure that people, especially those in the lowest socioeconomic strata, can access affordable services. Budget support for FP commodities would be a clear indication of GOM commitment to FP. USAID should support the MOH to meet its 5%, 10%, and 15% financing commitments for FP commodities by 2015; such support could include technical assistance in procurement processes if the MOH deems this necessary.

SUPPLY OF FAMILY PLANNING SERVICES

Short-term (2 Years or Less)

1. A significant expansion of the FP program will require the MOH to increase the number of MCH nurses and make the requisite investments in pre-service and in-service training. One of the objectives of the national Family Planning and Contraception Strategy 2010–2015

(2020) is to improve the availability and quality of FP services. As part of that objective, a vital activity will be introduction of more long-acting and permanent methods, which are currently not a significant part of the program and which must be delivered by skilled personnel in hospitals and health centers. The effective implementation of this part of the FP strategy relies heavily on well-trained human resources at health facilities.

2. As part of the planning underway for the five-year Health Sector Strategic Plan, USAID should ensure that the MOH conducts a workforce planning analysis to meet projected demand for MCH nurses, particularly at Level I and Level II health facilities, and to provide any necessary technical assistance. As part of this analysis, USAID and MOH should identify a number of underserved districts in Nampula, Gaza, and Maputo provinces that will need extensive community outreach to improve FP use. Those districts should receive priority for recently graduated MCH nurses to ensure adequate clinic coverage, especially when mobile brigades are traveling to communities.

3. To improve the method mix, particularly IUD utilization, USAID should provide assistance to the MOH for IUD refresher training for MCH nurses.

4. MOH and USAID should consider expanding the MCHIP postpartum IUD insertion program in additional model maternity facilities.

5. The SCIP project should widely disseminate the results of its IUD study in Nampula and scale-up the program in districts that demonstrate interest and readiness. ESD should select several districts in Gaza and Maputo where the SCIP model could be replicated.

6. Implants are reportedly in high demand among women who are aware that they are available. USAID should help the MOH to cautiously scale up the implant program over the next two years. USAID projects should provide technical assistance to the MOH to draw up training guidelines for implant insertion, removal, and follow up.

7. The MOH should be commended for its efforts to increase community participation in the FP program, and particularly for increasing the number of *APE* CHWs. USAID should assist the MOH in modifying the FP guidelines for allowing *APEs* to provide an initial offering of pills and injectables. The USAID-funded ESD pilot for service delivery of injectables by community workers may offer an important opportunity to produce evidence for policy change. The methodology needs to be carefully designed, depending on whether the providers will be the *APEs,* community volunteers, or both. The study should also document global evidence on the topic for presentation to the MOH.

8. To increase the availability of contraceptives in local communities, ESD and SCIP should help the MOH to reinforce referral systems and increase the frequency and reach of mobile brigades since many women cannot access a health facility regularly. These projects should assist provincial and district health offices to conduct research to determine the actual (rather than theoretical) frequency of mobile brigades in Nampula, Gaza, and Maputo provinces. Project assistance should help the MOH to analyze the need for additional mobile brigades (fuel costs, personnel requirements, supplies, contraceptives, etc.). Project assistance should also identify district and community needs for transport to a health facility. Once needs have been clearly identified, performance-based budgeting could provide an excellent mechanism for increasing financial support to the Provincial Health Directorate for mobile brigades and for improving referral systems.

9. There are several small but significant improvements in which USAID could assist the MOH to make at the facility level. USAID should disseminate best practices information (available from USAID/W) and set up meetings with MOH officials to demonstrate the efficiencies gained by offering an initial three-month supply of pills to new FP acceptors. USAID projects

(ESD and SCIP) should also accelerate at once the printing of counseling materials that have already been developed by the MOH to ensure that MCH nurses and all CHWs have the materials they need to do their jobs effectively. This would include printing FP pamphlets, flip charts, multimethod brochures, and counseling checklists. ESD should help the MOH to review the efficacy of the MCH FP cards. A pregnancy and FP checklist should be added to the MCH cards to ensure that women are screened for pregnancy, and after delivery are provided with contraceptives.

10. Rumors, myths, and misinformation continue to affect knowledge and attitudes toward the IUD. ESD and SCIP should review training curricula for the project-supported community volunteers to ensure that IUD information is accurate and current. These projects should also develop post-training tests of community volunteers to ensure that they fully understand the benefits and risks of IUDs. ESD should increase supervision over community volunteers to ensure that correct information is being provided to families. Finally, its new Civil Society Strengthening Program would provide an opportunity for USAID to provide small grant assistance to local community-based organizations to conduct research on issues surrounding IUD demand.

11. USAID projects should review contraceptive supplies in district warehouses and ensure that buffer stocks are available. A buffer stock of three months is recommended for OCs and injectables and two months for IUDs at each warehouse. In addition, future quantities and budget levels for contraceptive commodities should be estimated to ensure that buffer stocks are available.

12. USAID projects (DELIVER, ESD, and SCIP) should immediately provide support to the MOH for pilot testing improvements in MOH commodity reporting forms. In particular, the monthly logistics data should include the two most important indicators, "stock on hand" and "consumption." Essential medicines should also be preprinted on requisition forms to save providers time.

13. Several changes could be made to USAID's integrated social marketing program to strengthen the role of the private sector in delivering contraceptives. The assessment team could not assess the needs or opportunities in depth, but make the following preliminary recommendations: (a) include OCs and implants in the integrated social marketing program; (b) increase the number of private franchise clinics that can provide OCs, injectables, and implants through financial support to DKT; and (c) increase the utilization of private clinics and assess their potential impact on the use of OCs, injectables, and implants by having *animatores* provide outreach within communities and, where feasible, make referrals to private clinics. USAID should consider commissioning a technical assessment or strategy to identify specific opportunities for strengthening private sector FP provision and for making project design (and re-design) recommendations. The strategy should define objectives, indicators, regional focus, and local implementation mechanisms.

Longer-term (More than 2 Years)

1. USAID should help the MOH to conduct a financial and technical needs assessment of pre-service and in-service MCH nurse training institutions in provinces that will receive USAID assistance. USAID should consider performance-based budgeting grant mechanisms to improve both pre-service and in-service training.

2. USAID should consider supporting development of a training program for surgeons and MCH nurses at district and rural hospitals so as to expand the availability, use, and quality of female permanent contraceptive methods.

3. USAID and MOH should examine the feasibility of adding responsibilities to the cadre of the basic nurse to include FP information and counseling. If feasible, assistance should be provided to build up pre-service and in-service training for this cadre.

4. USAID should help the MOH to mobilize additional resources for contraceptive procurement. USAID should consider drafting a sustainability plan so that it can phase out its budget support for contraceptives within five to ten years.

5. As part of an expanded private sector effort, USAID should assess opportunities for delivering FP services in Mozambique's rapidly expanding resource extraction industries. Expansion of FP to these industrial workplace settings may offer attractive new opportunities.

6. In its new strategy, USAID should consider supporting the MOH to add emergency contraception and the standard days method (SDM) as part of the mix of services delivered in youth-friendly service programs.

GENERATING DEMAND FOR FP SERVICES

Short-term (2 Years or Less)

1. Stronger SBCC/IEC efforts stressing the maternal and child health benefits of FP and safe delivery will be needed if Mozambique's FP efforts are to gain traction. Special attention needs to be given to youth, men, and PLHWAs in future demand generation efforts. FP messaging should be integrated with child survival and maternal health communication campaigns. Mobile technologies should also be explored as a way to increase FP demand.

2. The SCIP and ESD projects place considerable faith in the ability of volunteer community workers to mobilize local communities and generate FP demand. However, these cadres are not compensated for their efforts. It is unclear whether they will be motivated to do their jobs well or continue working as volunteers for very long without some form of compensation. USAID/Mozambique and representatives from the SCIP and ESD Projects will need to consider options for providing subsidies to CHWs (as PEPFAR is doing). The capacity of CHW volunteers to organize into associations could be strengthened so that they could submit proposals and possibly receive local funding from the 7 million *Meticaish* fund.

3. It is too early to pass judgment on the effectiveness of these community-based efforts to raise FP demand, but an honest appraisal of current deficiencies along with concerted steps to remedy problems could greatly enhance prospects for effective FP demand creation by strengthening community mobilization efforts.

4. Community health worker volunteers interviewed noted numerous needs to make their work routines easier. The most common requests were for a torch (flashlight) for moving about at night, sturdy boots to defend against cobra bites, name tags, umbrellas, and transportation vouchers to pay for travel between their assigned health center and their community coverage areas. Efforts should be made to better provide for these needs.

Longer-term (More than 2 Years)

1. Greater demand for FP services should also be generated by addressing social and cultural norms inhibiting FP use. A useful mechanism might be the new Civil Strengthening Program. Priority program areas should include
   - Delaying the age of marriage
   - Delaying the age at sexual debut and first birth
   - Encouraging higher educational attainment for females
   - Creating more employment and career opportunities for women
2. Additional efforts are needed to strengthen the reproductive rights of women so that they have more individual autonomy when engaging in sexual activity and initiating child-bearing. A rights-based approach to FP demand generation should emphasize women's ability to employ contraception before and within marriage, determine the timing and number of their offspring, and access high-quality obstetric services and emergency contraception in cases of sexual abuse and rape.

