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Opportunities and Challenges for Contraceptive Service Delivery in Cyclone Idai-Affected Areas of Mozambique

Case Study

October 2020

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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Cover photo: Reproductive health and family planning clinic within a rural hospital in Buzi. To the right an SAAJ, a dedicated adolescent-friendly health facility. Neither facility was operational at the time of data collection due to cyclone Idai flooding. © Katherine Gambir/WRC

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Contents

Executive Summary 1
- Our key findings 1
- Our top recommendations 2

I. Introduction 4
II. Background 4
III. Overview of Methods 6
- Methods and sampling 6
- Ethics 8
- Limitations 8

IV. Findings from Key Informants 10
- Service delivery 10
- Key terminology 11
- Coordination among partners 14
- Commodities 15
- Data collection and use 16
- Skilled staff 18
- Community mobilization 19

V. Service Statistics 21
VI. Findings from Health Facility Assessments 22
- Health facilities assessed 22
- General infrastructure 23
- Contraception 24
- Post-abortion care 26
- Pharmacy and drug storage 26
- Data use 28
- Knowledge and attitudes of service providers 29

VII. Findings from the Community 31
- Practices and norms related to pregnancy and marriage 31
- Awareness of contraceptive methods and availability 33
- Reasons for contraceptive use, and positive attitudes toward contraceptive use 33
- Negative attitudes and misconceptions about contraceptives and contraceptive use 34
- Factors influencing contraceptive use 35
- Availability and accessibility of services 37
- Quality of services 39

VIII. Discussion 40
- Long-acting reversible contraceptives 41
- Emergency contraception 41
- Post-abortion care 42
- Stockouts and supply chain management 42
- Challenges, effective strategies, and opportunities for contraceptive uptake 43

IX. Recommendations 45
X. Appendices 48
- Appendix A: Data from key informant interviews 48
- Appendix B: Data from health facility assessments 49
- Appendix C: Provider knowledge and attitudes data 52

Acronyms and Abbreviations 55
Endnotes 56

Executive Summary

After days of rainfall in central Mozambique, Cyclone Idai made landfall near the city of Beira in Sofala province on 14 March 2019. The cyclone pounded Sofala, Zambézia, Tete, and Manica provinces with torrential rains and high winds, leaving catastrophic damage and extensive flooding in its wake. By the end of April 2019, an estimated 400,000 people had been displaced due to Cyclone Idai,[1] and in May 2019, 1.85 million people were reported to be in need of humanitarian assistance.[2]

Globally, studies have shown that disaster- and conflict-affected and displaced women and girls face heightened sexual and reproductive health (SRH) risks, including increased risks of maternal morbidity and mortality, gender-based violence, sexually transmitted infections, unintended pregnancy, and unsafe abortion and its associated complications. Therefore, contraceptive services, including the full range of methods, and post-abortion care are critical components of internationally accepted minimum standards for humanitarian health responses.

In December 2019, the Women's Refugee Commission conducted a case study of contraceptive service delivery in Cyclone Idai-affected areas of Mozambique, which aimed to document the important work that the government of Mozambique, its partner organizations, and other stakeholders were undertaking to provide contraceptive services and post-abortion care to affected communities, including internally displaced persons and host communities, to highlight challenges, and to document how some of these challenges were addressed.

The case study employed mixed research methods, including key informant interviews with Mozambican Ministry of Health personnel, United Nations Population Fund (UNFPA), and nongovernmental organization health and SRH program managers; health facility assessments, including SRH knowledge and attitudes surveys with service providers; focus group discussions with affected communities, including internally displaced persons; and a review of service delivery data from the Mozambican Ministry of Health.

This study is the final installment in a series of three case studies documenting contraceptive service delivery in humanitarian settings. The first case study was conducted in Cox's Bazar, Bangladesh, and published in June 2019. The second was conducted in Maiduguri Metro Center, Borno State, Nigeria, and published in May 2020.

Our key findings

- **Awareness of the Minimum Initial Service Package for SRH,** including Inter-Agency Reproductive Health Kit management, **was generally low among partners at the outset of the response.**
- **Long-acting reversible contraceptives were less available than short-acting methods.** Gaps in the availability of contraceptive and post-abortion care services persisted, even as the situation stabilized. At the time of data collection, nine months after Cyclone Idai, all five facilities assessed reported they had experienced a stockout of at least one method in the preceding three months.

- **Only one of the five facilities assessed had the equipment and supplies to provide intrauterine devices, and only one could provide emergency contraception, to an acceptable quality of care**. None of the facilities had the equipment and supplies to provide post-abortion care with manual vacuum aspiration with an acceptable quality of care.
- **Partner opposition and lack of contraceptive decision-making power among girls and women were key barriers to contraceptive uptake among community members**. Stigma among community members and providers was a key barrier for adolescents in accessing contraceptive services.
- **Mechanisms were in place to routinely collect contraceptive service delivery data from health facilities;** however, service delivery data from Agentes Polivalentes Elementares, Mozambique's cadre of community health workers, were captured separately from other contraceptive service statistics, and **data accuracy remained a challenge**. Many facility registers were destroyed during the cyclone, leading to gaps in data.
- **Very few health providers had been trained to provide post-abortion care with manual vacuum aspiration or misoprostol, and their knowledge of post-abortion care was very low**. Mobile health units were not authorized to provide post-abortion care services. Community members consistently reported a high incidence of unsafe abortion, particularly among adolescent girls.
- **Gender-based violence,** including sexual exploitation and transactional sex, and child, early, and forced marriage, **was reported to have increased after the cyclone.** However, community members had very low knowledge of emergency contraception, which can prevent pregnancy after unprotected sex, including rape, and three of five health facilities were stocked out of emergency contraception pills.
- **Supply chain management and commodity availability posed challenges for contraceptive and post-abortion care service delivery** over the course of the humanitarian response, primarily due to stockouts.

Our top recommendations

It is essential that the government of Mozambique and its partners maintain their efforts to deliver SRH services to affected communities and those who may be impacted by future disasters, including the most remote or isolated communities, and meet demand and need for contraceptive services, preventing mortality and morbidity, and fulfilling fundamental human rights.

