IFPP - Integrated Family Planning Program

Agreement No.

FY2016/2017 1st Year of the Project

2nd Quarter Report: January to March 2017

Date of Submission: April 30th, 2017

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Acronym list

Acronym	Description
APE	*Agente Polivalente Elementar – MOH approved Community Health Worker*
CBOs	Community based organizations
CDCS	Country Development Coordination Strategy
CF	Community Facilitator
CDFMP	Cenário de Despesas Fiscal de Médio Prazo (Midterm Fiscal Review)
CHW	Community Health Worker (including APEs, PTs, other health activists such as IPC Agents, …)
CR	Community Radio
CL	Community Leader
DDM	Depósito Distrital de Medicamentos (District Medications Depot)
DEPO	Depo-Provera
DP	District profile
DPM	Depósito Provincial de Medicamentos (Provincial Medications Depot)
DPS	Provincial Health Directorate
EMMP	Environmental mitigation and monitoring plan
FP/RH	Family planning/reproductive health
FS	Field Supervisors
FTP	First Time Pregnant
GIS	Geographical Information System
GRM	Government of the Republic of Mozambique
HCW	Health Care Worker
HF	Health Facility
HMIS	Management Information System
HP	Health Provider
HR	Human Resources
HRIS	Human Resources Information System
HSS	Health Systems Strengthening
HTSP	Health Timing Spacing Pregnancy
IEE	Initial Environmental Examination
IFPP	Integrated Family Planning Program
IMASIDA	National Malaria and HIV Indicator Survey
IPC	Interpersonal Communication Agents
IT	Information Technology
LARC	Long Acting Reversible Contraceptive
LOE	Level of Effort
MB	Mobile Brigade
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
MCSP	Mother and Child Survival Program
MISAU	Mozambican Ministry of Health
MOU	Memorandum of Understanding
MSC	Management Standards Compliance
NED	District Statistical Nucleus
NGOs	Non-governmental Organizations
OC	Oral Contraceptives
OVC	Orphans and Vulnerable Children
PDSA	Plan, Do, Study, Act
PES	Social and Economic Plan
PESOD	District Operational Social and Economic Plan
PSI	Population Services International

TA	Technical Assistance
TBA / "PT"	Traditional Birth Attendant / "Parteira Tradicional"
QI	Quality Improvement
SBCC	Social and Behavioral Change Communication
SDSMAS	District Health Welfare and Women Directorate
SGBV	Sexual and Gender-Based Violence
SiFO	Training Information System
SIS-MA	Sistema de Informação em Saúde – Monitoria e Avaliação (HMIS)
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
TBAs	Traditional Birth Attendants
TEM+	"*TEM mais" – Private clinic network*
ToR	Terms of Reference
ToT	Training of Trainers
TSO	Technical Support Officers
USAID	United States Agency for International Development
USAID AOR	Agreement Officer's Representative (USAID)
USG	United States Government
YFHS	Youth-Friendly Health Services

Project Summary

Project Duration: 5 years

Starting Date: June 2016

Life of project funding: $ 34,560,000.00

Geographic Focus: Nampula and Sofala provinces

The Integrated Family Planning Program (IFPP) is a five-year USAID/Mozambique funded initiative to increase use of modern contraceptive methods by target populations in 36 districts of Nampula and Sofala provinces of Mozambique. The IFPP responds to the USG strategy for development and foreign assistance in Mozambique through the Country Development Coordination Strategy (CDCS). The USAID/Mozambique CDCS outlines an overarching Development Objective Health Goal -- to "Improve the Health Status of Target Populations" through three results: 1.) Increased coverage of high impact health and nutrition services, 2.) increased adoption of positive health and nutrition behaviors, and 3.) strengthened systems to deliver health, nutrition, and social services (CDCS, 2013).

Aligning with this goal and results, IFPP aims to support the Government of the Republic of Mozambique (GRM) and Ministry of Health (MISAU) priorities and **increase the use of modern contraceptive methods by target populations** through three Intermediate Results: 1) Increased access to a wide range of modern contraceptive methods and quality FP/RH services, 2) Increased demand for modern contraceptive methods and quality FP/RH services, and 3) Strengthened FP/RH health systems. Under IFPP, the three Intermediate Results (IR) are integrated and mutually reinforcing. Activities under IR1 increase the quality of service delivery at facility and community level, activities under IR2 generate demand for those services and link the community with the facility. The health system strengthening activities proposed under IR3 are cross-cutting and support the sustainability and institutionalization of the service delivery improvement efforts (IR1) and demand generation interventions (IR2), and interact with IR2 activities to increase the community involvement in health system accountability

IFPP aims to reach women with particularly high unmet need for FP, namely: postpartum women; women living with HIV; adolescents, including orphans and vulnerable children (OVC); medium- and high-parity women; and post abortion women. In addition, IFPP recognizes that increasing uptake of contraception in Mozambique requires shifting inequitable gender norms. Therefore, men and boys, alongside other key influencers, are meaningfully and systematically engaged throughout all intervention areas and intervention packages.

The project is led by Pathfinder International with a team of global and local partners—N'weti, Population Services International (PSI), and Abt Associates.

Summary of the reporting period (January- March 2017)

Building on the strong foundation laid out during Q1, the IFPP project team attained rapid geographic coverage of high quality FP services carrying out 57 technical FP trainings, building knowledge and skills for 878 additional eligible health providers from 124 different health facilities (HFs), covering a total of 33% of all HFs in Nampula and Sofala provinces. During the reporting period, 95 HFs (78% of total) received one or more structured mentorship visit. In Nampula Province, a data-driven "optimization" workshop was organized by using Pathfinder's implementation Science & Learning (ISL) approach, which involved all project staff to share operational lessons learned and to refine mentorship strategies. A similar initiative is scheduled for the next quarter in Sofala Province, where key operational lessons from the project scale-up in Nampula are being effectively transferred.

The demand generation component succeeded in laying a strong foundation for smooth program roll-out and accelerated scale-up in all 36 Districts of Nampula and Sofala Provinces. In rural settings, 22 MCH nurses coming from different peripheral HFs were trained as TBAs trainers, in addition to the 17 MCH nurses trained during Q1FY1. In Q2FY1, 369 TBAs were trained through cascade trainings hosted at peripheral HF level, in Nampula province, in addition to the 48 already trained during Q1FY1. 190 community facilitators (CFs) were selected from 79 CBOs; trained and equipped to cover 122 rural HF's catchments areas. In urban settings, 143 IPC agents are carrying out small-group and one to one sensitization activities. Eight community radio stations were also trained to host structured FP broadcasting sessions.

Health Systems Strengthening (HSS) activities in the Jan-Mar 2017 quarter were focused on assessments of district management capacity using the management standards compliance (MSC) assessment tool, and performance evaluations of the main family planning (FP) indicators through the elaboration of District Profiles (DP). IFPP's HSS team implemented 11 district baseline MSC assessments of the FP health system in Sofala and Nampula provinces. Following the completion of each assessment, the project also supported district managers to draft quality improvement (QI) action plans to strengthen district management capacity and increase district alignment with MOH FP health systems standard operating procedures (SOPs). The project also supported each SDSMAS to develop a district profile (DP) of the key performance indicators (KPIs) for family planning. HSS technical advisors worked with district managers to set targets for all KPIs, and organized data analysis meetings with SDSMAS and HF staff involved in FP service delivery and systems management to analyze performance and develop action plans to guide follow-up QI interventions. TA was also provided to assess HF needs for FP health information systems (HIS) tools in these 11 districts, and to develop a commodity distribution plan to ensure all sites have access to the necessary forms, logbooks, and brochures.

Goal: Increase use of modern contraceptive methods

IR 1: Increased access to a wide range of modern contraceptive methods and quality FP/RH services

Sub- IR 1.1: Increased access to modern contraceptive methods and quality, facility-based FP/RH services

During this reporting period (Q2FY1), intensive roll-out activities reached all 36 districts targeted in the IFPP proposal (23 in Nampula and 13 in Sofala).

By the end of March, the probationary period has ended and some staff was changed but not key ones; recruitment proceedings were already started to ensure quick substitution; in Nampula, next quarter, the position of Provincial Senior Service Delivery Officer will be opened and fulfilled to ensure IFPP's quick expansion.

Cascade in-service training

Following the Q1FY1 TOTs, the project supported nineteen training teams (9 in Nampula and 10 in Sofala) to conduct 57 "eight-day" facility-based trainings (27 in Nampula and 30 in Sofala), involving staff from 94 different HFs (43 in Nampula and 51 in Sofala), reaching a total of 878 public health providers (415 in Nampula and 463 in Sofala).

Cumulatively to date, 124 HFs have benefited from "having at least one health provider trained"; 73 in Nampula and 51 in Sofala, representing 33% of all HFs

Table 1: Project-supported Health Facilities by District and Cluster, Nampula Province at end of Q2 FY1

Cluster	Districts	HFs hosting a training and HF staff targeted through trainings	
		Q1 FY17	Q2 FY17
1	Angoche	Angoche RH Inguri HC Namitoria HC	
	Mogincual	Namige HC	Quixaxe HC, Namige HC Xa-Momade HC Xa-Selemane
	Liupo		Liupo HC Quinga HC
2	Cidade de Nampula	Muhala HC Anchilo HC 25 de Setembro HC	Marrere GH Marratane HC 25 de Setembro HC
3	Eráti	Namapa RH Alua HC	Mirrote HC Samora Machel HC Jacoco HC
	Memba	Memba HC	Namahaca HC Memba HC Chipenhe HC Mazua HC
4	Meconta	Namialo HC Meconta HC Teterrene HC	Nacavala HC
	Nacaroa	Nacaroa Nahadge	Nachere HC
	Muecate		Muecate HC
5	Mogovolas	Nametil HC Iuluti HC Murrerimue	Nanhupo Rio HC
	Moma	Moma DH	Chalaua HC
	Lardes		Lardes HC
6	Monapo	Monapo HC Carapira HC	Natete HC Monapo DH Monapo Rio HC
	Mossuril		Nacuxa HC
	Ilha Moçamb.	Lumbo HC	
7	Nacala Porto	Urban HC Nacala DH	Murrupelane HC
	Nacala Velha	Nacal Velha HC	Mueria HC Barragem HC
8	Murrupula	Murrupula HC Cazuzu HC Umuatho HC	Nihessiue HC
	Rapale	Rapale HC Namaita HC	Namucaua hc Muleheia HC
	Mecuburi		Namina HC Nahipa HC Mecuburi HC Momane HC Popue HC
9	Ribáue	Ribaue RH Namiconha HC	Iapala Monapo HC Iapala Sede HC Mecuasse HP EBA HP
	Malema	Malema HC	Mutuali HC

in the Provinces. A total of 1,570 health providers have been trained to date, including 692 during Q1 and 878 during Q2.

Prior to training health providers, 49 HF assessments were conducted during Q2FY1, (25 in Nampula and 22 in Sofala); surpassing the 33 HF assessments carried out in Q1FY1. These baseline HF assessments focused on commodity management, infection prevention, client flow and adolescent-friendliness. Table 1, at right, and Table 2, below, show how pairs of trainers were assigned to a cluster of up to three Districts in Nampula and to four districts in Sofala, to accomplish this accelerated training program.