ANNEX A. FAMILY PLANNING ASSESSMENT SCOPE OF WORK

GLOBAL HEALTH TECHNICAL ASSISTANCE BRIDGE II PROJECT

Contract No. AID-OAA-C-12-00027

SCOPE OF WORK
AUGUST 16, 2012

I. **TITLE:** USAID/Mozambique: Assessment of USAID Support for Family Planning/Reproductive Health

II. **PERFORMANCE PERIOD:** To begin o/a August 30, 2012 and end o/a October 26, 2012

III. **FUNDING SOURCE:** Mission-funded through field support to GH Tech Bridge II

IV. **PURPOSE OF ASSIGNMENT:** To assess the current program and efforts to reposition the FP program as a priority on the national and local agendas. The team will meet with a variety of donors, implementers, and governmental officials, both at the national and local levels, to review the structure and operation of the national FP program and assess the overall performance of the USAID Mozambique FP/RH portfolio.

V. BACKGROUND

VI. SCOPE OF WORK

USAID/W has worked with the USAID/Mozambique Mission to identify a team of four persons, including representatives from various divisions of its Office of Population and Reproductive Health (PRH), to assess the current Mozambique program and efforts to reposition the FP/RH program as a priority on the national and local agendas. Two of the team members will be contracted by GH Tech Bridge II. The team will meet with a variety of donors, stakeholders, implementers, and governmental officials, both at the national and local levels, to review the structure and operation of the national FP program and assess the overall performance of the USAID Mozambique FP/RH portfolio. Field trips will be arranged to visit service facilities and provincial and district health officials and observe implementing partner activities. The following are some of the key issues that should be examined:

- National Program: What are the key components of the national family planning/reproductive health program, and which units of the GOM manage and coordinate them? What are the key gaps in the program and how should USAID address them?
- Implementing Partners: What are the elements of USAID's key Implementing Partner contributions to the national program and how are they performing? How are the partners coordinating their work? What components are successful and where can their performance be strengthened?

- Logistics: Examine the current situation on contraceptive logistics within the national drug distribution system and its impact on access to family planning services based on the recent Mozambique logistics management assessment by a GHB/PRH logistics specialist. Review that consultant's report and its conclusions and recommendations, and after further discussions with the Mission's logistics team and implementing partners, identify and summarize key gaps and challenges that characterize the logistics systems, and proposed recommendations to address them.

- Procurement: Since 2008 the Government of Mozambique has allocated funds for the purchase of contraceptives annually, but to date, these funds have not been spent and contraceptives are solely donor-funded (procured by USAID and UNFPA). Further, the amount allocated by the MOH is clearly not sufficient to respond the national FP policies. What can be done to ensure that contraceptives are actually procured and funded by "The GOM National Budget"?

- Expanding the method mix: What needs to be done to pave the way for Depo-Provera in uniject at the community level? What can be done to expand access to long-acting and permanent methods (LAPMs)?

- SBCC/IEC: What activities address social and cultural norms related to healthy timing and spacing of pregnancy, family size, contraceptive use: What type of formative research has been done/is needed; what SBCC activities are occurring/needed?

- Governance/Policy/Advocacy: How committed is the government to FP? Are population dynamics addressed in national development plans? What current efforts are taking place to put family planning back on the agenda? What policies exist that serve as facilitating factors or barriers to FP (e.g.: standards and guidelines for FP methods, service delivery modalities IEC/BCC/marketing of methods, etc.)?

- Human Resources: What types of providers are able to provide which contraceptives? How are human resources distributed, retained, and supported around the country? Are there any HR barriers that would limit expansion of FP services?

- Service Delivery: How diverse are the service delivery approaches to allow access to a range of methods at facilities, in the community, through outreach, etc.? What is the role and potential of the private sector providers, pharmacies, and social marketing? How are FP services integrated with other health programs, especially MCH, malaria, HIV, as well as with other sectors, such as economic growth, agriculture, environment, governance? What best practices are in effect, and what others could be useful to advance FP?

- Financing: What are the contributions of USAID, GOM, and other donors for FP, and in what areas (procurement, training, programs, etc.)? Is a cost recovery process in place, formally or informally (e.g., through informal payments to health providers)? What prices are charged to clients? How do these prices influence utilization of FP for method choice, discontinuation?

- Additional research needs: Are there additional research needs that the Mission should be conducting to strengthen our program, e.g., how best to strengthen community distribution networks, formative research on existing cultural barriers, etc., and operations research on why current methods are not being used (for example, LAPMs).

- Role of the private sector: What are the current status of provision FP in the private sector and recommendations to strengthen FP at this level?

Objectives. USAID/Mozambique is planning an assessment of its family planning and reproductive health (FP/RH) program. The objectives of this exercise are to:

1. Review the national demographic situation and trends and describe the current structure and functioning of the national FP/RH program that USAID currently supports;
2. Determine the extent to which USAID's FP/RH support program is achieving its planned results;
3. Broadly outline recommendations for refocusing and strengthening the national FP/RH strategy and program and building high level GOM commitment to it; and
4. Provide recommendations to guide the reshaping and strengthening of the USAID/Mozambique's strategy and support to the program over the next 5-7 years.

VII. METHODOLOGY

To achieve the assessment objectives, the assessment team, in collaboration with the USAID/Mozambique Mission, is expected to accomplish the following tasks:

- Shortly after GH Tech contracting is complete, conduct at least one conference call with the Office of PRH assessment team and the USAID/Mozambique Mission to review the assessment SOW and clarify expectations prior to departure for Maputo.
- Organize a two-day planning session in Washington to develop a work plan, clarify roles of team members, and discuss documents and other information available. USAID/W team members will participate as appropriate. Selected meetings or briefings with key informants in GHB may be arranged.
- The USAID/Mozambique Mission will send the appropriate background documents to the assessment team members as soon as they are confirmed to prepare for the assessment.
- The USAID/Mozambique Mission will identify key stakeholders and partners for the assessment team to interview.
- The USAID/Mozambique team will prepare a proposed schedule for the assessment team in-country activities.
- The assessment team will also conduct site visits to see key partner activities, meet government officials and service providers at all levels, and visit institutions and facilities such as logistics warehouses and outlets and service delivery points where various methods are provided (hospitals, health units, pharmacies, CBD agents, etc.).
- Following the first two weeks of in-country briefings, interviews, and field visits, the team will brief the Mission team, and later key stakeholders, on their findings and preliminary recommendations.
- The team will then spend the third week preparing a full draft report, to be reviewed by the Mission IHO team, who will provide comments before the team's departure.

- The final report will be completed by the GH Tech consultants in Washington during the last week of their assignment.

VIII. TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT (LOE)

The two team members to be contracted by GH Tech Bridge II are: (1) team leader and (2) demographer/data analyst/M&E specialist. In addition, a translator will be hired locally to assist the GH Tech team members.

1. The team leader will be responsible for
   - Overall planning and leading execution of the assessment;
   - Acting as spokesperson for the team and coordinating and integrating the roles/contributions of the other team members; and
   - Fulfillment of all deliverables, including coordinating the assessment process and schedule with IHO/Maputo, gaining review comments on the draft report from the Mission, and ensuring completion of the assessment report.
   - The team leader will also be responsible for hiring a translator in-country based on recommendations from the Maputo Mission and based on GH Tech arrangements.
2. Skills and experience required for the team leader:
   - A graduate degree in public health;
   - At least 15 years of experience in leading Family Planning/Reproductive Health programs in developing world settings and in planning/implementing assessments/evaluations;
   - Familiarity with USAID management of health programs, and its approaches to monitoring and evaluation;
   - Strong demonstrated leadership and teamwork skills in multiple settings;
   - Extensive experience in leading assessment or evaluation teams in developing country settings and in interacting with all levels of government and implementing partners; and
   - Strong organizational, verbal presentation, and writing skills.
3. The role of the demographer/data analyst/M&E specialist is to
   - Assemble, analyze, and integrate all available data/studies and service statistics to develop a key component of the assessment that describes the demographic/health situation, outlines the indicators that have been set for the FP/RH program and the results that have been achieved by the government and implementing partners;
   - From the data analysis, identify which factors appear to be key to improving program performance and results;
   - Assess the adequacy and quality of the data available to meet the requirements of the USAID/IHO results framework; and
   - Assist the team leader and other team members in drafting/editing the assessment report. Also assist in preparing team presentations.

NOTE: The 2011 DHS Preliminary Report for Mozambique is available, but the final report will not be available until Oct./Nov. 2012. However, access to data may be possible through direct contact with MACRO International.