- **SRH partners should reinforce and expand emergency and disaster risk management measures,** including for health and SRH, to mitigate the impacts of future disasters, and **build capacity for emergency response** at the national and community levels.
- **The Mozambican Ministry of Health, UNFPA, and other SRH partners should identify gaps in knowledge and capacity for implementation of the Minimum Initial Service Package**, including Inter-Agency Reproductive Health Kit management, and coordinate to deliver MISP trainings to the Mozambican Ministry of Health and other implementing partners.
- **The Mozambican Ministry of Health should continue to reinforce its integrated model for contraceptive service delivery and task-shifting policies** by ensuring all providers are trained, stocked and supported to provide the full range of methods that they are authorized to provide. In particular, the Mozambican Ministry of Health should ensure that midwives and traditional birth attendants are trained, stocked, and supported to deliver the full range of contraceptive

methods, and that Agentes Polivalents Elementares are trained, stocked, and supported to provide emergency contraceptive pills.

- **The Mozambican Ministry of Health should expand the availability and accessibility of contraceptive services in remote and isolated areas** by authorizing health providers and pharmacists to distribute oral contraceptive and emergency contraceptive pills in multi-month supplies, and authorizing women to self-inject DMPA-SC (brand name Sayana Press) and ensuring health providers and pharmacists are equipped to train and support women to self-inject.
- **SRH partners should strengthen the capacity of providers to deliver a full range of contraceptive methods**, including removals of long-acting reversible contraceptives, and post-abortion care, through pre-service training, regular refresher trainings, supportive supervision, on-the-job training, and values clarification and attitudes transformation activities.
- **SRH partners should strengthen community mobilization efforts** by expanding programming that supports attitudes and behavior change around SRH and rights, and targeted efforts to reach adolescents with SRH information and services.
- **SRH partners should continue and expand measures to strengthen capacity for supply chain management among providers, pharmacists, and supply chain managers**, including effective distribution, stock management, and the use of Mozambique's logistics management information system, SIGLUS.

A staff member of AMODEFA and a health provider display reproductive health IEC materials in the family planning and consultation tent in a rural health center in Dondo, Sofala Province.

Photo credit: Arturo Sanabria

I. Introduction

This case study is the third and final publication in a series documenting contraceptive service delivery in humanitarian settings. The Inter-Agency Working Group on Reproductive Health in Crises' (IAWG) 2012–2014 Global Evaluation of sexual and reproductive health (SRH) services in humanitarian settings[3] found a persistently weak evidence base for SRH service provision, particularly contraceptive services, in humanitarian settings.

The Women's Refugee Commission (WRC) subsequently embarked on a landscaping assessment to improve knowledge on the state of contraceptive services in humanitarian settings; assess progress and challenges to the successful implementation of contraceptive service delivery in humanitarian settings; and identify key recommendations to accelerate access to contraception for crisis-affected populations across the humanitarian-development nexus. The assessment comprised mixed methods, including a literature review, a global contraceptive programming survey of implementing partners, key respondent interviews with field and headquarters staff from humanitarian and development organizations, and the aforementioned case studies. The first case study was conducted in Cox's Bazar, Bangladesh and published in June 2019.[4] The second case study was conducted in Maiduguri Metro Center, Borno State, Nigeria, and was published in May 2020.[5]

II. Background

In March 2019, Cyclone Idai caused extreme, extensive damage in Mozambique's Sofala, Zambézia, Tete, and Manica provinces. After days of rainfall and flooding, Cyclone Idai made landfall near Beira City in Sofala province on 14 March 2019. Rivers overflowed their banks, exacerbating and causing additional flooding throughout the region. More than 600 people were killed, and more than 1,600 were injured. The cyclone also caused massive damage and destruction to infrastructure, partially or totally destroying an estimated 240,000 homes, partially destroying 89 health facilities and two health training facilities, and completely destroying three health facilities.[6] By the end of April 2019, an estimated 400,000 people had been displaced,[7] and as of May 2019,1.85 million people were reported to be in need of humanitarian assistance.[8] An estimated 74,650 women impacted by Cyclone Idai were pregnant. More than 43,276 pregnant women were expected to give birth in the six months following the disaster, and an estimated 7,465 pregnant women were at risk of life-threatening obstetric emergencies.[9]

Just six weeks later, Cyclone Kenneth struck the northern provinces of Cabo Delgado and Nampula. Critically, prior to the crises caused by the cyclones, Mozambique was already facing high levels of food insecurity due to the ongoing drought affecting the southern region of the continent —which was only exacerbated by the destruction of crops as a result of the cyclones.[10]

Data collection for the case study took place in December 2019, nine months after Cyclone Idai struck. As of 12 December 2019, the International Organization for Migration reported that 71 resettlement sites across Manica, Sofala, Tete, and Zambézia provinces were hosting 93,516 individuals.[11] Also in December 2019, the UN Office for the Coordination of Humanitarian Affairs reported that in Cyclone Idai-affected areas, more than half a million people, or an estimated 100,000 households, were living in damaged or destroyed homes, and that many resettlement sites lacked access to basic goods and services.[12]

Globally, studies have shown that disaster and conflict-affected and displaced women and girls face heightened SRH risks, including increased risks of maternal morbidity and mortality, gender-based violence (GBV), sexually transmitted infections (STIs), unintended pregnancy, and unsafe abortion and its associated complications.[13] Consequently, SRH services are an essential and lifesaving component of the basic health response in humanitarian emergencies, and therefore are included in internationally accepted minimum standards for humanitarian health response, as articulated in the *Minimum Initial Service Package* (MISP) *for Sexual and Reproductive Health*.[14] In the 2018 revision of the MISP, provision of contraceptive services was included for the first time as a priority objective within SRH service provision. The MISP for SRH is a set of priority lifesaving SRH activities and services that form a minimum standard that should be implemented at the onset of every humanitarian crisis to prevent excess morbidity and mortality, particularly among women and girls. The priority services in the MISP for SRH are integrated in the Sphere Minimum SRH and HIV Standards for Humanitarian Response.[15] As a crisis stabilizes, the response should transition as soon as possible from the MISP to the provision of comprehensive SRH services for all affected women, men, and adolescents.[16]

The 2012–2014 IAWG Global Evaluation of SRH services in humanitarian settings found that contraceptive services have lagged behind other SRH services.[17] Long-acting and permanent methods of contraception, as well as emergency contraceptives (EC), have been especially neglected.[18] This is despite evidence that a wide range of available methods increases overall contraceptive use,[19] and consensus that the provision of contraception is a lifesaving health intervention with far-reaching implications for recovery and resilience for individuals and communities[20] that accelerates progress toward global goals.[21] Across humanitarian settings, studies have shown that women demand contraception and will use it when it is available and of adequate quality.[22]

In 2017, the maternal mortality ratio in Mozambique was estimated to be 289 per 100,000 live births.[23] In 2018, the HIV prevalence among adults aged 15 to 49 was 12.6%—among women of the same age range, the proportion was higher, at 15.1%.[24] UNAIDS also reported that of the 2 million adults living with HIV in Mozambique, 60%, or 1,200,000, were women.[25] Family Planning 2020 reported the modern contraceptive prevalence rate among all women to be 35.6%, and the unmet need for contraception among married women to be 22.8%, in 2019.[26]

This case study aims to document the important work that the government of Mozambique and its partners are undertaking to provide contraceptive services to Cyclone Idai-affected communities, including internally displaced persons (IDPs) and host communities, to highlight challenges, and to document how some of these challenges were addressed.