At each HF level all clinical and technical staff were trained, where possible, in order to more fully integrate FP activities into the work of other wards, and to promote active FP integration as a key objective for each HF. Cleaning staff from each HF also participated during certain theoretical sessions of the training (non-clinical providers) to sensitize them regarding their role in removing possible barriers to access to quality FP services (for example, ensuring proper sterilization and storage of IUD insertion kits). Since January 2017, at each HF in Nampula that was used as a training center, the APEs serving the HF catchment area were invited to participate during the two first days of the training to refresh their knowledge and to boost HF-APE coordination mechanisms, including for FP commodities supply, referrals, and supportive supervision schedules.

Based on experiences during Q1FY1, the IFPP team opted to limit training sessions to HFs with an average of 80 institutional deliveries per month or more, to provide sufficient opportunities for practical counselling and method insertion exercises for all participants. The project also limited class sizes during the clinical trainings, from 25

Table 2: Project-supported Health Facilities by District and Cluster, Sofala Province - Q2 FY1

Cluster	Districts	HFs hosting trainings and HF staff targeted through trainings
		Q2 FY17
1	Gorongosa	Canda HC
		Casa Banana HC
		Gorongoza HC
		Mucodza HC
		Nhambondo HC
		Nhamissongora HC
		Pungue HC
		Tsiquir HC
		Vunduzi HC
		Jutchenge HP
	Marringue	Maringue HC
		Senga-Senga HC
		Phango HC
		Chionde HC
		Gumbalansai HC
		Nhamacala HC
		Subue HP
	Cheringoma	Inhaminga HC
	Muanza	Muanza HC
		Galinha HC
		Sanguze-Muana HC
2	Cidade de Beira	Ceramica HC
		Chingussura HC
		Munhava HC
		Ponta Gea HC
		Chamba HP
	Dondo	Chinamacondo HC
		Dondo HC
		Canhandula HC
		Samora Machel HC
		Savane HC
3	Nhamatanda	Nhamatanda RH
		Tica HC
		Lamego HC
		Chiadeia HC
		Muda HC
		Nhampoca HC
	Buzi	Buzi RH
		Chissinguana HC
		Estaquinha HC
		Marombe HC
4	Caia	Caia RH
	Marromeu	Marromeu RH
	Chemba	Mulima HC
5	Chibabava	Chibabava HC
		Muxungue RH
		Mangunde HC
		Mucheve HC
		Mutindire HC
		Nhango HC
	Machanga	Machanga HC

to 15, to offer more personalized attention to trainees. The 66 HFs used as training centers are underlined in tables 1 and 2, and represent 53% of all the HFs whose providers attended the trainings. The IFPP' approach to training aims to maximize the number of HFs hosting clinical trainings, as this experience has been shown to strengthen institutional buy-in and thus more rapid and sustained integration of FP services. Whenever a participating HF is located near enough to the HF hosting the training, IFPP trainers organize for the morning practicum sessions to be carried out at these nearby HFs. In this way, the participating health providers learned how to integrate the new services and tasks in the context of their daily work environment/consultation rooms, while performing their usual daily tasks. This approach helped the trainers and trainees to resolve site-level barriers *in situ* during the training, and prepared the participants to more easily continue with integrated service provision post-training. In general, participating trainees demonstrated a high degree of commitment.

Factors contributing to the successful roll-out of the clinical trainings include:

- Strong collaboration between Pathfinder training team members and MoH at National, Provincial and District-levels during trainings, post-training supervision and mentorship;
- Strong buy-in and support from management teams at each HF and SDSMAS; as evidenced by the provision of certain training supplies by SDSMAS, as needed.
- The IFPP Technical Director and the Nampula FP provincial supervisor carried out support visits in 4 out of the 27 training sessions, namely at the Monapo District hospital, the Liupo, Namina and Muecate Health Centers.
- HF Assessments being done prior to trainings helped to anticipate the needs of each provider and to better prepare each site in advance;
- HF Assessments resulted in HF-specific procurement plans to meet necessary equipment gaps in advance of trainings to bring HFs closer to "ideal" training conditions; items purchased during Q2FY1 based on HF assessments included but are not limited to: screens to ensure more privacy, gynecological tables and IUD insertion kits, removing kits for implants, sterilization pans, speculums, sphygmomanometers, LED gynecological lamps, small table with wheels and three shelves for medical material stowing, surgical and observation gloves. Additional procurements of necessary equipment are under process based on additional HF assessments.

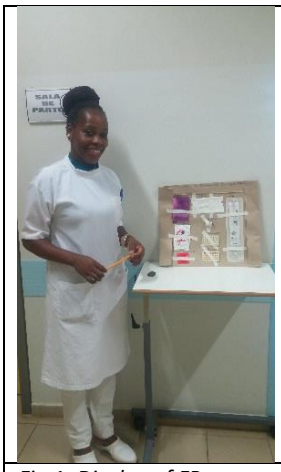


Fig 1: Display of FP methods by Head Nurse

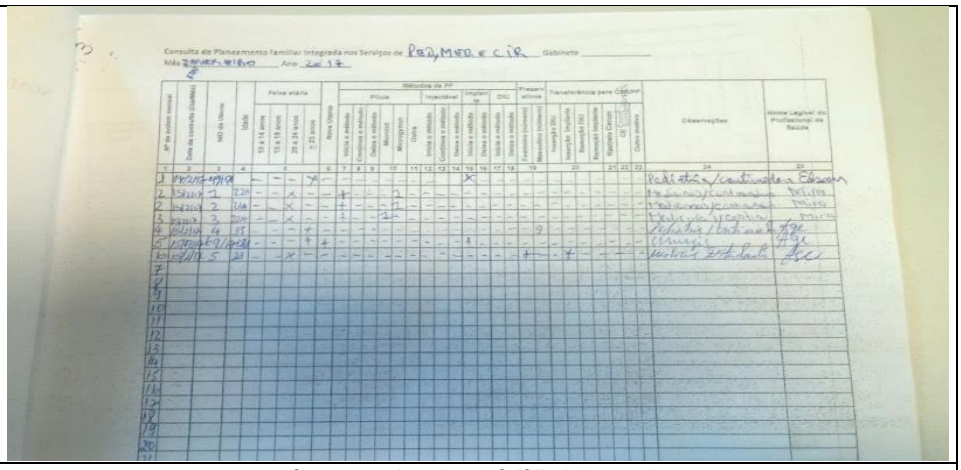


Fig 2: FP Integration register form introduced and fulfilled during the trainings

Some of the challenges encountered during the training roll-out include:

- Endemic poor sterilization practices related to a lack of basic sterilization resources, such as functioning autoclaves, usable pans, and firewood for heating. To resolve these issues (with exception of purchasing new autoclaves), the team is working with facility leadership, SDSMAS and DPS.
- To ensure smooth March 2017 trainings, IFPP had to purchase surgical gloves as well as carrying out contraception redistribution between HFs;
- Frequent requests from HFs for autoclave purchase is viewed by the project as symptomatic of the broader context of insufficient financing of the health sector; as biosafety is a critical point, broader coordination involving donors and health partners will be needed
- Integration of FP into curative services is new to most HF staff, including many medical directors. The IFPP training teams covered these topics in depth and used the recently released M&E data collection tool proposed by the MOH technical FP group (Figure 2). The roll-out of this tool was not clearly and consistently communicated at all levels within the MOH, however, and thus, some of the recently trained HFs staff have stopped using the form, causing some FP data under-reporting. In the next reporting period, IFPP will support the MOH (central and provincial levels) to more broadly disseminate the M&E FP integration tool and the approved FP integration guidelines.

Quality Improvement and Mentoring

Quality improvement (QI) is key to the project's success, in terms of achieving and maintaining a high quality of service provision, as well as garnering institutional support and buy-in to address

systemic challenges and to support the sustainability of FP integration efforts. Mentorship drives the QI cycle through regular visits by project MCH nurses and District Coordinators.

The objective of mentoring is primarily to guarantee that health providers trained by the project are engaged on a regular basis and supported to achieve and maintain clinical proficiency and service quality. Mentoring includes direct observation of service provision quality and supplementary on-the-job training. A secondary objective of the mentoring visits is to cultivate institutional engagement and ownership among HF management and staff to remove barriers to successful integration and greater uptake of FP services. The first mentoring visit is scheduled to be performed approximately 10 days after the end of the initial training, with subsequent mentoring visits scheduled for each health facility on days 25, 46, 67, and 88, post-training. Insofar as all HFs providers will be trained, IFPP teams will dedicate their time more fully to mentoring visits.

Typical Mentoring Visit Content

A typical mentoring visit will begin at the HF during the early hours to observe the handover from one shift of maternity ward nurses to the next; this daily meeting offers an important glimpse of the HF's client load and service flow, and provides an opportunity for active follow-up of parturient mothers for FP counselling and post-partum FP. MCH providers (FPC, PPC, ANC, and Immunization) as well as external consultation providers already trained to provide FP services are also provided with constructive feedback and coaching during the visits. Where necessary, remedial action plans are developed to address critical skill gaps. At the end of each mentoring visit, a short debrief meeting is carried out with the HF's management team to share results and to jointly explore solutions to overcome identified challenges.

Table 3, at right, categorized the HFs in Nampula Province per the number of mentoring visits received since October 2016; the number of total visits received to date is different per the day of the original training; to date 72 of the 73 HFs that received training also received at least one mentorship visit, and all are scheduled to continue receiving visits, per the illustrative mentorship schedule shown above.

Table 3: HFs categorized according to the # of mentoring visits already received at end March 2017 in Nampula province

Cluster	6 visits	5 visits	4 visits	3 visits	2 visits	1 visit
1	HR Angoche	Namitória		Namige Quixaxe Liupo	Quinga	Xa - Momade Xa - Selemane
2	Muhala Expansão	25 Setembro	Anchilo	HG Marrere		Marratane
3	HD Namapa Alua	Memba sede		S. Machel Jacoco Namahaca	Mazua Chipene	Mirrote
4	Namialo Meconta		Nacaroa	Nachere Muecate		Teterrene Nacavala Nahadge
5	Nametil HD Moma	Murrerimue Iuluti		Nanhupo Rio Larde		Chalaua
6	Monapo	Carapira	Lumbo	HD Monapo Nacuxa	Monapo Rio Natete	
7	Urbano HD Nacala Porto	Nacala Velha		Murrupelane Mueria	Barragem	
8	Rapale Namaíta	Murrupula	Umuatho	Namucaua Muleheia Cazuzu Mecubúri Namina	Nihessiue Nahipa Momane Popue	
9	Ribáue Namiconha	Malema	Mutuáli Lalaua	Mecuasse EBA HP		Iapala Monapo Iapala Sede
TOTAL	15	9	6	22	10	10