4. Skills and experience required for the demographer/data analyst/M&E specialist:

   - A PhD in demography or epidemiology;
   - A strong record of demographic analysis, survey design, and data presentation;
   - At least fifteen years of experience in organizing and leading assessments and evaluations in developing world settings; and
   - Strong teamwork and organizational skills; excellent presentation and writing skills

A skilled translator will be hired by the Mission in Mozambique to assist the non-Portuguese-speaking team members in translating during government and partner discussions, meetings, and field visits during the two-week period of in-country meetings and field visits.

Other non-GH Tech Bridge-supported members of the assessment team:

In addition to the GH Tech contracted consultants, two USAID staff from the Global Health Bureau (GHB) will be part of the team for much of the preparatory and in country phases. These are:

Ms. Patty Alleman, from the Policy, Evaluation and Communication Division in the Office of Population and Reproductive Health (OPRH), is a senior technical advisor on health governance, particularly multi-sectoral government alignment, government/donor/ multilateral collaboration, policy development/implementation/monitoring, financing, and civil society participation.

Ms. Nandita Thatte, from the Service Delivery Improvement Division of OPRH, is working on family planning service delivery and program research. She focuses on FP/RH issues among youth, social and behavior change communications (SBCC), and health systems strengthening.

The two USAID staff will take part in the two days of team planning in Washington, currently scheduled for September 5-6, and will provide additional background information to the team leader and demographer and arrange for other meetings or briefings that may be suggested. Based on consultation with the team leader, the role and expected contribution of each will be outlined during the planning sessions and included in the assessment work plan. Both USAID staff will also travel to Mozambique for the field phase of the assessment, with travel funded by USAID/W and local hotel costs funded by the Mission.

During the in-country phase, two or three members from the Integrated Health Office will support the team as informants and facilitators in arranging meetings, discussions, and accompanying field travel as needed. The Mission will also assist the team members in making hotel reservations and arranging field travel.

In addition, Ms. Lilly Banda, an experienced FSN professional working in FP/RH with the USAID/Malawi Mission, will work with the team while in Mozambique to bring her wide Africa region experience and provide a neighboring country perspective.

It is anticipated that the dates of the Mozambique in-country field work will be September 10-29, 2012. The assessment team will conduct interviews, roundtables, and meetings with relevant government officials, donor organizations/international agencies, selected NGOs, implementing

partners, and program managers at province and district levels, as well as service providers, community health workers, and other key respondents identified during the planning meetings, to solicit their inputs.

As soon as the assessment team members are confirmed, key documents will be sent to them by IHO. Preparatory work (e.g., document reviews) should begin as early as possible. The final draft report should be submitted no later than October 12, 2012. The Mission will review this draft and either provide sign-off on this draft or send comments to consultants for further revisions. Once sign-off on the draft is received, GH Tech will professionally edit and format the final report and make it 508 compliant. The final report will be finished approximately 30 days after receiving USAID sign-off.

Level of Effort (LOE)

Activity	Team Leader	M&E Specialist	Period of Performance
Reviewing project documents, preparing for Team Planning Meeting (TPM) at home	3 days	3 days	8/30-9/4/2012
TPM, Washington DC	2 days	2 days	9/5-6/2012
Travel: Washington to Maputo	2 days	2 days	9/7-8/12
Work in Maputo and field visits, draft report	18 days	18 days	9/10-28/12
Travel: Maputo to Washington	2 days	2 days	9/29-30/2012
Complete 2nd draft of report at home	5 days	5 days	10/8-12/2012
Incorporating Mission comments into final report at home	2 days	2 days	10/22-23/2012
Total LOE	34 days	34 days	8/30-10/24/12

A six-day work week is approved while in-country.

IX. LOGISTICS

GH Tech will be responsible for all international travel and consultant logistics. GH Tech Bridge II should also make allowance in the contract for air travel in-country (locations will be identified when in-country schedule is complete) and car rental both in Maputo and during field visits as needed.

USAID/Maputo will prepare the in-country schedule and plan logistical arrangements for meetings and travel in-country.

X. DELIVERABLES AND PRODUCTS

- During planning days prior to departure for Mozambique, and on arriving in country, the team will finalize a work plan outlining each member's role and responsibilities, and share with the IHO team for review.
- Participate in Mission in-briefings, arrive at mutual clarification of expectations. Develop draft outline of assessment report for discussion with IHO team.

- At the end of the team's first two weeks in country following initial interviews, field visits and meetings, the assessment team will brief IHO/Mission on preliminary observations and identify key issues/questions, and elicit IHO team inputs.
- During the third week in country, the assessment team will draft the assessment report and deliver it to USAID/Mozambique, with an oral briefing, two days before the team's departure. Within one day, and before the team's departure, USAID Mozambique will provide comments to the assessment team to be addressed in the final draft document.
- Provide a Mission debrief and later a general debriefing for the MOH and stakeholders on September 27.
- After returning to Washington (Oct 8-12), the team leader and demographer/data analyst/M&E specialist will complete the second draft assessment report which incorporates feedback from USAID Mozambique, by October 12.
- If the Mission requests further edits, the consultants will incorporate Mission comments into a third draft and submit it by October 24.
- GH Tech Bridge will provide the edited and formatted final document after USAID provides final approval of the content. The report will then be released as a public document on the USAID Development Experience Clearinghouse (DEC) (http://dec.usaid.gov) and the GH Tech project web site (www.ghtechproject.com). The contractor shall submit two hard copies and one electronic copy of the final report to the USAID/Mozambique.

XI. RELATIONSHIPS AND RESPONSIBILITIES

GH Tech will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team.
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.

USAID/Mozambique will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before In-Country Work

- SOW. Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Tech, preferably in electronic form, at least one week prior to the inception of the assignment.

- Local Consultants. Assist with identification of potential local consultants (translators), including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line item costs.
- Lodging and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and if necessary, identify a person to assist with logistics (i.e., visa letters of invitation, etc.).

During In-Country Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the evaluation team to key stakeholders, government and non-governmental implementing partners, and, where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.
- In addition to the GH Tech team leader and demographer/analyst/M&E specialist, the USAID/Mozambique will support
  - Two technical staff from the Global Health Bureau (GHB);
  - One technical specialist from a neighboring USAID Mission; and
  - Two or three members from the Maputo Integrated Health Office to support the team in-country as informants and facilitators in arranging/participating in meetings, discussions, and accompanying field travel.

After In-Country Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XII. MISSION CONTACT PERSON

POC Alyssa Leggoe
IHO Director

Ana Bodipo-Memba
IHO Program and Management Operations Division Chief

Until September 20, 2012:
John Rogosch
Acting IHO Deputy Director

XIII. COST ESTIMATE

GH Tech will provide a cost estimate for this activity.

ANNEX B. KEY DOCUMENTS REVIEWED BY FP ASSESSMENT TEAM

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ANNEX C. FAMILY PLANNING ASSESSMENT INTERVIEW GUIDES

INTERVIEW GUIDE NO. 1: GENERAL AND OVERVIEW QUESTIONS

Current FP/RH Landscape:

1. What are the current Government of Mozambique priorities for FP?
    a. What about linkages to broader RH, for example, maternal health?
    b. Are there committees, working groups, or other mechanisms?
    c. What are laws, policies, and/or guidelines outlining the priorities?
    d. Are there current health committees in parliament?
    e. What is the government financial allocation and expenditure in FP/RH?
2. Who are the principal partners in providing FP/RH services?
    a. Can you please describe the public health FP/RH service delivery system?
    b. Are there any NGO and/or other private sector involvement in providing FP/RH services?
    c. Are there any NGO and/or other private sector involvement in supporting demand for FP/RH? E.g., women's groups, religious groups.
3. What are the principal challenges in improving the quality of FP/RH services in Mozambique?
4. What are the current gaps in the health system to providing a mix of FP/RH services?
    a. Financing
    b. Supplies
    c. Referral structures
    d. Accessibility of services in terms of coverage service provision
    e. Challenges with decentralization
    f. Human resource cadres, clinical and/or community
    g. Mix of service providers, e.g., private sector
5. Do you think there is demand for FP/RH that is not being met, or is there a still a majority preference for large family size?
    a. Is this different by urban or rural residence?
    b. Religion, other socioeconomic, or other factors?
    c. Are there any SBCC efforts?
6. Who are the donors supporting FP/RH?
    a. How much is invested, and for what programming priorities?
    b. How are these programming priorities in line with the GOM priorities for FP/RH?
    c. Is there a donor coordinating mechanism? Is USG/USAID represented?

d. Is there a specific donor health consortium? Is USG/USAID represented?

7. What are the current opportunities to build upon with FP/RH? Any new commitments to FP/RH? London Summit, etc.?

   a. What is USAID's competitive advantage in FP/RH programming?

   b. What gaps can USAID programs fill?

INTERVIEW GUIDE NO. 2: ESSENTIAL QUESTIONS TO ASK IN THE FIELD

National Policy and Strategy for FP/RH

- Is there a policy for cost recovery for FP?
- Ask provincial directors if they are advocating for any specific policy changes with central level MOH.
- Where is policy advocacy for FP most needed?