To conduct this case study, WRC partnered with the International Planned Parenthood Federation's member association in Mozambique, the national nongovernmental organization (NGO) Associação Moçambicana para Desenvolvimento da Família (AMODEFA). AMODEFA supported WRC to arrange key informant interviews (KIIs) and facility assessments, and supported the organization of focus group discussions (FGDs) in Mandruzi Resettlement Center and the rural hospital in Buzi. AMODEFA played an important role in the SRH response to Cyclone Idai, additional details on which will be included in this report.

III. Overview of Methods

Methods and sampling

The case study employed mixed methods, including KIIs with government representatives, the United Nations Population Fund (UNFPA), and health and SRH program managers at NGOs; health facility assessments, including SRH knowledge and attitudes surveys with service providers; FGDs with affected communities and IDPs; and a review of service delivery data from the Ministry of Health of Mozambique (MISAU).

Prior to data collection, official approval to conduct the case study was granted by MISAU. The credential letters authorizing the case study were signed by the Directorate of Public Health and presented to partners at the central, provincial, district, and health unit levels.

Table 1: Case study data collection methods

Data collection type	Number
Number of key informant interviews	10*
Facility assessments	5
Provider knowledge and attitudes questionnaires	10
FGDs with community members	11, composed of 112 participants

** Multiple representatives included in interviews, and multiple interviews were conducted with more than one entity.*

Case study tools: Data collection tools were adapted from validated instruments used in the 2012–2014 IAWG Global Evaluation,[27] MISP evaluations,[28] and a multi-country baseline study on contraceptive services in humanitarian settings conducted by WRC, the United Nations High Commissioner for Refugees (UNHCR), and the US Centers for Disease Control and Prevention in 2011 and 2012.[29]

KIIs: WRC conducted individual interviews with key informants to understand contraceptive and PAC service delivery available to communities affected by Cyclone Idai, including challenges and successes in implementing contraceptive services in affected areas. Key informants were purposively selected based on the following criteria:

- working at MISAU at the national, provincial, or district level, UNFPA, a local NGO, or an international NGO that has been directly implementing or supporting contraceptive services in affected areas or to affected communities; and
- individuals within those organizations working as health or SRH program managers or coordinators and available in person during the case study field work.

Based on these criteria, key respondents from 11 organizations that were participating in the humanitarian SRH response were invited to participate in in-person interviews at a convenient time and place in Maputo, Beira, or Buzi. Two international NGOs, one national NGO, MISAU, and UNFPA

responded and were available to participate in interviews **(see Appendix A, Table 10).** Representatives from MISAU at the central, provincial, and district level participated. Interviews were conducted in English, or in Portuguese with a Portuguese-speaking researcher, in a quiet and private or semi-private location. The Portuguese-speaking researcher provided interpretation from Portuguese to English during the interviews. All interviews were conducted with at least two researchers, with one party taking notes. The Portuguese speaking researcher subsequently listened to recordings of the interviews that took place in Portuguese, and took detailed notes in English. WRC then collated all responses and carried out thematic analysis to identify recurring and unique themes across the interviews.

Facility assessments: WRC conducted health facility assessments to evaluate the readiness of facilities to effectively provide contraceptive and PAC services. NGO participants in the case study purposively selected the health facilities to be assessed. The assessments included interviews with facility staff and a room-by-room walkthrough and inventory of essential drugs, supplies, and equipment. Five facilities were assessed: one rural hospital, three urban or rural health units, and one mobile health unit.

Provider questionnaires: In each health facility, WRC administered a questionnaire to health workers providing SRH services to determine their knowledge and attitudes concerning contraception and PAC. Questionnaires were administered on paper forms in Portuguese. WRC collected 10 questionnaires from 10 health workers. The results were entered into a spreadsheet for descriptive analysis.

FGDs: The WRC researchers organized 11 FGDs with IDPs and host or affected community members in order to elicit attitudes, experiences, beliefs, and preferences of community members toward contraception. FGDs were conducted with adolescent girls (15–19 years old, most of whom were unmarried), young married and unmarried women (20–24 years old), older married or widowed women (25–45 years old), adolescent boys (15–19 years old), married men (20-29 years old), married men (20–45 years old), and married men (30-45 years old). The groups included between six and 13 participants. The FGD participants were recruited by community activists with support from an NGO partner from the catchment area of a health facility offering contraceptive services or from within the Mandruzi resettlement center. Participant recruitment included targeted outreach to people living with disabilities; however, only two individuals who self-identified as living with a disability participated in the FGDs.

A total of 11 FGDs were held in private spaces in a resettlement center in Dondo and within the compound of a hospital in Buzi. The discussions were facilitated by a young woman and a young man respectively, who could speak both Portuguese and the local language Ndao. Five FGDs were conducted in Portuguese and six were conducted in Ndao. With consent of the participants, the moderators audio-recorded the discussions. Subsequently, the moderators transcribed and, where necessary, translated the discussions from Ndao into Portuguese. The Portugese transcripts were then submitted to an external translation service to be translated into English. WRC researchers then developed, piloted, and iterated a codebook. Each transcript was coded by WRC staff in the NVivo 12 Plus software package, and discordances between coding were resolved through consensus of coders and/or adaptation of the codebook.

Service delivery statistics: WRC reviewed contraceptive and PAC service delivery data from Mozambique's national health management information system, SISMA. The data were cleaned, aggregated, and submitted for descriptive analysis (see **Figure 1, page 21, and Figure 2, page 22**).

Ethics

WRC adapted the case study methodology from prior case studies carried out by WRC and in accordance with its established *Ethical Guidelines for Working with Displaced Populations*.[30]

Key respondents and FGD participants were informed of the study's purposes, risks, and benefits and given the opportunity to verbally consent to participate in the interview. Names and other identifying information were not collected from FGD participants. WRC provided an information sheet to each respondent with WRC's contact information and directions for anonymous reporting channels. FGDs were audio-recorded with the consent of the participants; audio recordings were then transcribed into text, and translated into English. The recordings were subsequently deleted. Any names mentioned during the FGDs were deleted during transcription.