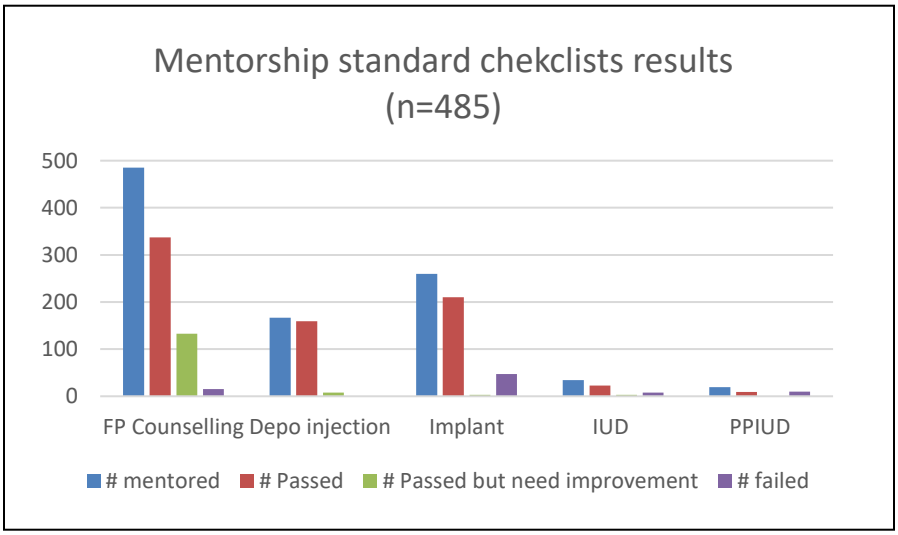
Table 4, below, shows the HFs benefiting from one or more

Table 4: HFs categorized per the # of mentoring visits already received at end March 2017 in Sofala province						
Cluster	6 visits	5 visits	4 visits	3 visits	2 visits	1 visit
1			Dondo	Ponta Gea	Chingussura	Munhava
2				Nhamatanda Buzi	Estaquinha	Tica Chiadeia Muda
3		Muxungue			Chibabava Mutindire	
4			Gorongosa	Inhaminga Marringue		Canda, Juchenge, Nhambondo Tsiquir
5	Caia			Mulima	Marromeu	
# of HFs	1	1	2	6	5	8

mentorship visits in Sofala province: 23 received mentorship visits, out of a total of 51 HFs with at least one provider trained. According to reports made by visiting IFPP mentors, those health providers reached multiple times with project mentorship activities significantly improved in their FP counselling skills, their use of new FP data logbooks and FP daily summaries, and there were increases in the availability of FP commodities within consultation rooms (other than the FP consultation room). Unfortunately, intense rains during the latter part of the quarter made roads to several peripheral HFs impassable, and thus, a few mentorship visits scheduled for the end of March were temporarily delayed and will continue during the first weeks of the following trimester.

Mentorship App

To facilitate follow-up on action plans developed during mentoring visits from one visit to the other, IFPP has developed and trained all project staff to use a mobile app. This allows trainers to create health provider-specific electronic note-taking and follow-up action plans, which are shared with the mentored providers at the time of each visit. The app provides prompts for mentors to guide them in each step of the mentorship process, and notifies mentors with reminders of the next mentoring visit to ensure providers requiring additional support are reached at appropriate intervals. IFPP staff began using the Mentorship App during this quarter and received two supportive visits from the IFPP digital health officer to assist with trouble-shooting. Thirty percent of mentees



needs to improve their counseling skills, and this will be tackled during following mentorship visits.

Sub- IR 1.2: Increased access to modern contraceptive methods and quality, community-based FP/RH services

Traditional Birth Attendant (TBA) Trainings

IFPP's rural supply-side strategy involves identifying, training, and supporting traditional birth attendants (TBAs) to conduct home visits and community-based FP counseling with women in rural districts and in rural areas of combo districts. TBAs are selected according to pre-determined selection criteria; and are trained and supervised by the HF's own trainers in partnership with the IFPP district coordinators. It is expected that TBAs will generate demand through improving knowledge of FP, countering prevailing misconceptions and biases, conveying the importance of HTSP, increasing self-efficacy, and promoting linkages with contraceptive service delivery points (IR1). TBAs are expected to reach all women and adolescents of reproductive age, and to target FTPs who are pregnant and postpartum, as well as medium- and high-parity women (defined by IFPP as women with 3 or more children). TBAs also engage household influencers and gatekeepers (e.g., male partners and mothers-in-law).

During Q2FY1, 22 MCH nurses coming from different peripheral HFs were trained as TBAs trainers, in addition to the 17 MCH nurses trained during Q1FY1. This Q2FY1, 369 TBAs were trained through cascade trainings hosted at peripheral HF level, in Nampula province. Trainings in Sofala province are planned for next quarter.

Trainings included: TBA role in FP promotion; effective community-level promotion and referrals; sexual and reproductive rights; female and male reproductive system; adolescent pregnancy; STIs, HIV and AIDS; impact of gender imbalance on health issues; contraceptive methods; importance of male involvement in FP activities.

IPC Agent Training

During the previous quarter, 39 IPC agents were trained for Nampula (25), Nacala (10), and Ilha de Moçambique (4). During the current reporting period, 45 additional IPC agents were trained in Sofala province for Beira (25) and Dondo (20). The project's urban demand creation strategy builds on the successful TEM+ model already used by PSI, which seeks to create informed demand for family planning directly at the households and community-level.

Community Facilitators (CF) training

190 CFs were selected from 79 CBOs working at community level in the two provinces, and trained during this Q2FY1 (144 in Nampula and 46 in Sofala). After selection, CFs were trained in FP methods, Gender and Social norms, Harmful social norms to FP and all were equipped to

conduct Community Dialogues (CD). The training they received provided them with correct information about FP methods, gender roles and power relations in society. This information will support them during the process of facilitation of CD group discussion and gradually deconstruct harmful social norms. The CFs are residents within the catchment HF's areas and they will be responsible to conduct CDs. The 95 CFs pairs are expected to cover 122 rural HF's catchments areas (94 in Nampula and 28 in Sofala), mostly aligned with the HFs that already benefited from FP trainings.

In Nampula, out of the 73 HF already benefiting at least from one health provider (HP) trained in FP, only 5 (Jacoco, Namucaua, Muleheia, Riane, Mecuasse) do not yet have an active demand creation CF on the ground; meanwhile, 35 HFs catchment areas were already equipped with a demand creation activist but still must carry out the HF's FP training; this point will be addressed during Q3FY1.

In Sofala, 24 HFs were equipped with a demand creation activist (urban and rural settings); an additional CFs training is planned for Q3FY2. Meanwhile, 9 HF catchment areas (Siluvo, Pedreira, Guara-Guara, Sena, Chupanga, Goe, Chinamaconde, Savane) were already equipped with a demand creation activist but have no HP trained in FP, these HFs will enter in the coming FP HF training' priorities for next quarter.

Targeted Mobile Brigades (MBs) for priority populations:
In Rural areas, support to MBs have already started this quarter in Nampula and Sofala provinces, focusing on HFs which previously benefited from a FP technical training. A total of 457 MBs were supported this quarter (226 in Sofala and 231 in Nampula). Coordination meetings are being held with SDSMAS and MCSP prior to implementation of MB activities in order to align the timing of these events with local calendars.

The TEM+ model led by PSI is already carrying out MBs in some urban districts (Nampula City, Beira, Dondo). IFPP will provide complementary support through monthly MBs tailored to secondary schools, beginning during the next quarter.

Sub-IR 1.3: Improved and increased active and completed referrals between community and facility for FP/RH services

To improve and increase active and completed referrals between the community and the HF, IFPP is using Movercado, a mobile technology platform, to provide referrals and/or vouchers to public sector facilities, private sector TEM+ clinics, and pharmacies (for condoms and Oral Contraceptives).

IFPP is working with the existing IPC agents and make small modifications to the existing Movercado system to allow for immediate implementation of counselling and referral activities to generate rapid results in line with the IFPP year one strategy.

Movercado can enable, track, incentivize, and measure interactions in a program, such as:

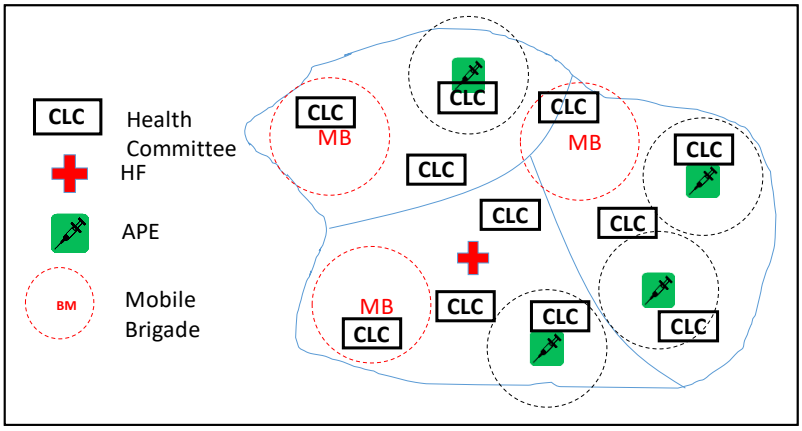
- Sending clients personalized follow-up messages about visits from IPC Agent;
- Sending vouchers for OCs and condoms to enable free or discounted distribution;
- Monitoring community-based agent's activities;
- Collecting service data from HFs to enable project monitoring;
- Tracking and monitoring referrals;
- Generating incentive schemes to health providers or community-based agents**.**

During this reporting period, IPC urban component had 8,041 confirmed referrals from the communities to HFs for FP services, which attested to a quick start-up of demand creation in urban settings (compared to 791 confirmed referrals from last quarter).

Strengthening the coordination at the HF catchment area between HF and community teams
To harvest a maximum of IFPP demand generation efforts, it's important to succeed a programmatic IR1 and IR2 activities' alignment, but *increasing coordination between HF and community teams*, in each HF catchment area, will be also very important; it's one of the main keys for increasing access to FP methods at local level; the IFPP Field Supervisors (15 in Nampula and 9 in Sofala) has a key role with support of IFPP districts coordinators (9 in Nampula and 5 in Sofala) and Technical Support Officers-TSOs (3 in Nampula and 2 in Sofala); This will be ensured through:

- Integrating the CFs pair at HF level, the IFPP technical team will ensure the presence of CFs and discuss their community activities at the HF level, the district coordinator mentorship visit at the HF level will be instrumental.
- The CFs will be introduced to the TBAs and the APEs, the simplest opportunity is during the training of the TBAs at the HF level supported through IFPP and carried out by the HF MCH nurse trained as FP TBAs facilitator;
- Other opportunities for coordination are the monthly/quarterly TBAs monitoring meetings held by the above referred MCH nurse; note that the meeting should concur with the monthly APEs meeting at the HF level as often as possible, as APEs and TBAs must develop a true partnership and APEs, frequently, are the closest FP referral for TBA's clients. During these meetings, APEs FP commodities must be delivered, APE data forms must be discussed, TBAs experience in face to face FP sensitization must be shared particularly for the specific target groups (pregnant women, high parity women, adolescent and adolescent couples).

- The TBAs and the APE (when existing in this area) will be included in the influent leaders' community dialogue sessions.
- A mapping (a drawn map is useful at the beginning but should be progressively substituted with a GIS map) of the catchment HF area is key to operationalize with efficiency the interaction between the HF and the community human resource available (APEs, TBAs, Community Health Committees and the ones that are already involved in the Community Dialogues sessions); to carefully choose the best spots for carrying out the integrated FP MBs; important to remember that each HF catchment areas – once the HP are trained - should carry out 3 MBs per month – meaning one MB per week as the first week of the month isn't appropriate (HF data closing week); each IFPP Field Supervisor (FS) is equipped with a motorbike and two helmets, it's expected that he supports partly the logistic of the MBs proceeding from the peripheral HF; renting of a local service motorbike can be planned to complement the FS efforts; also, BMs can be planned during the mentorship visits at this HF, using the IFPP car.