Provincial Level (ask Provincial Health Director)

- Where is MCH program structurally located in the Provincial Health Office?
- What office/who is primarily responsible for managing the priorities for FP within the provincial office? How many staff positions allocated for FP management at the provincial level? Percent positions vacant?
- How many staff positions allocated for FP service delivery? Percent vacant?
- Given all of the health problems in your province, do you think FP is a high, medium, or low priority?

District Level

- Where is MCH program structurally located in the District Health Office?
- How many staff for FP management at the district level? For FP service delivery?
- 1,400 facilities: number of positions allocated for MCH nurses? Percent funded? Percent vacant?
- In Nampula province: same as above

National health infrastructure

- What is total number of facilities that exist at each level of the system?

MOH Budget for FP

- MOH has only seven budget line items – what are they?
- How do you track the funding allocated for FP since the budget is not allocated by program?
- Do you think FP is adequately funded? If not, how do you advocate for additional funding? What are the more serious needs?

Policy Implementation (ask at Central, Provincial, and District levels)

- Do you have an implementation plan for implementing the FP RH policy at each level: Central? Provincial? District?
- What are the most serious obstacles to the implementation of the MOH FP/RH policy in your province? District?
- Coordination: areas of strengths and weaknesses for coordination among various levels: Central to province? Province to district? District to facilities? Do you have any suggestions for improving coordination mechanisms between central, provincial, district, etc.?
- Ask provincial directors if there are any policy changes that should be advocated more strongly with the central MOH leadership.
- Ask district health directors if there are any specific policy changes that should be advocated with provincial health leadership.

Logistics and supply

- What are the most serious issues facing contraceptive supply and delivery at provincial level? At district level? At facility level?
- Ask whether there have been any stock-outs. If so, for what methods? Are health facilities rationing to clients?
- For provincial directors: would you support the idea of a donor-funded regional adviser (would handle several provinces) to improve the management and distribution of contraceptives to lower levels?

Service Delivery

- Data on increased use of facilities for deliveries?
- Data on increase in new FP acceptors?

Private Sector

- What is the plan for introducing OCs in the private sector?
- Should the private sector play a larger role in FP/RH? If so, how?
- Role of pharmacists?
- Where is advocacy most needed (within MOH? outside of MOH?)

Community-Based Distribution

- SCIP has two models; check if there is a diagram; how is effectiveness evaluated?
- Are any voluntary community-based organizations actually functioning as community associations? Are there any local funds which could be made available to them?
- What is your budget for the recurrent costs for the MOH-funded portion of the CBD program?
- Does MOH have any plans for subsidizing the volunteer CBD workers (APH, CLs, etc)?

- How is MOH ensuring the sustainability of the volunteer CBD workers?
- How does MOH reward/acknowledge the contributions of the volunteer CBD workers?

Role of NGOs (international and local)

- Is there a role for NGOs to play in helping to increase support for FP and improve service delivery of contraceptives? If so, where is it most critical?
- What role do the NGOs play in your province?
- Same for district?
- In what areas have NGOs been most successful?
- How could NGO participation as partners in FP/RH be strengthened?

Service providers at facilities

- Who provides FP/RH services at this facility?
- What methods do you offer to clients?
- What has been working well?
- What are your most serious challenges?
- Please "walk us through" the process for a new client? A returning client? Does the client have to go to different offices for different services?
- Do you ever conduct "client satisfaction" surveys?
- May we see your FP register book?
- Who/how does counseling work in this facility?
- What IEC and materials do you have?
- Are you working to increase knowledge, attitudes, and practices for the use of injectables? IUDs? If so, how?
- Do you think any policy changes are needed for facility-based service delivery of various methods: OCs? Injectables? IUDs? Others?
- Do you think policy changes are needed to strengthen CBD for various methods: OCs, injectables, IUDs, implants?
- Have you heard of implants? Would you like to be trained to provide services for this method?

ANNEX D. INDIVIDUALS, ORGANIZATIONS AND SITES VISITED

INDIVIDUALS, ORGANIZATIONS, AND SITES VISITED

US Agency for International Development

USAID/Washington

Regina Parham, Senior Country Advisor Rwanda and Mozambique, Bureau for Global Health

Coite Manuel, Senior Supply Chain Advisor, Bureau for Global Health

USAID/Mozambique

Polly Dunford Zahar, Acting Mission Director

Alyssa Leggoe, Health, Population and Nutrition Officer and Director, Integrated Health Office (IHO)

Ana Bodipo-Memba, Chief, Management Operations Division, IHO

John Rogosch, Senior Health Advisor, Interim Deputy Director, IHO (through Sept. 21, 2012)

Odete Paunde, Health, Population and Nutrition Activity Manager, IHO

Lilia Jamisse, MD, Maternal, Neonatal, Child Health, Reproductive Health, PMTCT, Nutrition Division Leader, IHO

Sereen Thaddeus, Health Promotion Team Leader, IHO

Conceicao Rodrigues, Clinical Outreach Specialist, IHO

Benedito Chauque, Commodities Activity Manager, IHO

Armenio Silva, Project Management Specialist (Logistics), IHO

Susan Mathew, Development Leadership Initiative, Junior Health, Population and Nutrition Officer, IHO

Sarah Rose, Community Monitoring and Evaluation Specialist, IHO

Karin Turner, Senior Advisor for Health Systems Strengthening, IHO

Mary Ellen Duke, Gender Advisor

Kevin Pilz, Health Commodities Advisor, Directorate of Planning and Cooperation and Central Medical Store (MOH)

Elias Cuambe, Health Sector Specialist, IHO

Verónica Pinto, Administrative Assistant, IHO

Celina Cumbi, Administrative Assistant, IHO

Madalena Morais, Travel Specialist, EXO

Other US Government Agencies

U.S. Centers for Disease Control and Prevention

Dr. Edgar Monterosso, Country Director

Judite Langa, PMTCT Lead

Neli Honwana, Counseling and Testing Adviser

Paula Simbine, Prevention Team

PEPFAR

Shawn Wesner, Deputy PEPFAR Coordinator

Government of Mozambique, Ministry of Health

Ministry of Health (Central Level)

Lidia Chongo, MD, MPH, Public Health National Director

Aida Theodomira Libombo, Maternal Child Health Adviser

Nazir Amade, Maternal Child Health Reproductive Health Officer

Olga Sigaúque, Family Planning Reproductive Health Officer

Ministry of Health, Nampula Province:

Dr. Mahomed Riaz, Provincial Health Director

Dr. Jocelina Calavet, Planning and Cooperation Office, Provincial Health Directorate

Maria Isabel Verol, MCH Nurse for Nampula Province

Joselina de Sousa, Nurse, Health Facility First of May, City of Nampula

Community health volunteers affiliated with First of May health facility catchment areas

Pedro Mazembe, District Health Director, Mogovolas District

Jacinto Carlos, Chief Administrative Post, Muatua Sub-District

Community leaders and volunteers affiliated with Muatua Sub-District

Janete Antonio Chau, District Health Director, Monapo

Nurse, Health Facility, Mecuco

Community volunteers in Mecuco

Water access point in Netia Sub-District

Fernando Mucuaria, District Health Director, Ribaue

Ministry of Health, Gaza Province:

Isaias Ramiro Manuel, Provincial Health Director (Xai Xai)

Bertur Alface, Provincial Medical Chief

Moises Malo, District Health director, Chibuto District

Community health committee and community volunteers affiliated with Chaimite health facility

Eduardo Mondlane, Director, Pre-service Teachers Training Institute, Gaza

Peer educators from Pre-Service Teachers Training Institute

Ana Quimasse, Health Director, City of Xai-Xai

Gerónimo Mário Tembe, Chief Nurse for Youth Friendly Services, Xai Xai Health Center

Model maternity ward, Xai Xai Provincial Hospital

Luís Nhaia, District Health Director, Chokwé

Fernando Saide, District Health Director, Chonguene

Ines Nhacuavane and Elsa Dazdoris, MCH nurses, Chonguene District Health Center

Ministry of Health, Maputo Province:

Dr. Cremilde Alice Muambe Anly, Provincial Health Director

Filipe Adage, Planning and Cooperation Department

Carla Somata Cumbe, District Chief Medical Officer, Matola District

Belarmina, MCH nurse, Matola II City health facility and maternity

MCH nurse, Health Facility, Congolote subdistrict

Community volunteers, Congolote subdistrict

USAID/Mozambique Implementing Partners

DELIVER

Tim Rosche, Country Director, Deliver and SCMS

Arturo Sanabria, Field Distribution Team Leader

Barry Scavitz, Deputy Director, SCMS

Emerson Ribeiro, Contraceptives Logistic Associate

JHPIEGO—Maternal and Child Health Integrated Program

Maria da Luz Vaz, Acting Chief of Party

Kathryn Boryc Smock, Senior Program Manager

Isabel Ana Nhatave, Quality Improvement Team Leader

Mario Samucindine, Reproductive Health Advisor

Ernestine Castelo David, Maternal Child Health Area Coordinator

Pathfinder International—Strengthening Communities through Integrated Programming (Nampula)