All data collected for this report were stored securely on password-protected devices once uploaded and transferred to WRC, and data were not shared outside of the WRC case study team. All individuals or entities named in this report are named with their explicit consent.

Limitations

This case study was intended to document the state of contraceptive and PAC service delivery available to IDP, host, and affected populations at a specific point in time in select Cyclone Idai-affected areas of Mozambique. While the researchers spoke to the primary providers of these services, their responses may not be representative of service delivery for the affected population, across all cyclone-affected areas, or across all time periods. The health facility assessments and FGDs were conducted in Sofala province only; however, the researchers conducted interviews with key informants from MISAU, UNFPA, and INGOs based at the central level, who provided insights into Mozambique's national SRH response. The organizations delivering contraceptive services may continually be changing practices and the humanitarian situation in country continues to evolve, so it is possible that the situation of contraceptive service delivery across the affected areas represented in this case study has changed since the time of the case study data collection.

Due to concerns that WRC researchers were affiliated with USAID, respondents in one facility in Dondo did not provide complete or accurate information about the provision of PAC, potentially limiting researchers' ability to obtain accurate information about the provision and availability of services in the district. Additionally, this raises the possibility that other respondents did not provide complete or accurate information about the availability or provision of PAC services.

Six FGDs were conducted in Ndao, and translated into Portugese; all FGDs were translated from Portuguese into English. It is possible that some nuance and detail were compromised or lost over the course of the translation process. All quotations included from FGD participants are translations, and may not reflect the participants' exact words.

Seven of 11 KIIs were conducted primarily in Portuguese. The Portuguese-speaking researcher listened to the interview recordings and took detailed notes in English. It is possible that some nuance and detail were compromised or lost during notetaking.

This report may be impacted by response bias. One reason for potential response bias is that FGDs were conducted in locations with ongoing contraceptive and PAC service provision; therefore, participants may have been more likely to report familiarity with or provide positive responses on

contraceptive services, compared to participants from communities without similar access. This report may have also been impacted by social desirability bias. One reason for potential social desirability bias is that an NGO involved with SRH and contraceptive service delivery in each community led the recruitment of FGD participants; therefore, participants may have been more likely to provide positive responses on contraceptive services if they associated the FGD facilitators with the NGO.

WRC carried out analysis of the datasets in the United States. Due to time and COVID-19-related constraints, the WRC study team was not able to involve study participants in analysis or to share preliminary results for community validation; therefore, interpretation of some of the data may have been affected by researcher bias.

Maternal and child health services were set up in a tents adjacent to the permanent health facility in a rural health center in Dondo, Sofala Province.

Photo credit: Arturo Sanabria

IV. Findings from Key Informants

Service delivery

General context

In the immediate aftermath of Cyclone Idai, the UN Inter-agency Standing Committee activated nine clusters, including the health cluster. The response was led by the government of Mozambique, and the health cluster was led by MISAU and the World Health Organization (WHO).[31] In addition to the health cluster, MISAU convened and led a sub-cluster on SRH with UNFPA. Notably, one NGO respondent reported that, in addition to the clusters and technical sub-working groups, partners also convened at the district level to coordinate health activities, including SRH services. All partners worked in partnership with MISAU, and through MISAU-led systems and facilities. More information on coordination and partnerships can be found below in ***Coordination among partners*** (page 14).

The health system suffered extensive damage due to the cyclone. In addition to structural damage to health facilities, respondents reported that damage to supplies, commodities, and registers impeded the ability of MISAU and its partners to deliver SRH services, including contraceptive services and PAC, in the immediate aftermath of the cyclone.

Displaced persons—many of whom were sheltering in schools and other public buildings in the immediate aftermath of the cyclone—were directed to accommodation centers as the situation stabilized. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) reported that as of 3 April 2019, there were 136 accommodation centers across Sofala, Manica, Tete, and Zambézia provinces.[32] All accommodation centers were closed by or in June 2019, with those persons who were still displaced directed to resettlement centers.[33] The resettlement centers were established in sites that were identified as being less vulnerable to natural hazards, and suitable for long-term habitation.[34] In addition to displaced persons, one respondent reported that persons living in areas that were determined to be non-habitable were also asked to relocate to resettlement centers. A MISAU respondent reported that, eventually, there would be permanent health units constructed in the resettlement centers.

Respondents reported that, as part of the first stage of the health response, tents, or "mobile health units," were established in the accommodation centers to provide health services. When resettlement centers were later opened, they also had mobile health units. A respondent from MISAU reported that the mobile health units were staffed by an integrated mobile team from the district.

Tents were also established on site at damaged health facilities to ensure that provision of services could continue until the facilities were repaired, and during reconstruction. As of December 2019, when data were collected, three of the five health facilities assessed were still providing some or all health services out of tents. In two of these facilities, all contraceptive and PAC services were being provided in tents.

A respondent from MISAU at the central level confirmed SRH services were included in the humanitarian response plan and consolidated appeals process. However, one MISAU respondent at the district level in Dondo reported a lag in funding, and stated that funds were not allocated until May. The respondent reported that this delay had a particular impact on MISAU and partners' ability to reach remote or isolated affected communities with SRH services, as they were not able to support mobile brigades.

UNFPA reported providing Inter-Agency Reproductive Health (IARH) Kits[35], including clean delivery kits, and dignity kits directly to the government for distribution approximately three weeks after cyclone Idai. Providers in one health facility reported receiving IARH kits, but did not receive instruction on how to use the kits. More information on the availability of skilled staff and how supplies and commodities were procured can be found below in ***Commodities*** (page 15).

Respondents noted that, at the outset of the response, there was not widespread familiarity with the MISP for SRH among MISAU staff and health providers, and that MISAU staff and providers were not initially familiar with the use of the IARH kits. UNFPA reported supporting the government to provide training on the MISP for nurses, and on GBV services and referrals. Another key informant reported that International Planned Parenthood Federation (IPPF) and Australian Aid deployed staff to Mozambique in March 2019 to provide training of trainers sessions on the MISP to AMODEFA. Additionally, AMODEFA was engaged to implement and coordinate MISP activities in Sofala province, including Dondo, Buzi, and Nhamatanda districts and Maputo City, and in Zambézia, Tete, and Manica provinces.

Key terminology

Accommodation center: temporary site housing internally displaced persons.