- Quarterly co-management health committees *(comités de co-gestão)* will be supported (preparation of the meeting with the health center responsible; involvement of the CFs to remember the meeting date to the members; logistic support in some exception – very distant community representative)
- Quarterly logistic support for the APE HF supervisor focusing, among others topics, on FP service delivery and potentially attending the clients who selects the implant as the contraceptive method of choice.

IR 2: Increased demand for modern contraceptive methods and quality FP/RH services

IFPP prioritizes high impact demand generation activities at the individual (Sub IR 2.1) and social level (Sub IR 2.2) to be implemented in line with the phased roll-out of the project's IR1.

Sub IR2.1: Improved ability of individuals to adopt healthy FP behaviors

As mentioned above in Sub IR1.2, at end of Q2FY1, 417 TBAs were trained and have progressively started their sensitization activities at the community level; however, IFPP isn't yet reporting TBA's community referrals through the Movercado mobile platform as its operationalizing for rural settings and TBAs characteristics is tough (TBAs are not easy-users of mobile technology,

her literacy levels are usually low, insufficient mobile money counters in rural areas. TBA Trainers have been trained on Movercado, and subsequently the training of the TBAs has been rolled-out in a few HF catchment's areas, but no TBAs referrals have yet been registered on Movercado, even in the sub-group of those who own a mobile phone. More intensive follow up with those first 87 potential users will be used to understand other possible barriers they are facing in using Movercado platform.

As also mentioned in Sub IR1.2, at the end of Q2FY1, IFPP leveraged PSI's existing "*TEM+"* intervention, with 143 IPC agents distributed in following districts Nampula City (40), Nacala Porto (10), Ilha do Moçambique (4), Anchilo (10), Murrupula (15), Beira (44), Dondo (20). The IPC agents are providing individual counseling to the IFPP target groups, particularly adolescents and youth and post-partum women, and were immediately registered within the Movercado platform to provide referrals and/or vouchers to public sector facilities, private sector TEM+ clinics, and pharmacies (for condoms and OCs). Eight-thousand and forty-one referrals (compared to 791 reached in Q1FY1) were registered in Q2FY1.

The 190 CFs will start referring FP clients during next quarter, referral slips were already ordered and are expected to be delivered early next quarter.

Private sector involvement in family planning

PSI trained 10 pharmacy staff in Nampula and 9 in Sofala in the use of Movercado. Once pharmacy technicians are trained, they can redeem each voucher for oral contraceptive pills. While private pharmacies offer privacy and discretion, most people in Mozambique still favor going to public sector facilities to receive free contraception services. However, as part of this project increasing demand to an additional channel in the market is thought to increase access and provide an anonymity that health facilities often are unable to do. PSI also needs to establish a commercial partnership with pharmacies by selling donor-donated contraception at a reduced fee and allowing them to redeem vouchers either for free oral pills or subsidized. Within this setup, IFPP/PSI is leveraging efforts with two other FP-focused projects aimed at youth to ensure that there is proper demand creation for TEM+ Pharmacies, building on the 50 peer educators trained in Nampula (reaching 8 schools) and the 82 peer educators in Beira/Dondo (reaching 20 schools).

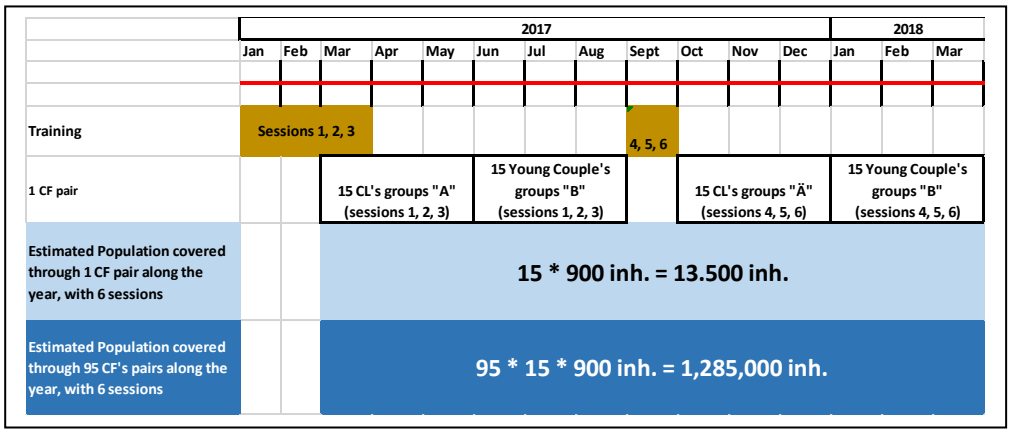
To date, in Nampula, five pharmacies purchased 240 cycles of Microgynon pill and sold 34 cycles in March. In Sofala, pharmacies acquired 180 cycles. While the numbers are still low, IFPP believes that this number can increase once we understand other motivation to get women seeking pharmacy services. It is worth highlighting the great challenge of the rotation of trained pharmacy

technicians. All pharmacies work with technicians under a service contract regime, thus they are always looking for other employment opportunities.

Rural community facilitators of the Community Dialogues (CD):

IFPP rural community component launched CD sessions in March 2017 with the CFs trained in January and February. The first round of CD addressing social roles and FP have reached 1,576 women through the first 108 groups organized in Q2FY1. The contents of the sessions deconstruct norms and beliefs which hinder FP interventions. The CD are ideal spaces for interactions/discussions about gender and social norms between girls and boys and women and men. These women are now able to identify specific FP issues which are beliefs socially constructed but not necessarily true. For instance, the belief that FP prevents a woman from bearing a child for good.

The formative research has shown that women in general have good knowledge of FP methods but that male partners, "societal gatekeepers", and CL are the ones who make decision about FP. Therefore, the participation of influential women where gender roles and social barriers are addressed is a very important step for raising awareness and fostering changes.



At the end of Q2FY1, IFPP selected, trained and equipped a total of 95 pairs or 190 Community Facilitators (CFs) out of 300 proposed, (144 in Nampula and 46 in Sofala), covering 122 rural HF catchment areas (28 in Sofala and 94 in Nampula) out of 313 rural HFs; these 190 CF starting a year cycle of FP awareness and demand generation activities for an estimated 1,285,500 inhabitants (972,000 in Nampula and 310,500 in Sofala) through 2,850 groups. CFs are operating in pairs (one woman and one man) and sensitizing along the year a population estimated at 13,500 inhabitants through 6 sessions of community dialogue targeting one group of 25 community leaders and one group of 15 young couples within each agglomerate of 900 inhabitants.

mCenas!

mCenas is an SMS based platform which allows young people to receive critical information around family planning and contraception in a format that is appealing and culturally relevant,

and that addresses some of the social contexts within which reproductive choices are often made. Under this project, mCenas was initially planned to be linked to the Movercado platform so that adolescents could self-enroll into the program and receive the mCenas messages every week. Participants would also be able to request additional information on contraceptives by selecting from a drop-down menu. However, the costs that would be incurred to operationalize the platform through Movercado are not worthwhile, therefore IFPP decided to negotiate with other options for this service. We have purchased a short code for the intervention from the National Institute of Communications, this will allow us to use reverse billing services and easily integrate the number with all existing in-country phone operators. Negotiations are underway between Pathfinder, TextIt (the company and platform that mCenas is being designed and configured for message management) and SISLOG (Mozambican SMS aggregator used by the local operators for SMS exchange). The integration tests between SISLOG and TextIt has been successful, and the roll out will take place in the next quarter.

Sub-IR 2.2: Improved community environment to support healthy FP behaviors

To contribute to the IR2, IFPP/Nweti is implementing a systematic community dialogue process which involves groups of adolescent girls, young couples, key community leaders and influencers. The rationale behind the community dialogues is to address the social and gender norms and drivers of non-use of modern FP, and to create more enabling environments at the community level for adherence to the FP modern methods.

Staff recruitment

At the end of the Q2FY1, a total of 31 staff are carrying out community activities – 1 National Senior Manager, 1 Provincial Senior Officer (PSM), 5 Technical Support Officers (TSOs), 24 Field Supervisors (FSs); note that the National Senior Manager recruited at the starting of the intervention has resigned during the probational period and a part-time National Senior Manager has been recruited.

Leveraging community partnerships and mapping local CBOs

Building on previous Nweti experience of “Tua Cena”, IFPP leveraged the transfer of Nweti specific knowhow to the IFPP community team, to identify and sign MoUs with the CBOs, and selecting the Community Facilitators (CFs). 190 CF were selected from 79 CBOs, working at community level in the two provinces, and trained during this Q2FY1 (144 in Nampula and 46 in Sofala). Most of the CBOs where the CF were selected from have relevant experience in Health, SRH, HIV-AIDs, TB or Malaria. They conduct campaigns to raise community awareness on health matters. In general, they have more than 5 years of experience in the field. The numbers of CF needed by catchment areas were planned and prioritized in alignment with IR1 roll-out. To conduct the community dialogues, one pair of facilitators, on average, operate in each health

facility catchment area. They conduct one community dialogue per day for three weeks in a specific community area, and then move to a new community area until the whole health facility catchment area has been covered.

Formative research

During the second quarter, the Formative Research field work was conducted and concluded in the 13 pre-selected districts (5 in Sofala and 9 in Nampula). The preliminary report shows that:

About FP knowledge, attitudes and practices:

Women in general know more about FP than men. Urban women know more about FP than rural women. In Sofala, CHW and community leaders have distorted information about FP and there is great belief among women that some FP methods prevents them from bearing a child for life. In general women are among the ones who falsely believe that if they do FP, they will never bear a child again, or yet that the "implant method" could circulate inside your body and get lost and cause infertility. Some women also believe that IUD can affect the baby when a decision to get pregnant emerges. The "traditional method" used by some women is the "lace around the waist". In Nampula, in general women and men know about FP specially women who at some point attend FP services in HF. Even non-users of HF have heard about FP. Compared to Sofala they prefer DEPO and pills. DEPO because they can easily keep track of the dates while pills they could forget. Unfortunately, in Nampula there is a strong believe that FP causes infertility to women.

About norms and sociocultural practices:

Health in general but specifically femininity and masculinity are part of socially constructed gender norms. This, as well as the expectations that society has for women and men, are influencing decisions related to FP. In Sofala, the culturally accepted "lobolo" (a compensation men pays to the bride's family) apparently "dictates" that women should bear as many children as the husband wants. In other words, the men decide. In Nampula, many factors influence the decision to do FP. Marriage is thought of with the goal of procreating, so women's fertility is something very important. Men, CLs, and gatekeepers believe that many children in each family will ensure continuity of the family and younger ones will look after the elders. Men and social gatekeepers ("*matronas"*) are in general the ones who decide about FP in the families.

Harmful social norms found at community level are related to misinformation about FP, in Sofala, it was mentioned that when men know about the benefits of FP methods and consider it as something positive it is more likely that they will support women to use FP. Because they are the ones who make decisions in the family, sensitization efforts should strongly include men (power relations). However, CLs and HCWs are very influential and trusted, as such, also influence decision about FP in families. In Nampula, harmful social beliefs found are also misinformation,

strong beliefs that FP causes infertility and other health problems. Women fear adverse effects of FP methods based on unfounded misconceptions (for example, “IUD could harm your heart”). Women in this province mention needing authorization from their husbands to do FP and most of the time men don’t accept.