Luc Van der Veken, Chief of Party

Mady Diallo, Director, Integrated Services

Sofia Bandomia, BCC Manager

Alicia Mehl, Monitoring & Evaluation Specialist

Abdul Rachid, SCIP District Coordinator

Erenesto Malendzela, SCIP District Coordinator

Pathfinder International—Family Planning Initiative, Expanding Service Delivery

Carolien Albers, Chief of Party

Jorge Matine, Provincial Coordinator, Maputo

Ivone Pascoal, Provincial Coordinator, Gaza

Catia Amade, Provincial Family Planning Officer, Gaza

Nina Yenso, Youth Coordinator, Maputo Province

Albertina Edilia, Family Planning Officer, Maputo Province

Marcus Benedeti, Technical Adviser

Baltazar Chilundo, Monitoring & Evaluation Specialist

Julie Shumaker, Intern

Population Services International—Integrated Health Social Marketing Program

Sohail Agha, Chief of Party

Julian Circo, Country Representative

Benoit Renard, Marketing Director

International Donor Organizations

Canadian International Development Agency

Morag Humble, Health Cooperant, Canadian Cooperation Office

Jeea Saraswati, Team Lead for Health

United Kingdom Department for International Development

Etelvina Mahenjane, Health Advisor

United Nations Population Fund

Amir Modan, Reproductive Health Program Officer

Helen Christensen, Senior Reproductive Health Program Analyst

World Bank

Laura Rose, Senior Lead and Senior Health Economist, Human Development Department, Africa Region

World Health Organization

Alicia Carbonell, Sexual Reproductive Health and Maternal Program Officer

Private Sector Organizations

DKT Mozambique (in Matola)

Jeff Seed, General Manager and Country Director

Local Nongovernmental and Community Organizations

Kutenga Youth Association

Alberto Massaye, Youth Coordinator, Kongolate

Ntwanano Community Based Organization, Gaza

Other

Official Translator

Antonio de Carvalho

ANNEX E. DEMOGRAPHIC AND FAMILY PLANNING PERFORMANCE MEASURES, MOZAMBIQUE AND SELECTED NEIGHBORING COUNTRIES (DHS RESULTS AND UNITED NATIONS POPULATION DIVISION ESTIMATES)

Table E-1: Summary Demographic Estimates for Mozambique and Neighboring Countries (United Nations Population Division)

Country	Total Population (Millions) (Mid-2012)	CBR	CDR	RNI
Mozambique	24.4	39	15	24
Madagascar	21.9	36	7	29
Malawi	15.9	44	14	30
Tanzania	47.8	42	12	30
Zambia	13.9	45	17	28
Zimbabwe	13.1	29	15	14

CBR: Crude Birth Rate – Number of annual live births/Total population
CDR: Crude Death Rate – Number of annual deaths/Total population
RNI: Rate of Natural Increase – CBR – CDR = RNI

Figure E-1: Total Fertility Rate (TFR), Mozambique and Selected Neighboring Countries, 2006-2012 (DHS Results)

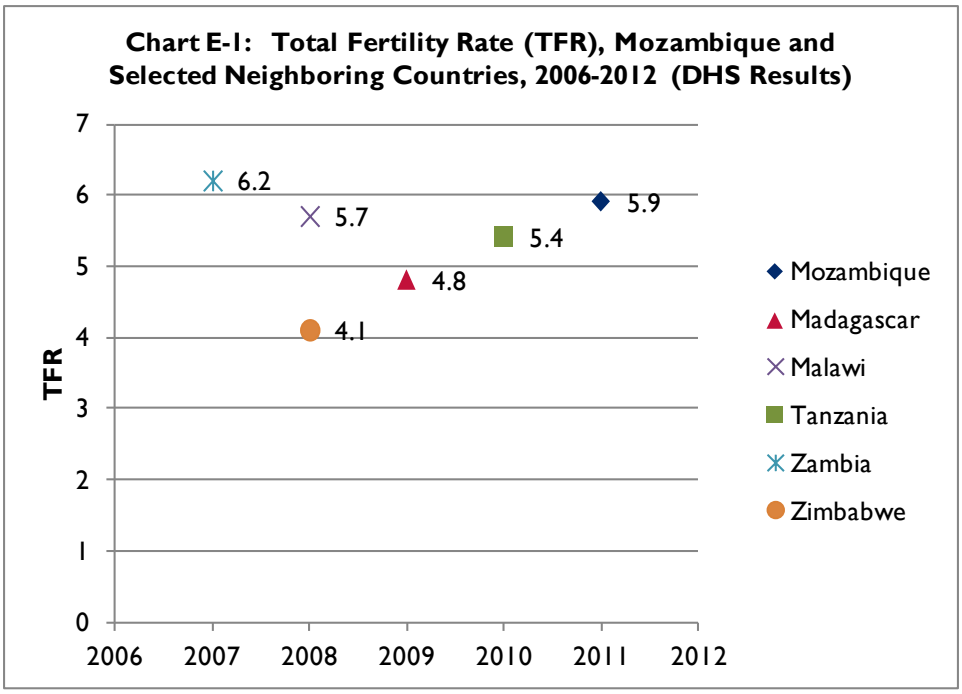


Figure E-2: Percentage of All Births Occurring to Women Aged 15-19, Mozambique and Selected Neighboring Countries, 2005-2010, (United Nations Population Division)

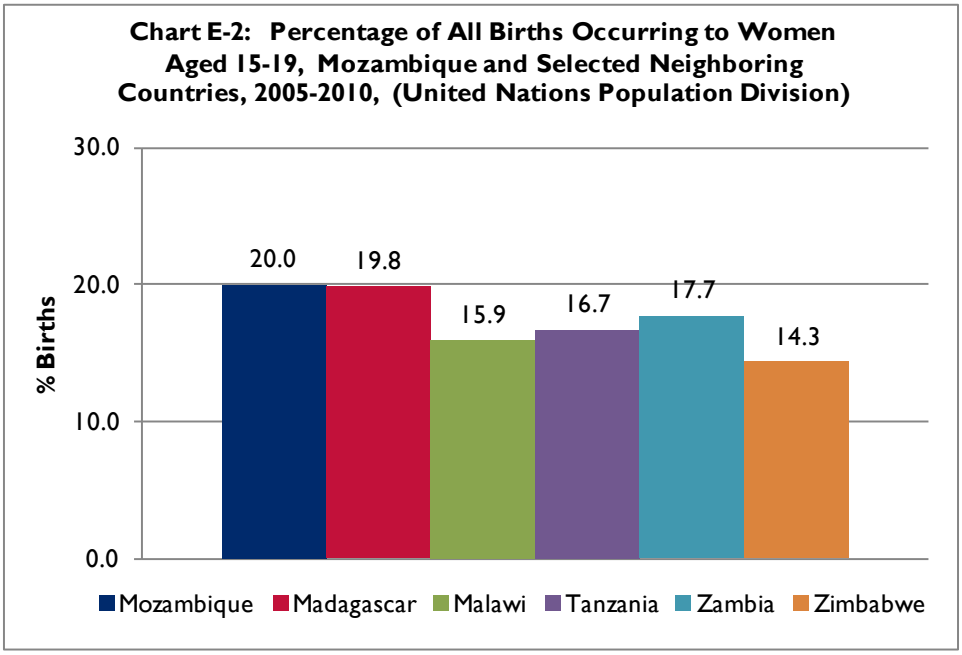


Figure E-3: Infant Mortality Rate (IMR), Mozambique and Selected Neighboring Countries, 2006-2012 (DHS Results)

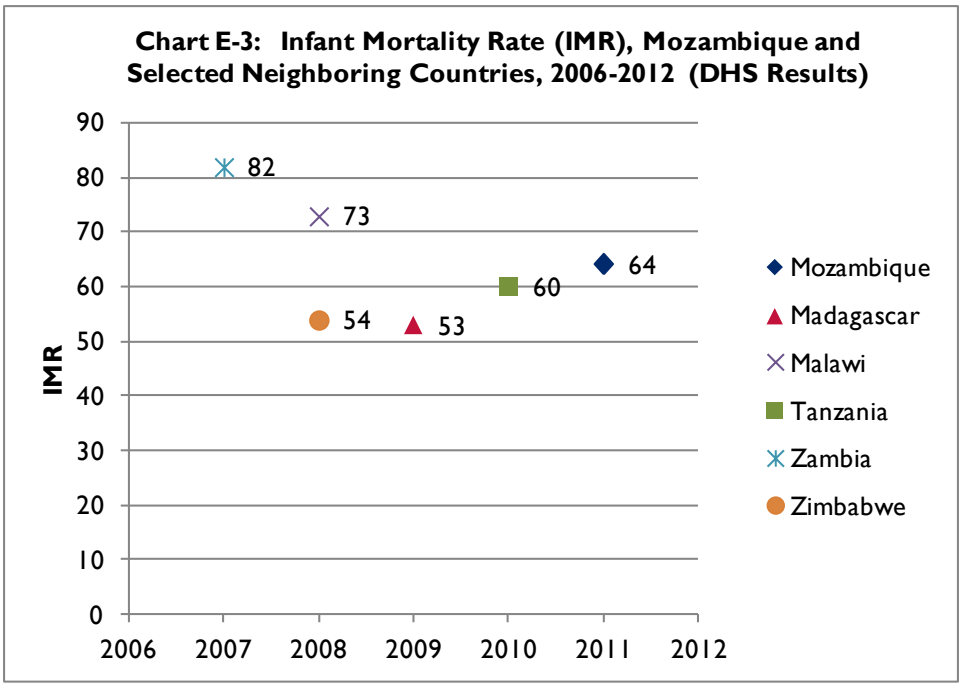


Figure E-4: Percentage of Currently Married Women Aged 15-49 Using Any FP Method, Mozambique and Selected Neighboring Countries, 2006-2012 (DHS Results)