Resettlement center: permanent relocation site for internally displaced persons, or persons residing in an area identified as being high risk for future displacements.

Health facility: static health unit.

Mobile health unit: mobile health units were tents established in accommodation centers, and later resettlement, centers, to provide basic health services.

More broadly, multiple respondents noted a general lack of emergency preparedness, including for health and SRH. One NGO respondent based in Beira reported that WHO provided training on emergency response following the cyclone, but researchers did not obtain detailed information as to the focus and content of the training, its participants, or when it took place. Several respondents expressed the need for more training on emergency preparedness.

Respondents from MISAU at the district level reported receiving funding from the provincial directorate of health (DPS) and UNFPA several months after the cyclone to deploy mobile brigades to reach remote or isolated communities with integrated services, including antenatal care (ANC), immunizations, contraceptive service delivery, and nutrition services. Respondents reported that mobile brigades began in September 2019. One NGO respondent reported that there was a need to deploy mobile brigades more frequently to reach remote or isolated communities, but that there was not sufficient funding to do so.

AMODEFA also reported supporting health fairs offering GBV and contraceptive services, including STI diagnostic services, through mobile health units, and conducting community mobilization activities to generate demand and increase awareness about SRHR. Similarly, the organization CUAMM reported working with MISAU to organize health fairs at the district level. In addition to providing HIV testing, nurses provided contraceptive counseling and referred potential clients to health units.

Notably, all respondents confirmed that health facilities, including mobile health units, provided services at no cost to all individuals.

Contraception

Overall, respondents reported that male condoms, injectables, and oral contraceptive pills (OCPs) were available several days to a few weeks after the cyclone; however, LARCs were not available for a few months post-cyclone. One respondent from MISAU at the central level reported that when contraceptive service provision was launched in accommodation centers and resumed in health facilities, it was limited to the injectable DMPA-SC (brand name Sayana Press), OCPs, and the distribution of male condoms. Another MISAU respondent reported that condom distribution in the accommodation centers was reinforced following reports of increases in transactional sex and sexual violence. One respondent, based in Buzi, reported that demand for contraceptive services increased one month after the cyclone, as users were increasingly reaching the point where they needed to replenish their OCPs or receive injections.

A respondent from MISAU at the central level reported that after three months, LARCs—intrauterine devices (IUDs) and implants—and female condoms were made available. When the provision of LARCs resumed, they were only available in health facilities; they were not available in mobile health units in accommodation centers. At the time data collection took place, implants were being provided in resettlement centers; however, insertions and removals of IUDs and removals of implants were not available in resettlement centers.

WRC received conflicting information from respondents at MISAU at the provincial and central level, respectively, as to whether emergency contraceptive pills (ECPs) were made available with short-acting methods and male condoms, or with LARCs and female condoms after a period of three months. Meanwhile, a respondent from MISAU at the district level in Dondo reported that ECPs were made available both as a part of clinical management of rape and when women sought services after an incident of unprotected sexual intercourse.

When queried as to the reasons why the provision of LARCs was delayed, a MISAU respondent reported that efforts to deliver LARCs, in particular, were impeded by the perception among MISAU staff that contraceptive services were not lifesaving. The respondent reported that during and immediately after the cyclone, the response was focused on evacuating people from flooded areas, and then establishing accommodation centers and relocating displaced communities. The lack of priority for commodities was reportedly exacerbated by the reality that contraceptive commodities can be bulky and created challenges when MISAU attempted to secure space for contraceptive commodities in transportation from the central to the provincial level.

Additionally, respondents reported that the delay in the provision of LARCs was related to the conditions in the mobile health units in the accommodation centers, including the inability to properly sterilize equipment, and the availability of equipment. Even after IUD and implant insertions were made available in health units, and implant insertions in mobile health units, women were required to go to health units to have implants removed due to the conditions (e.g., lack of hygiene and sanitation) in the mobile health units in the accommodation centers—and later in the crisis, in the resettlement centers.

Notably, a respondent from MISAU at the central level reported that, in the aftermath of the cyclone, women were arriving at mobile health units in accommodation centers and seeking LARCs, only to find that they were not available. Women were referred to health units—static facilities with the requisite supplies and conditions— to receive LARCs, but transportation was not readily or routinely available, and the respondent reported that many women seeking LARCs resorted to short-acting methods.

Another MISAU respondent, when queried about challenges, cited the relatively low uptake of LARCs as compared to short-acting methods. A different MISAU respondent felt strongly that, in responding to any emergencies in future, it would be critical to ensure LARCs were made available at the outset of the response, particularly for adolescent girls, as the respondent perceived there was an increase in sexual activity among adolescents in the aftermath of the cyclone.

One respondent from MISAU at the provincial level expressed that MISAU was "surprised" by the demand for contraception, and reflected that many people were able to access contraceptive services for the first time through the humanitarian health response.

Prior to the cyclone, MISAU had established focal points for contraceptive service delivery at the district and provincial levels. One MISAU respondent at the central level expressed that because these focal points were in place at the outset of the response, they were able to participate in the response and advocate for the inclusion of contraceptive service delivery.

Post-abortion care

One MISAU respondent at the provincial level noted that for the first month following the cyclone, destruction of infrastructure and inability to secure power led to challenges with sterilization and, therefore, health facilities could not provide PAC with manual vacuum aspiration (MVA). The respondent reported that facilities prioritized providing sterilization to maternity facilities and that challenges with sterilization were resolved after one month. However, the respondent did not explain whether PAC with misoprostol was provided in the interim.

MISAU and NGO respondents reported that, as a matter of policy, PAC was not offered in accommodation and resettlement centers. The respondents also reported that the conditions in the mobile health units (e.g., lack of trained staff and adequate sanitation) did not support the safe provision of MVA. Although PAC with misoprostol can be safely administered in environments with limited resources, provided there is adequate information provided to clients and a functioning referral system in the event of complications,[36] respondents reported that PAC was only permitted in health units with maternity facilities.

However, when queried about the function of the referral system for PAC, providers at a mobile health unit in a resettlement center indicated that they did not have a system in place to notify the health unit or follow up with clients for non-emergency cases. They also reported that women were generally responsible for identifying and funding their own transportation to get to the facility, unless it was an emergency, in which case they would support emergency transportation. Additionally, when queried about the referral system, respondents at a receiving health unit reported that the referral system was not fully functional.

Notably, over the course of key informant interviews, researchers received conflicting or unclear information about the availability of PAC services, including the facility level at which PAC services should be available.