Harmful social norms found at institutional level: in both provinces, distance to access the services, quality of services, lack of staff in US, and FP methods unavailability are among the most mentioned as preventing women from using FP, in Nampula.

About FP information and communication:

Rural women in Sofala receive FP information through activists and sometimes Health Mobile Brigades organized by SDSMAS. However, fewer activists deal only with FP. They usually integrate FP messages within ARVT, HIV&AIDS and TB messages which clearly might not be very effective. Usually messages are focused on pregnancy prevention without highlighting other benefits of FP methods such as pregnancy spacing which are beneficial for the mother and child. Information does not mention that when a woman decides to bear a child again, she could discontinue pill or go to HF to remove the implant/IUD etc. For these reasons, there is a strong belief that if a woman decides to do FP she will never ever bear a child again. In Nampula, the face-to-face sensitization carried out by APEs and activists seem to work well in promoting awareness about FP methods. “Talks” at US level, mobile brigades, radio programs from *Geração Biz* in schools were among the ones mentioned as a source of information about FP. Beneficiaries prefer Palestras at US, radio program because they explain advantages/benefits and possible adverse effects of FP methods. They suggested training community members to disseminate FP at community level as well.

Use of community radio to amplify the community dialogues focused on HTSP, FP, and benefits for healthy families and communities

IFPP/Nweti will build on the dialogues and work with community radios to host shows (including dramas, interviews, radio programs and other content) to help to demystify and minimize barriers linked to FP at community level.

In Nampula province, eight CRs were identified and MoUs signed, followed by CRs staff capacity building on FP matters. The selected CRs have a minimum 50km coverage radius and should potentially reach 391,000 inhabitants. Coastal areas where lack of knowledge about FP is noticeable (information supported by the Formative Research report) were prioritized. In total, 24 people (reporters, coordinators and producers) attended a seven-day training and were trained in designing and disseminating of informative contents that promote Sexual and Reproductive Health and Rights (SRHR) and FP; their skills and techniques in broadcasting FP and other health related messages were strengthened. The CRs will complement the messages transmitted during CD sessions by CFs; they are intended to promote the rights and duties of citizens in relation to SRHR and FP and to raise public awareness about SRHR and the benefits of FP services.

Radio name	Localization	Coverage radius	Average # of inhabitants covered	Used idioms
Parapato	Angoche	50 Km	56.350 inh.	Macua, Ekote e Português
Nacala	Nacala	70km	71.094 inh.	Macua e Português
Memba	Memba	70km	29.124 inh.	Macua e Português
Mossuril	Mossuril	70km	25.810 inh.	Macua e Português
RTVC de Namialo	Namialo	70km	35.017 inh.	Macua e Português
RTVC de Erati	Erati	70km	71.543 inh.	Macua e Português
RTVC Ribaue	Ribaue	70km	28.596 inh.	Macua e Português
Radio Gemeas	Cidade de Nampula		73.672 inh.	Portugues

These radio spots are prepared to produce 16 SRHR and FP programs that will be broadcast live, once a week for 45min to 1H, in their local languages and programs will be repeated once during the same week.

CRs will also explain to the listeners that when the broadcast in not on the air they should be able to contact the platform "Tua Cena" to continue interacting with project staff and have their questions answered. All participants expressed their satisfaction for the opportunity to learn new content through the broadcast with such dynamic methodologies and practical sessions.

	The 16 program themes
1	"Sex - What Now?" informing about the beginning of sexual life;
2	"It is also your right to have access to quality health care";
3	"Family Planning - part 1" - reporting on what is meant by family planning (concept);
4	"Family Planning – part 2" informing about advantages of FP – inviting youths to talk about their FP;
5	"Adolescent Pregnancy - Risks – part 1" talk about risks of pregnancy in adolescence (physical, emotional and individual development);
6	"Adolescent Pregnancy - Risks – part 2" – clarify obstetric fistula risks during pregnancy in adolescence;
7	"Methods of contraception – part 1" report on what contraception means; when to start using; how to choose the method;
8	"Methods of contraception – part 2" inform about contraceptive methods
9	"Methods of contraception – part 3" inform about barrier methods
10	"Methods of contraception - part 4" inform on oral hormonal methods;
11	"Methods of contraception – part 5" report on injectable hormonal methods;
12	"Methods of contraception – part 6" talk about implants;
13	"Methods of contraception – part 7" talk about the IUDs;
14	"Female Sterilization & Vasectomy";
15	"Myths and Wrong Ideas about Family Planning";
16	"Contraceptive Methods RECAP Program"

Sub-IR 2.3: Improved systems to implement and evaluate (Social and Behavior Change Communication) (SBCC) interventions

This activity has not yet started as the SBCC portion of the project has not yet started.

IR 3: Strengthened FP/RH health systems

HSS activities in the Jan-Mar 2017 quarter were focused on the assessments of district management capacity through the management standards compliance (MSC) assessment tool, and performance evaluations of the main family planning (FP) indicators through the elaboration of District Profiles (DP).

Activities in Sofala Province were launched in January 2017, starting with planning and collaboration meetings between various IFPP technical teams and with MOH partners. This was an opportunity to introduce the FP-focused MSC tool and associated approach for strengthening FP related health systems, incorporating contributions from counterparts in the MCH, HR and Planning & Cooperation departments within the provincial health directorate (DPS).

During this reporting period, IFPP's HSS team implemented 11 district baseline MSC assessments of the FP health systems in Sofala and Nampula provinces. This represents a 73% achievement against the quarterly target to conduct 15 assessments during this period. Following the completion of each assessment, the project also supported district managers to draft quality improvement (QI) action plans to strengthen district management capacity and increase district alignment with MOH FP health systems standard operating procedures (SOPs). In addition, the project also supported each SDSMAS to develop a district profile (DP) of the key performance indicators (KPIs) for family planning. HSS technical advisors worked with district managers to set targets for all KPIs, and organized data analysis meetings with SDSMAS and HF staff involved in FP service delivery and systems management to analyze performance and develop action plans to guide follow-up QI interventions. TA was also provided to assess HF needs for FP health information systems (HIS) tools in these 11 districts, and develop a commodity distribution plan to ensure all sites have access to the necessary forms, logbooks, and brochures.

Once all 15 districts have completed their MSC assessments, district profiles and HIS distribution plans, the project will provide follow-up technical assistance to support the systematic implementation of each QI action plan to ensure systematic improvement and FP services and associated health systems.

Sub-IR 3.1: Improved FP financial management, strategic planning, and budget execution

Activities within this sub-IR will include capacity building and technical assistance to the districts and DPS to appropriately include and budget for evidence-based FP strategies in the annual provincial plans (Plano Económico e Social [PES]) and district plans (the Plano Económico e Social Distrital [PESOD]).

During the reporting period, technical assistance and recommendations were provided for improving and realigning the 2017 Nampula and Sofala PES for the FP program, considering the objectives of IFPP. The 2017 PES and respective budget for FP activities were realigned as well as the monthly, quarterly and semester work.

In total, 2 DPS and 33 SDSMAS (21 Nampula; 12 Sofala) received TA to monitor the performance of the 2017 PES and methodologies for dissemination and use of the strategic information produced during the implementation of the 2017 PES/PESOD.

Several aspects influenced the performance of this indicator, including:

- Program / sector work plans (annual, quarterly and monthly) were not aligned with PES/PESOD plans in DPS Nampula, and Angoche, Chibabava and Caia SDSMAS (DPS Nampula and Angoche SDSMAS did not prepare monthly and quarterly plans);

- Poor capacity and know-how for:
    - Elaborating and using the CDFMP and PESOD (FP program) by MCH managers and some NED officers;
    - Measuring activities and products in PES/PESOD2017;
    - Monitoring of implementation of PES/PESOD 2017 activities;

- To improve this indicator the project provided on-the-job training to DPS Nampula, Sofala and 12 SDSMAS (during the MSC Assessments and DP elaboration) in the above mentioned subjects.

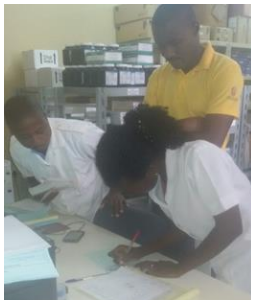
Sub-IR 3.2: Improved management of commodities to ensure availability at local levels

During the reporting period, contraceptives stocks trended below the minimum required at the health facilities level, and at the SDSMAS and DPS storehouses. Subsequently stock-outs at SDPs occurred. In order to avoid and /or mitigate the length of the SDPs stock-out, IFPP teams support a more efficient communication between stakeholders at all levels (DPS, DDM, IFPP District Coordinators and HF) to track FP commodity stocks, prevent and/or minimize existing stock-outs through the redistribution of commodities from low demand sites with stock to high demand at imminent risk of stock-out or with stock-out. The project supported a timely satisfaction of HF's emergency restock requisitions for FP commodities available at district and provincial depots using IFPP vehicles, as well as from other partners operating in the FP area in these provinces.

# of contraceptives stock-out	# of Mentored HF			stock-out (%) (per provinces)		stock-out in 2 provinces (%)	
	Nampula	Sofala	Total	Nampula	Sofala	No	yes
0	26	6	32	51%	55%	52%	
1	14	3	17	27%	27%		27%
2	7	2	9	14%	18%		15%
3	4	0	4	8%	0%		6%
Total	51	11	62	49%	45%	52%	48%

As IUD stock level at Sofala DPM level dropped below the minimum required, IFPP supported CMAM to transfer 8,000 IUDs from the Quelimane DPM which was in surplus and had low consumption rates, to the Sofala DPM.

TA to MCH Nurse in filling out the FP stock control



Furthermore, IFPP provided TA to seven district DDM (*Deposito Distrital de Medicamentos)* managers in Nampula Province[1] in the elaboration of distribution plans of HIS/MCH-FP tools, which resulted in more effective coordination and activity planning between the DPS MCH-FP focal point, DDM and the IFPP District Coordinators. This was particularly effective at improving the systematic distribution of FP commodities and medicines, and increasing the provision of FP outreach services through mobile brigades.

IFPP provided logistics and technical support for two provincial FP task force (FP-TF) meetings in Nampula Province, resulting in QI action plans that led to:

- Development of comprehensive terms of reference for the task force outlining major responsibilities and activities of the FP-TF;
- TA to revitalize and operationalize three District FP-TFs, including Angoche, Monapo and Nacala Porto;
- Sharing best practices and lessons learned from the HSS interventions to improve FP logistics systems (i.e. interventions and mechanisms for monitoring and avoiding contraceptive stock outs) and IFPP support with other DPS partners, namely MCSP and DKT.

One of the standards measured in the systems assessments requires that districts and DPSs have a clearly documented systematic plan to receive and distribute FP commodities to satisfy growing demand.

TA provided in the Logistics component of FP commodities and medicines from DPM to DDM resulted in:

- More efficient communication between actors at all levels (DPS, DDM, IFPP District Coordinators and HF) to track FP commodity stocks and act to reduce the stock outs;
- More timely completion of restock requisitions for FP commodities available at district and provincial depots using IFPP vehicles, including from other partners operating in the FP area in these provinces;
- Redistribution of commodities from low demand sites with stock to high demand at imminent risk of stock outs, as well as through emergency requisitions to provincial and district depots.