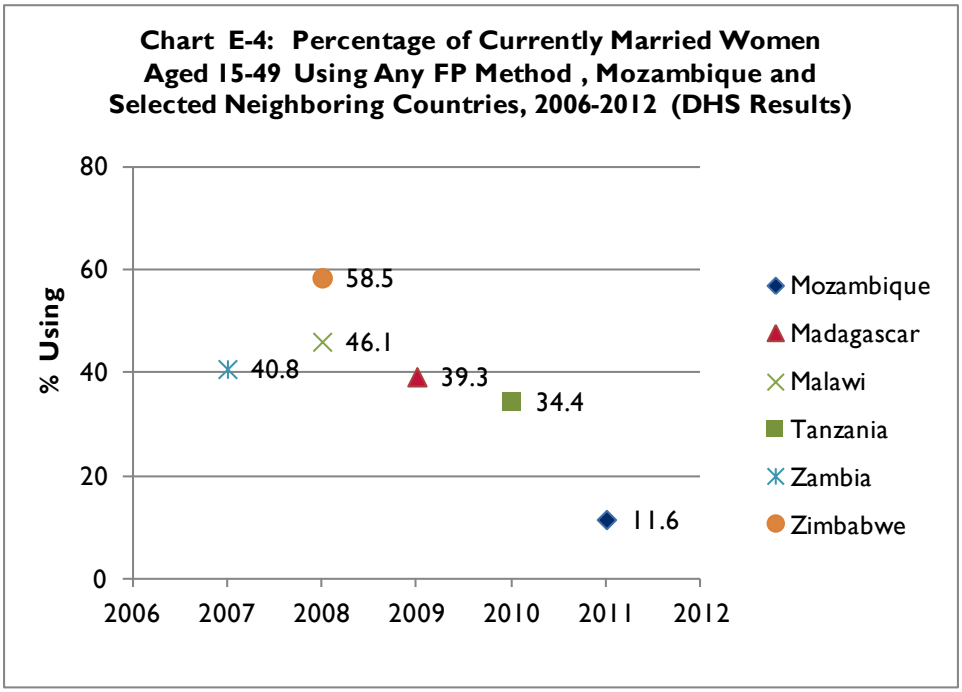


Figure E-5: Percentage of Currently Married Women Aged 15-49 Using Any Modern FP Method, Mozambique and Selected Neighboring Countries, 2006-2012 (DHS Results)

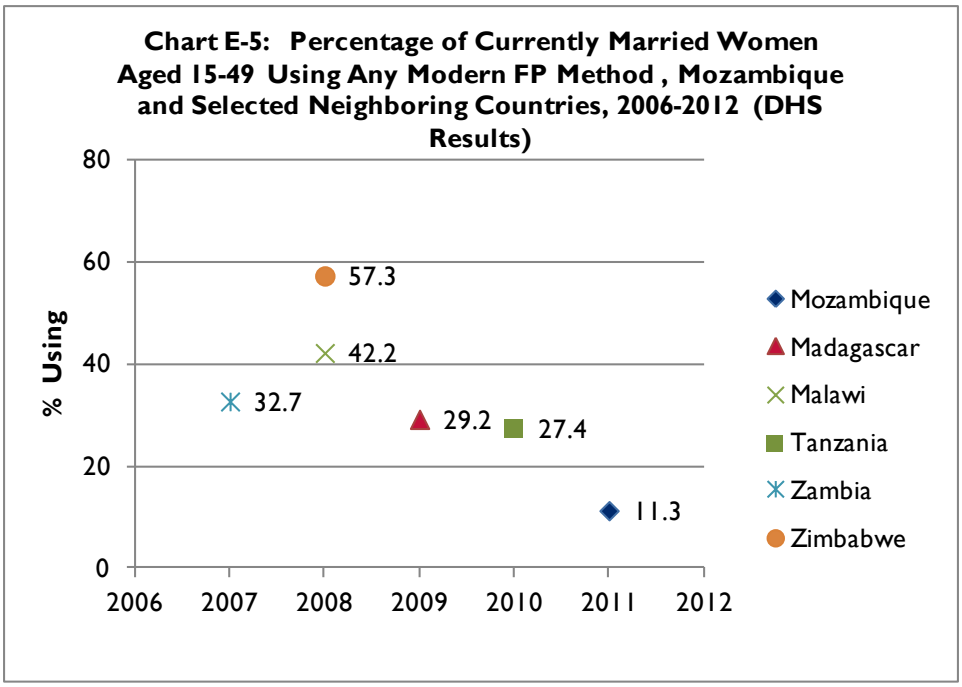


Figure E-6: Percentage of Currently Married Women Aged 15-49 with Unmet Need for Family Planning, Mozambique and Selected Neighboring Countries, 2006-2012 (DHS Results)

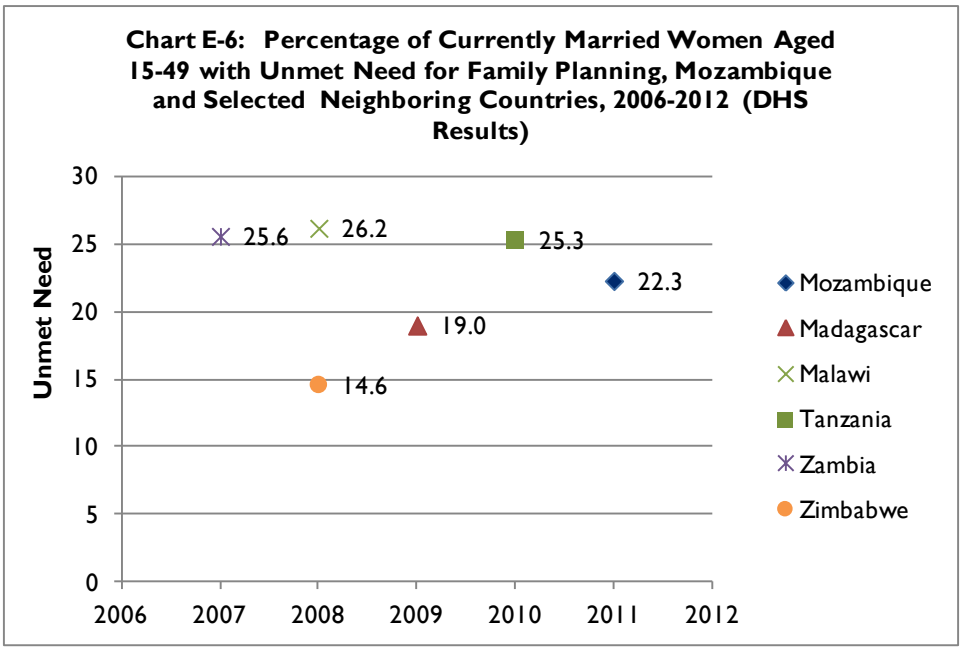


Figure E-7: Trends in the Mozambique TFR, 1997-2011, National, Urban, and Rural (DHS Results)

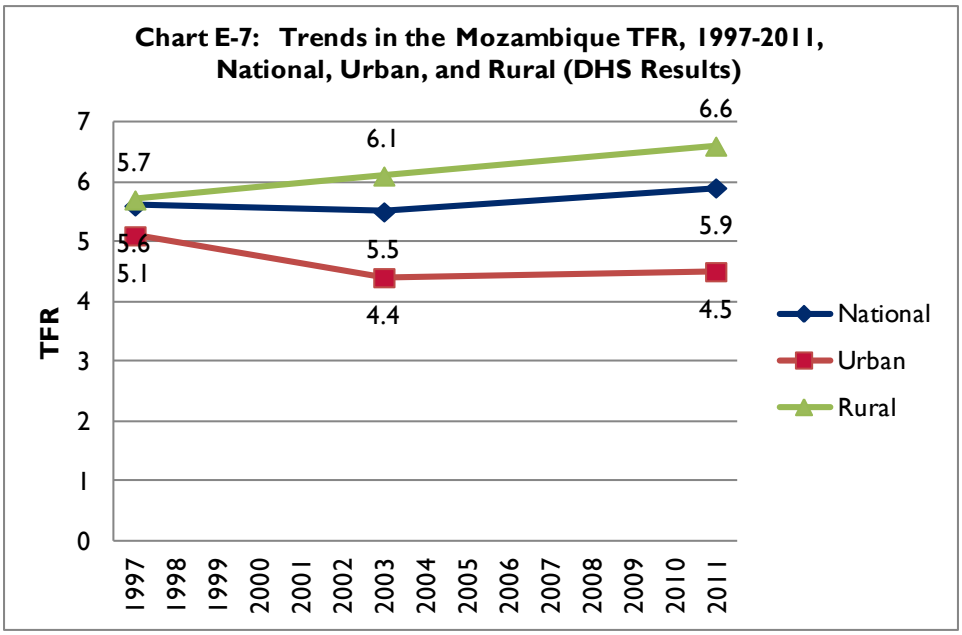


Figure E-8: Trends in the Mozambique IMR, 1997-2011, National (DHS Results)