At the time of data collection, respondents at MISAU at the provincial level in Sofala and the district level in Dondo reported a stockout of misoprostol that affected the availability of PAC services. Additional information about supplies and commodities, including stockouts, can be found in below in ***Commodities*** (page 15).

Adolescents

When queried about adolescent girls' awareness of contraception, NGO respondents reported that girls understood the importance of contraception; however, one MISAU respondent in Dondo

noted that while contraceptive and PAC services were fully available to adolescents, adolescents faced additional barriers when seeking services due to parental opposition. Additionally, one NGO respondent at the central level said that providers may be less likely to make LARCs available to adolescent girls.

Gender-based violence and sexual exploitation

Respondents reported a high and increased incidence of GBV and sexual exploitation in the aftermath of the cyclone. Respondents specifically mentioned lack of food supplies contributing to transactional sex and sexual exploitation, with one NGO respondent reporting that they had received reports of community leaders exchanging food for sex. One district-level MISAU respondent reported that reinforcing the food supply lowered the incidence of transactional sex and sexual exploitation.

Respondents from AMODEFA reported that cases of GBV increased after the cyclone; however, they noted that survivors rarely reported these cases. In response, AMODEFA launched community sensitization activities on the availability of services for survivors of GBV in accommodation centers, and on the importance of reporting incidents of GBV. Volunteers with AMODEFA were trained to provide psychosocial support and to refer survivors of GBV to the health units and police. Respondents from AMODEFA noted that accommodation centers, and subsequently resettlement centers, implemented safety and security policies and social action, and that services for survivors, including psychosocial support and nutrition services, were made available in the health units and police posts in all centers.

Coordination among partners

As previously noted, the Inter-agency Standing Committee activated nine clusters, including the health cluster, following Cyclone Idai. The health cluster was led by MISAU and WHO, and the sub-cluster for SRH was led by MISAU and UNFPA. Coordination mechanisms operated at the national and provincial levels, and one NGO respondent also reported that partners convened at the district level to coordinate SRH activities.

Multiple MISAU respondents reported that the participation of partners was essential for the successful SRH response. Key informants reported that partners in the SRH response included UNFPA, AMODEFA, Pathfinder International, CUAMM, Population Services International, and DKT International.[37] Notably, AMODEFA reported that it was the only national NGO that participated in the SRH sub-cluster. Respondents from AMODEFA reported that their organization played an essential role in connecting communities with coordination mechanisms–AMODEFA staff collected data and information in accommodation centers on a weekly basis to share with partners.

MISAU and NGO respondents reported that meetings were used to coordinate activities and allocate responsibility among partners to ensure coverage of services and avoid duplication. Respondents also reported that the coordination mechanisms supported partners to identify and address challenges. Coordination also focused on transportation and commodities. NGO respondents reported partnering with other NGOs on activities, including trainings and mobile brigades. The coordination meetings also supported information sharing and communication. For example, one respondent cited a WhatsApp group that was used to share information about the availability of supplies.

MISAU respondents at the central and provincial levels reported that coordination mechanisms functioned well, successfully engaged partners, and improved the SRH response. Respondents from several NGOs also expressed generally positive perceptions of coordination within the SRH response, with one respondent citing the government's support for cooperation and partners' willingness to share information and collaborate.

However, several respondents also described coordination challenges, particularly at the beginning of the response. One NGO respondent reported that the influx of organizations arriving to respond to the cyclone complicated coordination efforts, as many of these organizations were not familiar with the context and required an orientation before they could effectively participate. Additionally, one respondent from an organization that participated in the SRH sub-cluster in Beira expressed the perception that the meetings were focused on information sharing, as compared to being action-oriented; the respondent also expressed the perception that there were "gaps in what [partners] said they were doing, as compared to what they were actually doing." Finally, one NGO respondent reported that some partners were not able to speak Portuguese, impeding their ability to fully participate when translation services were not available.

At the time of data collection, respondents reported that MISAU and partners providing SRH services had resumed standard technical working group meetings on a monthly basis.

Commodities

As previously noted, health facilities sustained extensive damage in the cyclone, including damage to commodities and supplies. Flooding and damage to roads and infrastructure caused further complications for distribution of commodities and supply chain management. Respondents reported using aerial brigades to facilitate the delivery of supplies.

Over the course of the cyclone response, respondents reported that commodities were mainly provided by the government, with support from UNFPA and other partners, and were then distributed using the standard national processes for supply chain management—from the central level to the provincial level, then to the district level for distribution.

Several key respondents reported that heath workers, especially pharmacists, prioritized other commodities over contraceptives. One respondent reported that pharmacists would not accept contraceptives given their relative bulk and limited storage space. Another NGO respondent reported that that contraceptive commodities were usually the last commodity that the provincial warehouse sent to the district level, and the last to be distributed from the district level to health units. A respondent reported that they were sent last because they were bulky, and they were deprioritized compared to other essential commodities, such as anti-retroviral drugs, malaria treatments, and antibiotics.

UNFPA provided all 13 IARH kits to support the SRH response. Respondents reported that UNFPA led the distribution of IARH kits to accommodation centers and affected facilities, and provided training for health workers on the proper use of the kits.

One MISAU respondent noted that when commodities first arrived at the district level, accommodation centers were prioritized for distribution, causing stockouts at health units.

An NGO respondent reported that resettlement sites and accommodation centers did not keep reserve stocks of commodities, but authorities at district and provincial levels should maintain reserve stocks. Researchers did not verify if these reserve stocks were maintained.

Respondents reported that stockouts persisted over the course of the humanitarian response. One NGO respondent reported experiencing stockouts of every method in supported facilities at some point over the six months preceding data collection due to high demand and the deployment of mobile brigades, which depleted stocks at facilities.

Multiple respondents reported stockouts of ECPs. Additionally, some respondents reported that health providers used the ECPs in the IARH kits when their ECPs were out of stock. However, other respondents reported that the ECPs in the IARH kits were expired at the time the kits were provided. One respondent confirmed that despite the stockout of ECPs, providers with their organization ensured the availability of EC using the less effective Yuzpe method, a combination regime of estrogen and progesterone OCPs.[38]

Multiple respondents also reported stockouts of misoprostol; one MISAU respondent reported that misoprostol in the IARH kits was used to cover misoprostol stockouts. The same respondent reported a stockout of OCPs due to expiry. A district-level MISAU respondent reported stockouts of the implant Implanon and the injectable Depo-Provera. However, the respondent noted that implants and injectables remained available, as Jadelle and DMPA-SC were available. Respondents noted that as a matter of policy, the use of DMPA-SC was usually reserved for Mozambique's community health workers (Agentes Polivalentes Elementares, known as "APEs"), and the provision of injectables in static facilities and mobile health units was restricted to Depo-Provera unless it was not available.