[1] Including Nampula City, Angoche, Monapo, Ribaue, Erati, Meconta and Nacala Porto

Sub-IR 3.3: Strengthened governance, including civil society engagement, for an improved FP enabling environment

After the training of the community facilitators and the implementation of the community dialogue sessions, IFPP would carry out the community score card (CSC) process from May through July for 15 groups which is delayed to the next FY. Meanwhile, during the next quarter, IFPP will focus on the expansion of the demand generation component.

Sub-IR 3.4: Improved government capacity to increase supply, distribution, and retention of skilled workers

Based on the systems assessments and resulting capacity building and systems strengthening action plans, IFPP will support DPS and district managers to more effectively manage supply, distribution, and retention of skilled FP workers. In year one, the project will support DPS and district managers to track, report, and prioritize all FP/RH in-service and on-the-job trainings using the MISAU human resource information system (SIFo), and developing GIS maps to identify districts and HFs with FP/RH training needs.

To support this action, IFPP has:

- Provided TA for the coordination of in service training activities in 8 SDSMASs (Nampula: Angoche, Monapo, Ribaue, Erati, Meconta and Nacala Porto; Sofala: Beira and Dondo) through on the job trainings. The SDSMAS of Angoche, Monapo and Nacala Porto have already started with the in-service trainings; it is expected that in the next quarter they will start recording each training in the SIFO information system;
- Supported DPS SIFO operators to correctly enter data from the forms into the training information system for trainings provided to health providers trained by IFPP, which resulted in 275 health providers registered in the system in Nampula and 323 in Sofala during this quarter;
- Provided on-the-job training for the IFPP M&E staff in the use of the SIFO training information system, as well as providing access to the system password to allow them to enter the forms at SDSMAS level in the future.
- Determined that dysfunctional district in-service training centers created constraints in entering the SIFO forms in the system. In response, all forms are sent to DPS in Nampula and Sofala for their registration at provincial level, generating high volumes of forms to be entered by DPS SIFO operators. This system needs to be decentralized to district level to improve efficiency and increase accuracy of reporting.

Sub-IR 3.5: Improved generation, dissemination, and use of FP data for more effective decision-making

IFPP will develop district profiles for each of the year one IFPP districts. These profiles will integrate all the information gathered through the facility assessments, systems assessments, and HMIS, providing a useful dashboard of strategic information to guide evidence-based

decision making. These district profiles will be updated and used during quarterly data review meetings at district and provincial level to support strategic decision-making and prioritize allocation of IFPP resources and interventions. In addition, during year one, IFPP will use routine quality improvement visits and targeted training to HFs to ensure that HFs are accurately capturing all FP services in the new facility registers, and that summary reports are accurately filled and fed up to the district and provincial levels.

During this quarter, IFPP supported the data review meetings with the Nampula and Sofala DPS and 11 SDSMAS (Nampula city, Angoche, Monapo, Ribaue, Meconta, Erati, Nacala Porto; Beira City, Dondo, Chibabava and Caia). Throughout the 2017 FY, IFPP will apply the MSC and DP tools in 9 districts in Nampula and 6 in Sofala, with gradual expansion in years 2-5. Districts yet to be prioritized in year one include the following: Moma, Mecuburi, Gorongosa and Nhamatanda. During Q2FY1, TA was provided to the NEP and MCH Department in the DPS to present the results of the district MCH program at the monthly MCH-FP data analysis and discussion meetings based on the DP; Technical support in the data collection, aggregation, elaboration of the district profile together with NEP and presentation to the group led by the provincial chief medical officer in Sofala DPS.

Constraints and solutions proposed to overcome IR 3 challenges

Constraints

- Frequent unavailability of SDSMAS program managers (difficulty in bringing together all district and program staff from some districts to participate in the assessments of district FP systems, DP and presentation of results);
- Non-alignment between the activities contained in the work plans of the MCH-FP program and PES/PESOD 2017, impacting on the results of the program.
- Stock-outs of FP commodities and basic surgical supplies (e.g. sterilized gloves) at certain HFs continues to pose a recurrent challenge;

Solutions

- Advocate district leadership for greater involvement of SDSMAS technicians participating in HSS activities to ensure ownership and sustainability;
- TA in the elaboration of the sector work plans by period (Annual, Semester, Quarterly and Monthly) in line with PES/PESOD 2017.

Next quarter activities

- Provide follow-up TA to all 11 districts with QI action plans to support the successful implementation of corrective actions identified as necessary in the baseline assessments of District PF health systems (MSC);

- Monitor closely FP commodities stocks and support proactive stock management through SRH commodities taskforce and proper forecasting and request mechanism;
- Conduct MSC assessments and draft QI action plans in the remaining four districts not evaluated in this quarters goal to reach 15 districts; Produce geographic maps (GIS) using the MOH HR Information System (e-CAF & SIFO) to identify HR/FP training needs and develop QI action plans to address gaps; Provide TA and logistics support to hold planning workshops to assist the DPS and SDSMAS in the preparation of the 2018 PES and PESOD in collaboration with the IFPP M&E team.

Monitoring, evaluation, and implementation research

At the central level, the IFPP project team continued to hold meetings with the USAID M&E team to clarify and adjust the proposed PMP to reflect the best estimated targets while baseline survey data is being analyzed.

During this reporting period, the following key activities were conducted:

Baseline Survey (Population-based)

For the IFPP baseline, a population-based survey was conducted in Nampula and Sofala provinces. During the first month and a half of this quarter the project focused on pre-survey preparatory work, which included planning field work logistics and the obtaining authorization from local authorities.

Field survey officers training was held in Maputo from February 13th to 24th, with 10 officers per province. In each province, the enumeration areas were divided between 2 teams. Additionally, two M&E officers (one from each province) participated in field-supervisor training in order to oversee the field work. This training was conducted jointly by Pathfinder (for the digital health component for data collection) and National Institute of statistics (for field work and sampling), and the pilot took place in Maputo province (Matola).

The field work began on March 6th in both provinces and ended on March 31st for team I and on April 3rd for the team II of Sofala; in Nampula both teams III and IV completed the field work on March 28th.

Data analysis and report writing will be completed during the next quarter.

M&E Workshop

In February, a three-day M&E workshop was held in Maputo with the participation of all project M&E officers. The aim of the workshop was to establish a common understanding of IFPP

indicators and definitions, data collection and reporting tools, and to increase knowledge and understanding of the PMP.

Technical support and RDQA visits in HFs

The M&E team provided technical support visits in 11 districts in Nampula and 5 districts in Sofala. These visits allowed the team to work jointly with the HF and district teams to review the quality of data registry and reporting to ensure proper filling of all required fields in FP logbooks, clearly identify and report new and continuing users as well to prepare FP data for monthly data review meetings.

Data Review Meetings

Data review meetings were supported in all intervention districts, which proved to be instrumental in tracking progress on FP and other key indicators per HF. Meetings allowed staff to identify issues, for example, that not all APE data was being reported by the HF in the same catchment area. It also provided an opportunity for staff to discuss the available stock of SRH commodities in each HF.

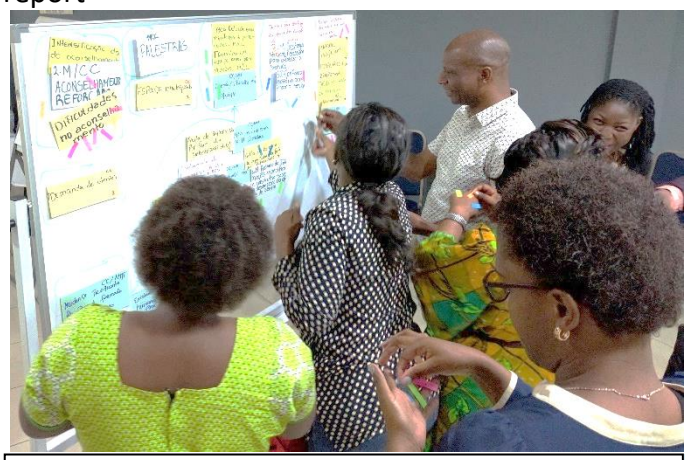
Key activities for next quarter:

- Conduct technical assistance visits to support health providers;
- Continue to conduct Routine Data Quality Assessments (RDQA);
- Continue to support HFs in preparing monthly FP data and reports;
- Participate in the district's data review meetings;
- Improve data analysis (SIS-MA) through use of the PivotTable;
- Train internal staff (CD, OP, advisors) in the management of SISMA-MOH.
- Analyze baseline data and write the baseline report

Implementation Science and Learning (ISL)

Building on lessons learned during Q2FY1, the Pathfinder IFPP team organized an interactive "optimization" workshop in Nampula, from March 20-23, in which project staff and MoH officials worked to identify data-driven insights to improve program performance.

During the workshop, the IFPP project leadership team and all Nampula-based clinical mentors and supervisors jointly reviewed health facility-level service statistics, clarified high impact practices and lessons



Participants vote to prioritize key opportunities for improving FP service integration during an Implementation Science & Learning (ISL) "Optimization" workshop held in Nampula on March 21st, 2017

learned to date, and worked to identify key inhibiting and facilitating factors driving program post-partum IUD and implant service provision within maternity wards and treatment wards.

In advance of the ISL "Optimization" workshop, a simple self-assessment survey was administered to 147 maternity ward nurses and treatment ward clinicians to quantify and compare health providers' perceptions of various factors inhibiting or facilitating FP service integration, including: contextual variables (adequate space, supplies, time constraints, etc.); client demand; measures of self-efficacy/technical confidence; motivation; and institutional support (feedback and perceived prioritization of LARC-PP by maternity ward management).[2] The 24-question self-assessment was administered by IFPP project staff to all available maternity ward nurses and treating clinicians at 18 project-supported health facilities during mentorship visits conducted from March 13-17, 2017. A total of 87 treatment ward clinicians and 59 maternity-ward nurses completed this survey, and results were presented to participants during the Optimization workshop to inform strategy development. During the 3-day "optimization" workshop, participants identified several opportunities for performance improvement:

- **Strengthen FP Counseling during ANC:** Sharing site-level observations of front-line project staff revealed a lack of consistent counseling on family planning (with emphasis on PP-LARC) during pre-natal counseling sessions, especially at lower-performing sites. The contextual analysis indicated that training and periodic quality-focused mentoring of ANC nurse staff on LARC counseling and method provision was necessary but insufficient to ensure sustained integration of this behavior into daily ANC nurse activities at all sites.
- **Increase offer of FP counseling during puerperium/recovery:** Project staff noted that in low-performing project sites women were not consistently offered family planning counseling (with emphasis on PP-LARC) during the immediate post-delivery recovery period, constituting an important missed opportunity for increasing post-partum adoption of IUD and hormonal implants. Workshop participants noted that maternity-ward nurses in low-performing sites were less likely to consider the offer of FP counseling during recovery as either "urgent" or "obligatory". Conversely, in health facilities with greater buy-in and support from the maternity ward staff in-charge, this task had become part of most maternity nurses' daily routine. Facility-level observations revealed that due to cultural reasons, many women attending the maternity wards (even those counseled on FP during ANC visits) did not initiate requests for FP services during their visits to the maternity ward,

[2] A health provider behavior-change framework was developed based on the *Opportunities, Abilities and Motivations* (OAM) framework developed by Ölander and Thøgersen (1995), and modified to better account for intrinsic and extrinsic motivations within an organizational/work-place context (Vallerand, 1997, Siesmen, 2008).

and instead awaited nurse initiation, resulting in significant lost opportunities for post-partum FP uptake.