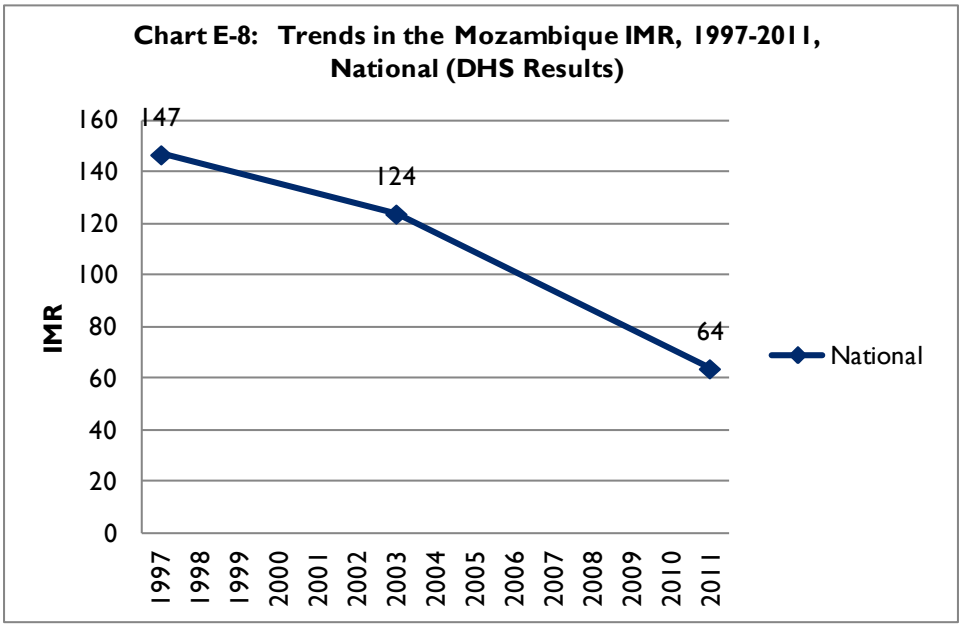


Figure E-9: Trends in the Mozambique CPR for Women Aged 15-49, 1997-2011, National, Urban, and Rural (DHS Results)

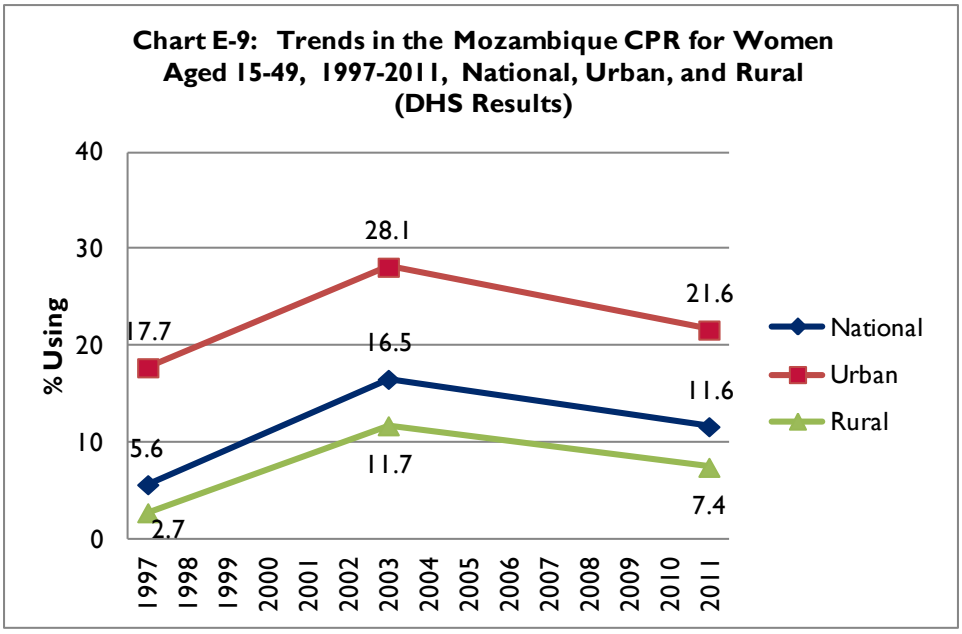


Figure E-10: Trends in the Mozambique CPR, Currently Married and Sexually Active Unmarried Women, Aged 15-49, 1997-2011, (DHS Results)

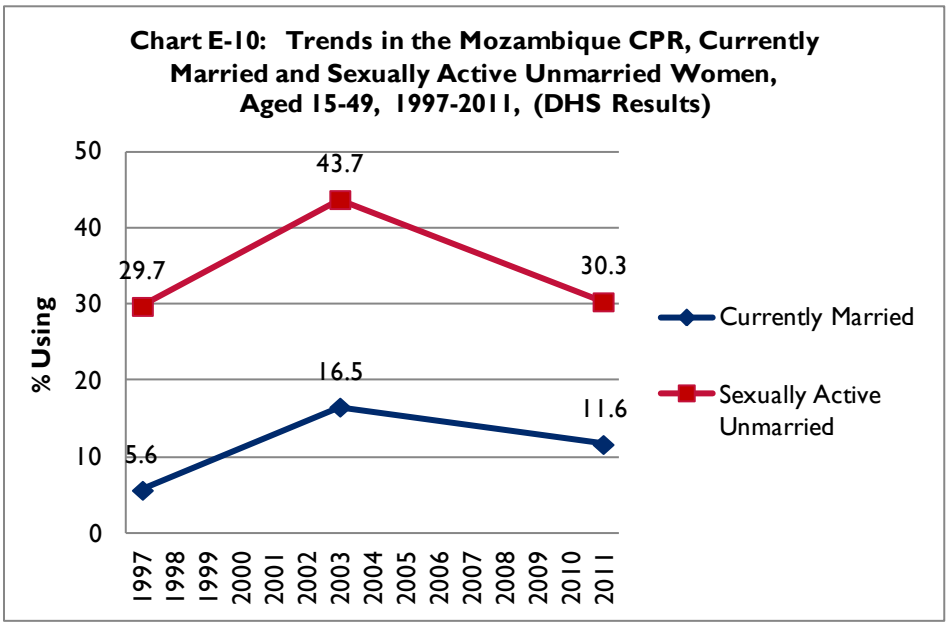


Figure E-11: Trends in the Mozambique CPR, Currently Married and Sexually Active Unmarried Women, Aged 15-19, 1997-2011, (DHS Results)

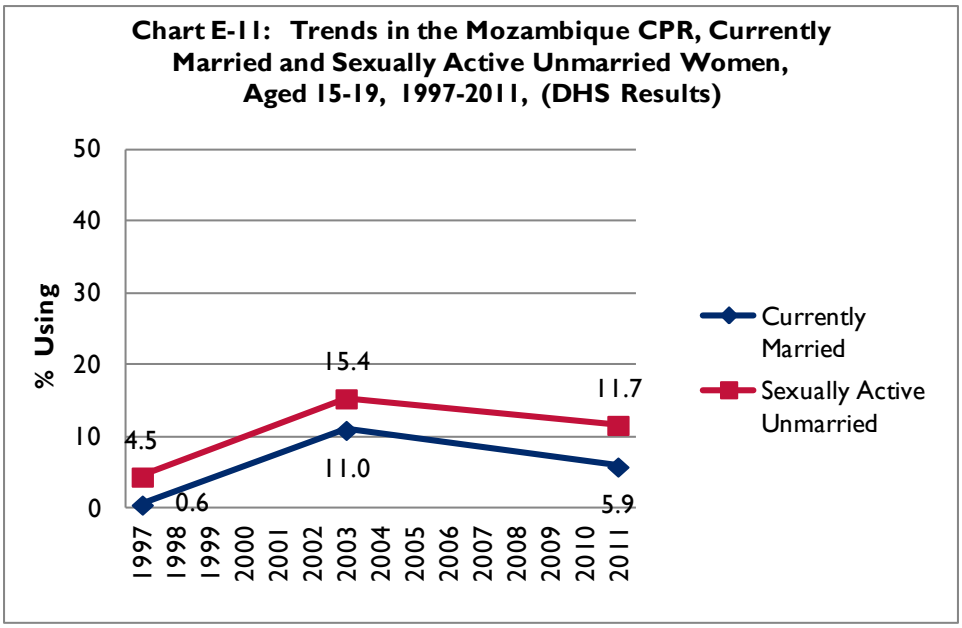


Figure E-12: Percentage of Currently Married Women Aged 15-49 Using Individual Methods, 2011, N= 9,332 (DHS Results)