Respondents reported that facilities were directed to use the first expired, first out (FEFO) system for stock management. When queried about stock management and storage more generally, the majority of respondents reported that they did not experience thefts and security did not pose challenges. However, several respondents reported that commodities sustained damage due to poor storage conditions—for example, commodities being stored in boxes in a damaged facility sustained water damage due to rain.

As noted above, respondents reported that supply chain management was conducted in accordance with existing national systems and procedures over the course of the response. Although respondents consistently reported the use of stock cards, respondents confirmed that all static facilities had transitioned or were in the process of transitioning to the national logistics management information system, Sistema de Informação e Gestão de Logistica para Unidades Sanitarias (SIGLUS). SIGLUS is an application linked to the "open-source health commodities logistics management platform, OpenLMIS."[39] Respondents from Pathfinder reported that the organization was in the process of planning for trainings on the SIGLUS system in Sofala province. The application is intended to replace paper-based forms used by health workers, but one respondent noted that facilities using SIGLUS were also using hard stock cards as a backup to the electronic system.

Data collection and use

Given the scale of the destruction caused by the cyclone and its aftermath, many women and girls lost their client cards. Client cards are physical cards that document individuals' health information, often including information such as dates and purposes for health visits, diagnoses, treatments, and dates for follow-up. An NGO respondent reported that resumption of contraceptive services was complicated due to the destruction of registers and clients' cards, and reported conducting outreach to disseminate information about service availability and encouraging clients to present at facilities, even if they did not have their cards. Two NGO respondents based in Beira reported losing one month of data and distributing new registers.

The existing national system for data collection was used over the course of the response. All facilities used standardized paper-based registers provided by MISAU. Data from mobile brigades and community-based distribution were also entered into the registers. The health facilities were required to produce a daily summary report, which was then aggregated into a summary data report produced by each facility on a monthly basis. This summary report was subsequently sent to the district level for entry into SISMA, the national health management information system (HMIS).

MISAU respondents at provincial and district levels reported that prior to the cyclone and outside of the emergency response, the standing national SRH technical working group reviewed data for all health indicators, including SRH and contraceptive services, on a monthly basis to inform decision-making. One NGO respondent explained that this data was shared at the biweekly health cluster meetings attended by national and international partners, and the data was used to inform decisions about which geographic areas to prioritize and provide greater support.

Responses varied as to whether facilities routinely generated and displayed data visualizations. Of the five facilities assessed, only one had current data visualizations displayed.

In addition to challenges with data loss and collection in the aftermath of the cyclone, partners discussed challenges for data collection and use outside of the emergency response. A central-level MISAU respondent indicated that data quality was variable, and that data was not always entered in a timely fashion.

The primary data challenge cited by respondents was data accuracy. Several NGO respondents reported that changes to the definition of a "new user of family planning" had caused issues with data reporting. Respondents indicated that the definition of "new user of family planning," which was previously defined as a person who was new to using a contraceptive method, regardless of whether the person had used a different method previously, was changed to a person who starts a method and has never used any method before. Respondents provided conflicting information on when the definition changed, but reported that this new definition was not clearly understood, and cited as evidence the existence of data in some catchment areas suggesting more new users of family planning than women of reproductive age.

A health provider discusses the contraceptive data displayed in the family planning consultation room in a rural hospital in Buzi, Sofala Province.

Photo credit: Katherine Gambir/WRC

Respondents also noted that data accuracy was compromised by limitations of SISMA: specifically, it was not possible to enter data from services provided by APEs and midwives, or for contraceptive services provided as part of integrated service delivery.

Multiple NGO respondents reported that proper data collection and data quality were included in training and supervision for staff. Additional information on training and supervision for staff can be found in the Training and Supervision sections below.

Skilled staff

Respondents reported that Maternal and Child Health (MCH) nurses and APEs were the primary providers of contraceptive services in Mozambique. MCH nurses were trained to provide maternal, neonatal, and child health services (MNCH), including a comprehensive contraceptive method mix for women and girls, while APEs were trained to provide short-acting methods, including DMPA-SC, OCPs, and condoms, through community-based distribution. However, APEs could only administer DMPA-SC after the woman attended an initial health facility consultation, and we received conflicting information as to whether APEs were authorized to provide ECPs. Respondents noted that MISAU had a policy to promote integrated service delivery, in which health providers that were not specialized in MCH or SRH were trained to provide short-acting methods and implants; however, we received conflicting information as to whether midwives or traditional birth attendants were authorized to deliver any contraceptive method. Prior to the cyclone, NGOs such as Pathfinder had been working with MISAU to train providers and support the integration of contraceptive service delivery, including counseling, into broader primary health services in Sofala and throughout Mozambique.

Additionally, one respondent in Sofala noted that there was an appointed family planning focal point for each district in the province. A respondent from MISAU at the central level specifically mentioned the family planning focal points at the provincial and district levels supported the inclusion of contraceptive services in the humanitarian health response, and reported that focal points participated in the response.

Respondents described an overall lack of skilled providers for contraceptive services, even prior to the cyclone. Multiple respondents reported gaps in clinical skills among MCH nurses, specifically IUD insertion and post-partum IUD insertion. The lack of skilled providers exacerbated challenges providing contraceptive and PAC services following the cyclone.

Multiple respondents noted that Buzi was particularly hard hit by floods after the cyclone, which directly affected the availability of providers in the area and caused high turnover of staff. Although multiple respondents noted that providers, including contraceptive service providers, returned to work only a few days after the cyclone and partners worked quickly to recruit, train, and deploy skilled contraceptive service providers to the cyclone-affected area, respondents from one organization felt there was a shortage of health workers in the overall response.

Multiple partners reported that the influx of international organizations in the aftermath of the cyclone, and their hiring of health providers, caused complications for national actors. One NGO respondent noted that the new international partners recruited nurses and doctors that were already working in the national health system, and were able to pay significantly higher salaries.

AMODEFA, which deployed nurses to support mobile health units in accommodation centers, reported recruiting health workers, psychologists, and APEs from the affected communities. Conversely, respondents from one organization reported challenges when attempting to hire national staff due to a lack of experience responding in humanitarian emergencies.

Additionally, respondents emphasized that it is critical for humanitarian actors to recognize that providers are also members of the affected communities and that it is essential for organizations to provide robust support, including psychosocial support, to ensure their ability to safely participate in the response and their well-being.