- **Learn from the success of HIV testing integration:** The participants identified an important insight: HIV testing had been effectively integrated into all project-supported maternity wards. Even though most women did not request the test, providers initiated the test to nearly all clients, and nearly all clients accepted. The project looked at factors that facilitated the integration of HIV testing into the maternity wards and found that the management had established testing as a priority and offered daily reminders to nurses, asking for written justifications for each case when an HIV test was not accepted by a pregnant woman. Over a period of time, the nurses began to see HIV testing as an obligatory part of their routine work in the maternity ward, and the managers did not need to prompt as often.

Through a systematic adaptation process, workshop participants identified five key "change-makers" as key to achieving more consistent, proactive and sustainable integration of post-partum LARC in all project sites: (1) maternity ward managers (head); (2) Clinical Directors; (3) Sterilization Officers; (4) Maternity Ward Nurses; and (5) Treatment Ward Providers. Participants then designed a program adaptation consisting of specific strategies to improve facility-level engagement. The intervention will focus on top-down involvement from the District to the Clinical Directors to the Nurse level; In-Charges will be supported to offer daily reminders and management support to the nurses. An "FP integration model clinic" matrix will be developed and disseminated to clarify the specific role of each "change-maker" cadre, with opportunities for recognition from District and Provincial-level authorities. In the following quarter, the IFPP project team will replicate the ISL "optimization" workshop with the Sofala team and will implement the project's adaptations in all project-supported HFs in Nampula, and will measure any subsequent changes in voluntary post-partum IUD and implant uptake.

A participant explains an action plan to improve facility-level management buy-in for FP service integration during the ISL "Optimization" workshop in Nampula.

Project Performance Indicators

Goal: Increase use of modern contraceptive methods

IR 1: Increased access to a wide range of modern contraceptive methods and quality FP/RH services

Indicator	LOP Target	Annual Target	Annual % Achieved	Q1	Q2	Q3	Q4
1.A. # new users of modern contraceptive methods	542,210	TBD		46,836	108,406		
	No target was set for this indicator since the new MCH data collection tools were introduced in April 2016 and impacting the "FP new user" definition (now defined as first time users in their life). A target will be set after one year of implementation of the new logbooks to avoid biased information. The Q2 reported number represents 36 districts in Nampula and Sofala Province when the Q1 reported number represented 17 most populated districts in Nampula Province.						
1.B. # continuers users of modern contraceptive methods	658,968	347,025	46%	58,246	100,692		
	IFPP is on track for this first year.						
1.C. Couple Years of Protection	2,922,512	249,272	77%	47,519	144,732		
	Data disaggregated by method is presented in the PMP in the annex. We have already achieved the yearly target as IFPP accelerated the start-up in all 36 targeted districts. Q1 was covering only 17 districts out of 23 in Nampula province; for Q2, 81,847 CYP were reported in Nampula and 62,885 in Sofala.						
1.D. # women receiving contraceptive services in HIV services	18,465	6,629	7%	80	416		
	Introduction of data collection form (FP integration logbook) at health facility level is progressive as it was introduced after provider's training; data collection through the pilot M&E form was disrupted in some HFs where MOH orientations have not yet been conducted. These data represent 25 HFs (14 in Nampula and 11 in Sofala located in 12 different districts in Nampula and 9 in Sofala). Next quarter, the MOH, together with IFPP will support the dissemination of the administrative orientation to this data collection form.						
1.E. # postpartum clients accepting a modern contraceptive method prior to or at discharge	330,059	10,420	68%	1,156	5,891		
	During the second quarter of this fiscal year 1,976 PPIUD were inserted (1,434 in Nampula and 542 in Sofala) and 3,915 women accepted another modern contraceptive method prior to discharge.						
1.F. # users receiving modern contraceptive methods from APEs at community level	83,612	15,857	53%	0	8,345		
	Support activities have been carried out this quarter in both provinces. 5,503 were reported in Nampula and 2,842 in Sofala.						

Comments

Indicators in general attested to the strong roll-out of IFPP.

Sub- IR 1.1: Increased access to modern contraceptive methods and quality, facility-based

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
1.1.1. # health providers trained on modern methods of contraception	1,665	274	573%	692	878		
	The annual target was defined taking in account a progressive start-up of activities; however, an accelerated start-up was carried out in order to reach the MOH 2020 FP targets; it's expected that 80% of all health providers are trained at the end of FY17. This quarter, 463 eligible health providers were trained in Sofala and 415 in Nampula						
1.1.2. % of health providers who have completed the training on modern methods of contraceptive with positive score in the post test	80%	80%	100%	94%	91%		
	This reporting period, 91% of trained providers completed the training and had a positive score in the post test. IFPP is on track to achieve the annual expected target (87% in Sofala and 95% in Nampula)						
1.1.3. % percent of supported service delivery sites providing family planning counseling and/or services	100%	66%	9%	9%	33%		
	All the 124 trained HFs are offering family planning counseling which represents 33% of the total number of HF (124/382). IFPP is on track to achieve the annual expected target						

Comments

The providers' trainings are expected to cover almost all providers during the first year as the phase-in and coverage increases to all intervention districts. The level of participation in trainings and knowledge retention after trainings was high, including providers' understanding of the content and willingness to provide services.

Sub- IR 1.2: Increased access to modern contraceptive methods and quality, community-based

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
1.2.1. # of additional USG-assisted community health workers (CHWs) providing family planning information and/or services	3,735	575	133%	87	678		
	IFPP has already achieved the annual expected target.						
1.2.2. # mobile brigades conducted including contraceptive services		1,352	34%	0	457		
	IFPP supported mobile brigades in HF catchment areas that benefited from a FP training this current quarter.						

Comments

During this reporting period 678 demand generation CHWs (190 CFs, 369 TBAs and 45 IPC agents and 74 APEs were trained and started to provide information on family planning at the community level (both in urban and rural).

Sub-IR 1.3: Improved and increased active and completed referrals between community and facility for FP/RH services

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
1.3.1. % confirmed referrals from communities to facilities for FP services	40%	20%		NA	13.6%		
	This indicator is only available with clients owning a phone: during Q2FY1, 259 referrals were confirmed at HF on a total of 1902 e-referrals activated electronically. Additionally, 7,782 paper vouchers were confirmed at HF by providers; below, IFPP is reporting the trend of the total number of confirmed referrals at HF whether it was initiated through an electronic voucher or a paper voucher.						
# of community referrals confirmed at facility level				**791**	8,041		

Comments

Numbers of confirmed referrals at the HF level have tremendously increased during this quarter and these numbers are only related to the urban demand generation component.

Next quarter, IFPP CFs will start their contact registration as well as their community referrals using paper based tools. For registering TBAs' contacts and community referrals, IFPP will monitor and support the pilot TBAs' groups already trained in Movercado. Meanwhile, alternative paper solutions will start to be conceived and designed for TBAs future use.

Challenges using Movercado

Movercado is an SMS platform that uses mobile phone text messaging to connect community health promoters, beneficiaries, health facilities and under this project, pharmacies, to expand access to health products and services. Movercado has two features – the use of electronic vouchers (onDemand) and paper vouchers. When using electronic vouchers the health promoter registers the beneficiaries phone number to the system providing immediate information on the person reached. This then allows IFPP to follow up with them and find out the quality of their session and/or health service. Using paper vouchers only provides information once the person reaches the facility and the code is validated by a nurse. Many beneficiaries do not own phones or are unwilling to share their numbers for fear of losing their privacy around their use. of contraception. During this reporting period, almost all the referrals were paper-based.

Once the beneficiary reaches a health facility, the nurse validates the code, either paper or electronic, to signal that the beneficiary came in for a service. When the client presents an electronic voucher, the nurse can automatically report the type of method chosen by the beneficiary.

In rolling out the project, we found that there are a few limitations to the system considering project requirements – the system does not capture the number of physical voucher given to

each beneficiary and, the number of FP sensitization sessions that took place but did not result in a referral. This information is considered important so that program managers can see how many people each actor (IPC agent, TBA) reaches during a reporting period. However, a new code was just created that will allow actors to register each interaction they have with a potential client. Another major challenge we currently have with the system is that many of the rural actors do not own a mobile phone, making this system incapable of recording the number of people reached or referred to a health facility. This limitation is a major barrier since it prevents IFPP from making mobile payments at the end of the month.

IR 2: Increased demand for modern contraceptive methods and quality FP/RH services

Sub-IR 2.1: Improved ability of individuals to adopt healthy FP behaviors

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
2.1.1. # contacts conducted by trained TBAs/activists to women	1,147,520	22,400	54%	791	11,260		
	143 IPC agents and 46 CFs were sensitizing during this quarter; note that the TBAs contacts are still not being registered thru Movercado.						

Comments

As mentioned above, the number of contacts has been challenging to capture through the Movercado platform, the Q2FY1 number of women contacts (11,260) **is surely underestimated** as it represents 7,782 confirmed paper referrals of IPC agents, 1902 e-referrals activated by clients and 1,576 women participating in the CD. Therefore, IFPP CFs will start their contact registration as well as their community referrals using paper-based tools. For registering TBAs' contacts and community referrals, IFPP will monitor and support the TBAs' groups already trained.

Sub-IR 2.2: Improved community environment to support healthy FP behaviors

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
2.2.1. # community dialogues conducted on FP (6 sessions completed)	13,056	768		0	0		
	Planned to be reported next FY as the 6 programmed CD sessions will end in Q2FY2						
# of CD sessions implemented	**78,336**	4,608	**7%**	0	**324**		
	We added this sub-indicator to monitor the progresses carried out by the community component; indeed, no Community Dialogue will be completed this FY1 as the 6 sessions completing a Community Dialogue cycle will be distributed along one full year.						
2.2.2. # community radio sessions broadcasted on FP/HTSP		84		0	0		
	The training of 24 Community Radio Members was completed during the last week of March and radio broadcasting sessions are planned to start next quarter.						

Comments

Originally it was expected that the formative research conducted by N'weti would take place in October – December 2016, and that this research would be taken into consideration during the development of the community dialogue tool, helping to answer questions related to the socio-anthropological complexity of the different areas of implementation. However, the first attempt for the recruitment of the formative research team was not successful as no suitable candidates submitted proposals and N'weti had to repeat the process. The formative research was carried out the Q2FY1 and results will be incorporated in the fourth, fifth and sixth sessions of the community dialogue cycle; this delay in obtaining the formative research inputs will consequently delay the 768 community dialogues which were planned to be completed during the first fiscal year.

Sub-IR 2.3: Improved systems to implement and evaluate SBCC interventions

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
2.3.1. # meetings held with SBCC project to plan/coordinate SBCC approaches		NA		NA	NA		
	The SBBC partner is still not present at provincial level						
2.3.2. # capacity building sessions for community radios and community groups in SBCC for FP	TBD	2	50%	0	1		
	24 Community Radio Members were trained in Nampula .						

Comments

UNICEF through its IREX project is one of the existing provincial partners, the other one is ICS – *Instituto de Comunicação Social*; coordination meetings as well as radio broadcasting were carried out this Q2FY1.