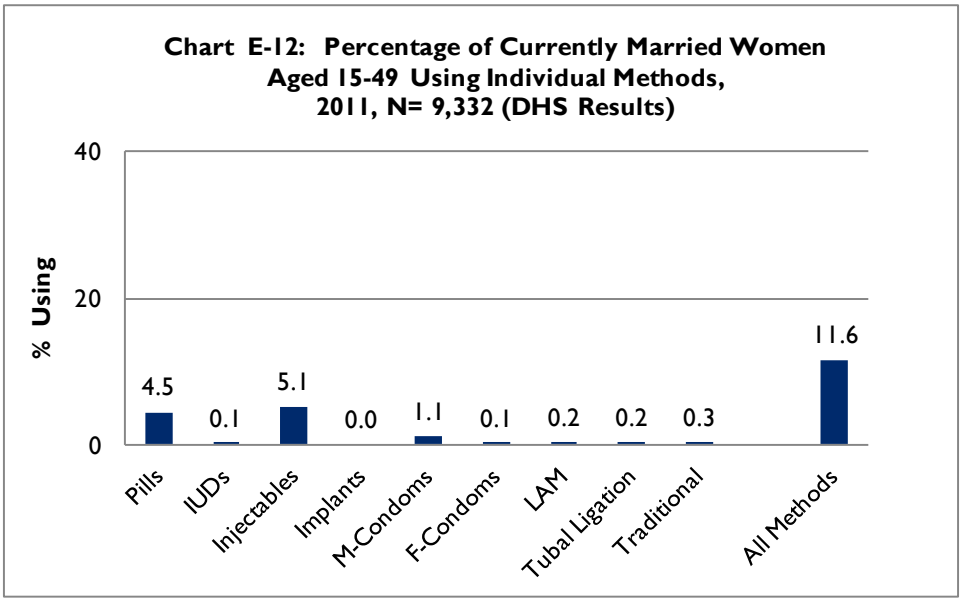


Figure E-13: Percentage of Sexually Active Unmarried Women Aged 15-49 Using Individual Methods, 2011, N = 1,150 (DHS Results)

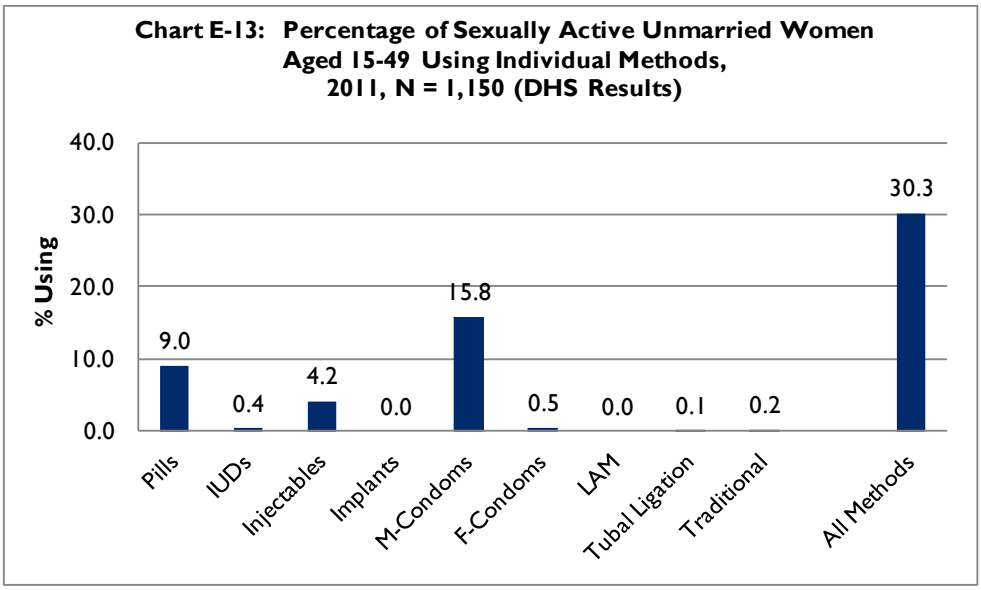


Figure E-14: Percentage of Current Users Aged 15-49 obtaining FP Supplies from the Public Sector, 2006-2012 (DHS Results)

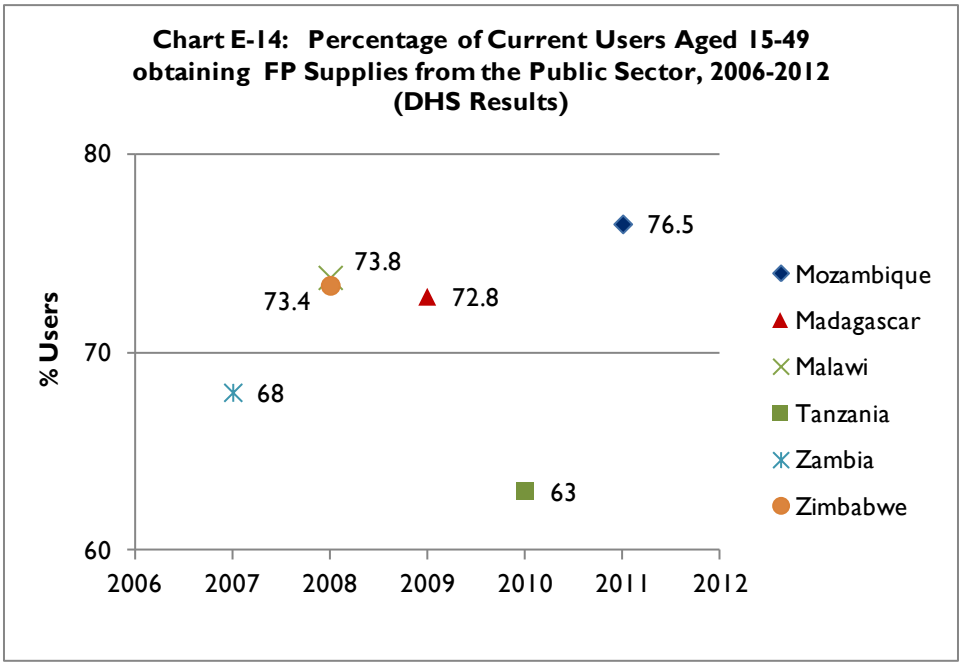
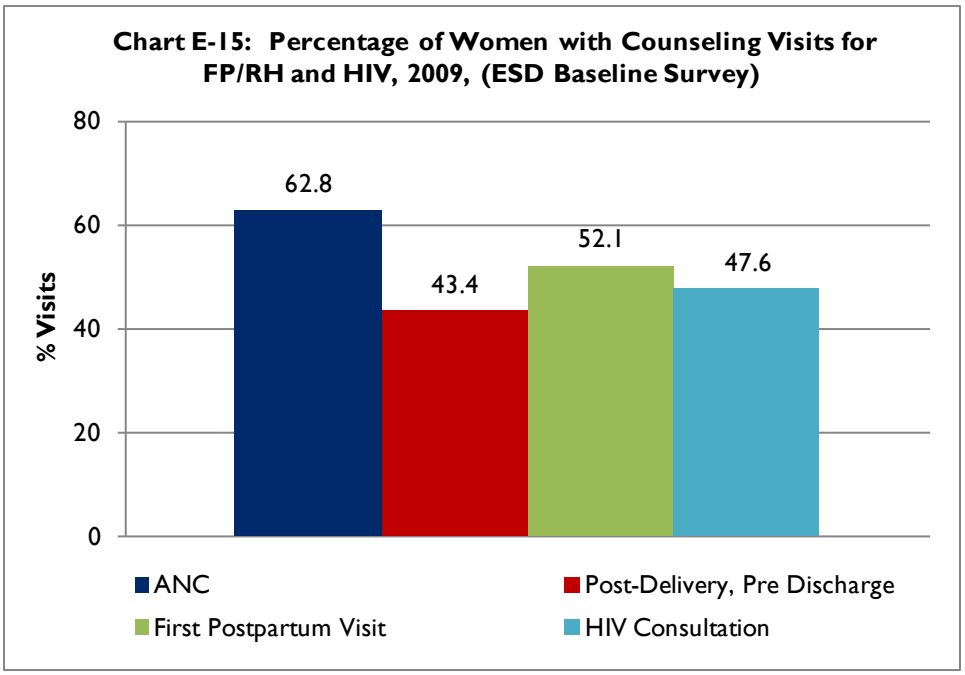


Figure E-15: Percentage of Women with Counseling Visits for FP/RH and HIV, 2009, (ESD Baseline Survey)



For more information, please visit
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