IR 3: Strengthened FP/RH health systems

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
3.A. # DPS including FP interventions in annual PES and budget	2	2	100%	1	2		
	Realigned the 2017 PES and respective budget for FP activities in Nampula and Sofala provinces; Alignment of the monthly, quarterly and semester work plans with PES and PESOD plans;						
3.B. # SDSMAS/DPS achieving satisfactory scores in MSC assessment	36	2	0	0	0		
	11 SDSMAS were assessed but none achieved satisfactory scores or a minimum of 80%: In Sofala Province: Beira City - 63%; Caia - 48%; Chibabava - 59%; Dondo - 38%						

	In Nampula Province: Nampula City - 39%; Angoche - 35%; Monapo - 50%; Ribaue - 44%; Erati - 37%; Meconta - 33%; Nacala Porto - 41%.						
3.C. % USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide	NA	20%	NA	NA	48%		
	Out of the 62 HFs monitored for stock-out, 30 experienced some stock-out; redistribution activities between HF and use of project transportation minimized the stock-outs;						
3.D. % of supported SDPs with all eligible health providers trained in a range of modern contraceptive methods	100%	60%	58%	7%	35%		
	35% of all health facilities of both provinces (68 HF in Nampula and 7 HF in Sofala) have all eligible health providers trained at the end of Q2FY1. [(68+7)/(225+157)]. Note that this indicator is cumulative.						

Sub-IR 3.1: Improved FP financial management, strategic planning, and budget execution

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
3.1.1. # DPS and SDSMAS staff receiving TA/capacity-building in FP planning, budgeting and implementation	60	60	65%	4	35		
	23 staff in Nampula and 12 in Sofala received TA.						

Sub-IR 3.2: Improved management of commodities to ensure availability at local levels

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
3.2.1. # of supported districts with a documented FP logistics map to optimize commodity distribution, requisition and reporting	2 DPS and 36 Districts	2 DPS and 29 Districts	35%	0	11 districts		
	In Sofala, 11 logistics maps were already developed by Abt staff under CHASS project (only Caia and Gorongosa do not have), and two districts need to be updated (Beira and Chibabava); TA was provided on the importance of using Logistic maps in the distribution of FP commodities especially in the definition of routes and quantification of fuels in case of interruption of the main routes						

Comments

The maps have not been elaborated in Nampula due to difficulties in obtaining the district maps with necessary information, such as access road information; however, preparatory activities were developed in order to produce the maps in the next quarter, including:

- Joint assessment with DPS/Logistics (DPM and Transports Department) of the database with necessary information to prepare the logistics maps for 9 districts in Nampula Province (priority in this year one of the project);
- Development of one route plan (from DPS to SDSMAS to HFs, and to APEs) of Nampula Province, to improve the distribution of contraceptives in the province and based on it, fill in the logistic map;

- Development of a monthly follow-up calendar, support and control of the requisition, and distribution of contraceptives by IFPP District Coordinators in coordination with the DDM and HF Pharmacy managers in Nampula Province;

Sub-IR 3.3: Strengthened governance, including civil society engagement, for an improved FP enabling environment

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
3.3.1. # of HF that undergo CSC feedback processes through community discussions at least once per year	280	15	0%	0	0		
	This activity is reported to next FY						

Comments

The activities contributing to this indicator were not planned for the present period, since they will be implemented after the dialogue process has started.

Sub-IR 3.4: Improved government capacity to increase supply, distribution, and retention of skilled workers

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
3.4.1. # DPS, SDSMAS & HF staff trained in family planning that are registered in e-SIFO (database)	1,665	274	326%	294	598		
	598 additional Technical/Health care providers trained at HF level in Integrated Family Planning with information recorded in SIFo,						

Comments

IFPP Annual target has already been surpassed; there is a need to review the target as IFPP intends to train about 80% of all the 1665 health providers planned for the LOP in the first year–Length of the Project. Dysfunctional district in-service training centers created constraints in entering the SIFO forms in the system. In response, all forms are sent to DPS in Nampula and Sofala for their registration at provincial level, generating high volumes of forms to be entered by DPS SIFO operators. This system needs to be decentralized to district level to improve efficiency and increase accuracy of reporting.

Sub-IR 3.5: Improved generation, dissemination, and use of FP data for more effective decision-making

Indicator	LOP Target	Annual Target	% Achieved	Q1	Q2	Q3	Q4
3.5.1. # of districts that hold quarterly data review meetings using district profiles	36	29	38%	0	11		
	District profiles and MSC health systems assessments were carried out in 11 SDSMAS, including 7 in Nampula and 4 in Sofala, setting the stage for routine quarterly data analysis meetings in these districts in the future; DPS Sofala is already using the district profile for data analysis in monthly and quarterly meetings;						

Comments

TA was provided to the NEP and MCH Department in the DPS to present the results of the district MCH program at the monthly MCH-FP data analysis and discussion meetings based on the DP; Technical support in the data collection, aggregation, development of the district profile together with NEP and presentation to the group was led by the provincial chief medical officer in Sofala DPS.

Major Implementation Issues

No major implementation issues are being faced by IFPP at this time. Two issues that are worth mentioning are 1) due to the geographic and FP activities overlapping with MCSP, divergence in implementation strategies were identified and triggered an unstable environment for implementation; an immediate intervention was required and meetings with USAID and Partners were held to clarify roles and responsibilities which will begin to be implemented beginning in the next quarter; 2) Stock-out of commodities, which could lead to interruption of method provision in supported HFs. This is mainly due to low national stocks for some of the methods such as the IUD. An exceptional redistribution was needed from Zambézia to Sofala, which was supported by IFPP.

Collaboration with other donor projects

During this reporting quarter, coordination meetings took place with Government (Ministry of Health, Provincial health directorates and District Directorates of Health) and other partners such as MCSP and ICAP.

The main agenda items of the discussion with Ministry of Health were the alignment of the Y1 workplan and to share the detailed activities and how all the activities contribute to Health System Strengthening. This was intended to ensure continuity of activities after project close-out. The project implementation strategy was praised and MoH recommended to include some

of the detailed activities was made. At the provincial and district level, meetings were held to coordinate and plan each month's activities such as trainings, mentorship visits, supervision visits, mobile brigades, and data review meetings.

A coordination meeting was held with MCSP and USAID once again to clarify roles, responsibilities and reporting at different layers of implementation (training, supervision, mentorship and technical assistance), followed by a half-day workshop where IFPP and MCSP presented project core implementation strategies and mechanisms for coordination at all levels.

Coordination with clinical partners such as ICAP in Nampula is continuously taking place as the roll out of FP/HIV integration in all ART health facilities takes place.

Upcoming Plans

IR 1: Increased access to a wide range of modern contraceptive methods and quality FP/RH services

- Support MoH roll-out of FP integration guidelines and data collection tools;
- Continue FP trainings at HF level and subsequent mentoring visits.
- Continue FP trainings for community based providers (APEs).
- Strengthen the availability of the contraceptive methods at the HF level and for APEs based within the catchment areas of the HF by reinforcing the SRH commodities taskforce at the central and provincial level.
- Coordinate with MCSP to share responsibilities in the support to be given in each HF which previously benefited from an FP technical training through Mobile Brigades to increase access of FP commodities to remote communities without overlap.

IR 2: Increased demand for modern contraceptive methods and quality FP/RH services

- Roll-out of the TBA training at the peripheral level prioritizing the HFs which already benefited from health provider training.
- Follow up of the TBAs and IPC agents trained in FP, including coaching on the use of Movercado.
- Refine community dialogues tools and roll-out based on formative research results.
- Train community facilitators to implement community dialogue sessions to boost an enabling environment in rural communities.
- Sign MoU with community radios and start broadcasting in combo areas in Sofala.

IR 3: Strengthened FP/RH health systems

- Continue to provide TA to the DPS and SDSMAS managers in PES and PESOD results-based planning, budgeting, implementation, and monitoring aligned with MoH 2018 priorities as announced by DPC-MOH.
- Refine the district profile tool and the MSC tool at the SDSMAS level.
- Finalize and roll-out the mapping of the contraceptive logistics system.

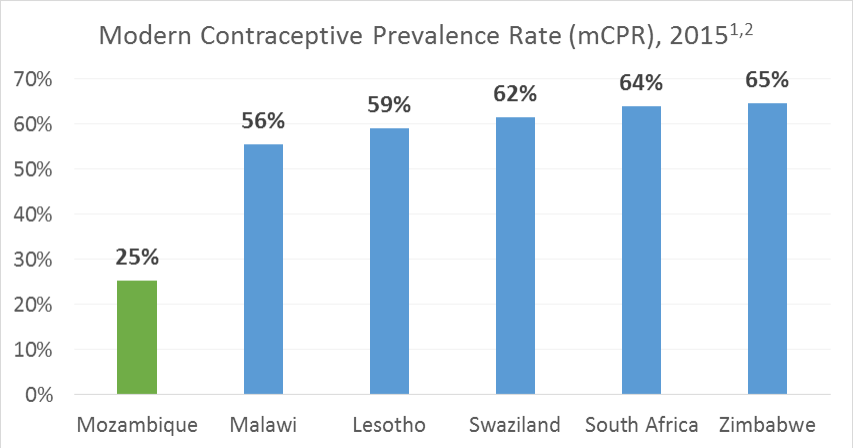
Evaluation/Assessment Update

Evaluations, Assessments, Studies, and Audits Include any and all types of evaluations, financial or programmatic, internal or external.
Planned: List evaluations, assessments, studies and/or audits planned for next quarter
• Formative research completed and data being used to inform the CD tools development • Baseline survey field work completed, data analysis and report will be presented next quarter

Success Story

National Multi-Sectoral Response to increase Family Planning Access and Acceptance: "Global Commitments, Local Actions"

Despite significant increases over the past four years, Mozambique continues to have the lowest utilization rate of modern family planning in Southern Africa, as seen in the graph below.[3,4] The Government of the Republic of Mozambique (GRM) has committed to more than double the modern contraceptive prevalence rate (mCPR), to 34%, by 2020, and has established a national FP Technical Working Group to accelerate improvements in FP utilization country-wide.



[3] Trends in Contraceptive Use Worldwide 2015, Economic & Social Affairs, United Nations.
[4] IMASIDA, 2015

Pathfinder International currently serves as the co-chair of the National FP TWG in Mozambique, and on March 27th of this year, Pathfinder supported the Ministry of Health (MoH) to organize a national-level meeting to inaugurate a multi-sectoral strategy to increase modern FP utilization. During the meeting, the first lady of Mozambique, Isaura Nyusi, the Minister of Economy and Finance, the Minister of Health, and the Governors' spouses from all eleven Provinces, came together with the single purpose of advocating for urgent and coordinated action to increase modern FP access and acceptance. These and other key governmental and non-governmental stakeholders from various sectors joined to make the case that increased promotion of modern FP is paramount for achieving the shared national goal of improving all Mozambicans' personal, social, economic and financial well-being.

Present at the meeting were representatives from the Ministries of Education and Human Development, Finance, Health, and Youth and Sports, as well as nationally-recognized leaders from various religious, cultural, youth, mass media, and civil society organizations. Recent data, including results from the 2015 IMASIDA survey, were presented to underscore the underutilization of modern FP methods, due in part to widespread misinformation and limited access to high quality modern FP services. The meeting concluded with specific recommendations to accelerate multi-sectoral integration of proactive modern FP promotion and monitoring at the national, provincial and district levels.

Annexes

- PMP
- Workplan
- Financial information