Training

Pathfinder and MISAU respondents said that, prior to the cyclone, Pathfinder International had trained most health care providers throughout Mozambique on contraceptive service delivery in support of MISAU's policy on integrated contraceptive service provision. Following the cyclone, multiple respondents reported that new partners, such as UNFPA and other NGOs, supported the training of health care providers on contraceptive service delivery. All respondents reported that health workers received both theory and competency-based trainings on quality contraceptive service provision.

Notably, we encountered a lack of clarity on training for PAC and the availability of skilled providers for PAC. One respondent in Dondo noted that the Provincial Health Directorate (DPS), an office of MISAU at the provincial level, in Sofala provided training on PAC to one doctor and two nurses in the district; however, researchers were not able to determine the types of training provided for PAC service delivery (theory- or competency-based, etc.), when the training took place, or which, if any partners, supported MISAU in delivering training on PAC.

Supervision

All respondents reported that MISAU conducted regular supervision in facilities at the district, provincial, and national levels using a national MISAU checklist and other supervision tools, often in collaboration with a partner organization, such as AMODEFA, CUAMM, DKT, Pathfinder, PSI, and/or UNFPA. Respondents did not provide additional information about the types of supervision tools used in addition to the checklist.

Respondents reported that supervision visits included reviewing the monthly facility report, verifying the data by reviewing registers, and assessing data entry in the register and stock management. When queried as to how issues were addressed if encountered, respondents reported that supervisors would conduct on the job training (OJT) and provide supportive supervision to assist the provider to improve their skills. OJT was cited as a key component of supervision by multiple respondents, including those from MISAU. A respondent from AMODEFA noted that supervision was conducted jointly by AMODEFA, UNFPA, and MISAU.

Community mobilization

Respondents described numerous and extensive community mobilization efforts to increase awareness, acceptability, and uptake of contraceptive services before the cyclone, and in its aftermath. MISAU and NGO respondents explained that ongoing community mobilization activities continued after the cyclone despite some delays in implementation, and that new activities were launched. Respondents also noted the use of radio programs and community theater to increase contraceptive awareness among community members. Following the cyclone, respondents reported that MISAU and partners engaged APEs to conduct dedicated campaigns for contraceptive awareness and cholera prevention. AMODEFA reported that its volunteers disseminated information about contraception, including EC, while distributing condoms, dignity kits, and clean delivery kits. AMODEFA also noted that their volunteers referred women to SRH services, including contraceptive services and ANC, and reported conducting targeted sensitization activities on SRH and contraception with men.

Respondents also reported engaging community and religious leaders in dialogues to promote contraceptive awareness and uptake, and engaging men in mobilization activities to address partner opposition.

Multiple respondents reported their organizations conducted targeted outreach to adolescents. AMODEFA engaged peer educators, and in their work with adolescents, CUAMM deployed youth activists to conduct sensitizations and promote uptake of SRH services, including contraceptive services. Multiple respondents reported working in and through schools, but researchers received conflicting information about teachers' acceptance of and support for programming focused on increasing access to contraceptives for adolescents.

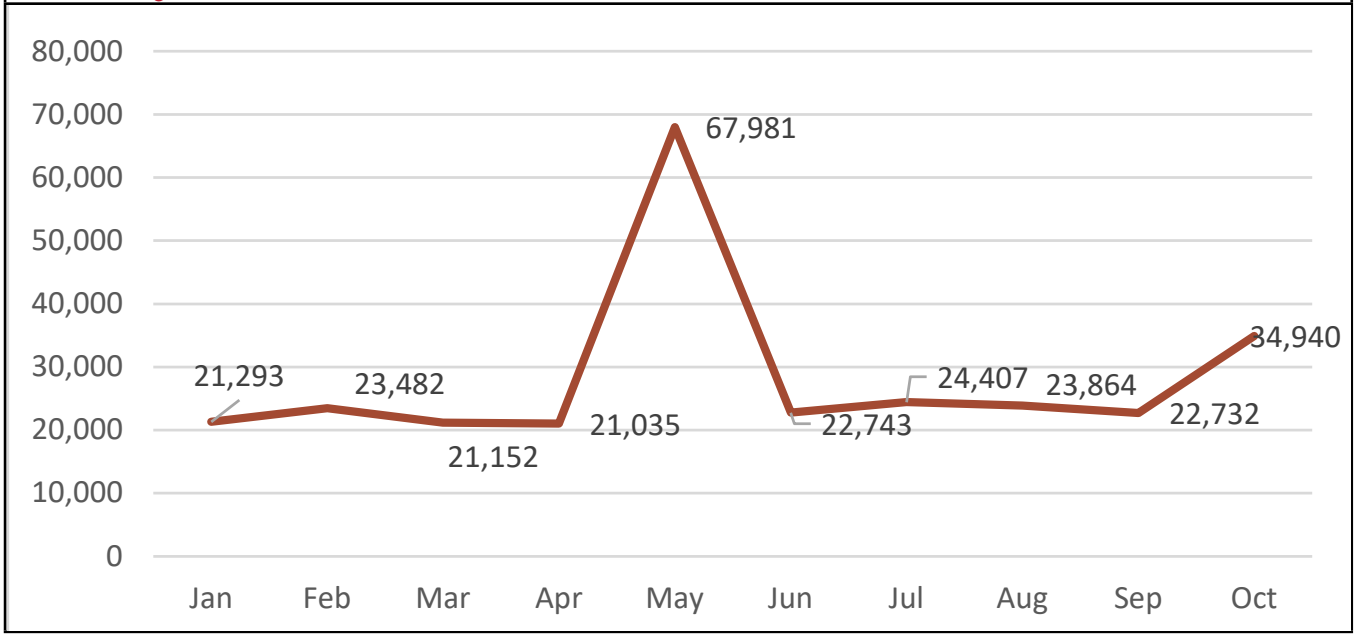
Respondents did not provide extensive information about community mobilization and sensitization efforts for PAC, or about community awareness of PAC. One respondent based in Dondo reported that communities were aware of the importance of seeking PAC, but researchers did not obtain additional detail. One respondent, based in Buzi, reported that individuals were increasingly learning about PAC through providers. The respondent recommended engaging community leaders to build awareness of PAC.

A health provider displays reproductive health IEC materials in a mobile health unit in the Mundruzi Resettlement Center in Dondo, Sofala Province.
Photo credit: Arturo Sanabria

V. Service Statistics

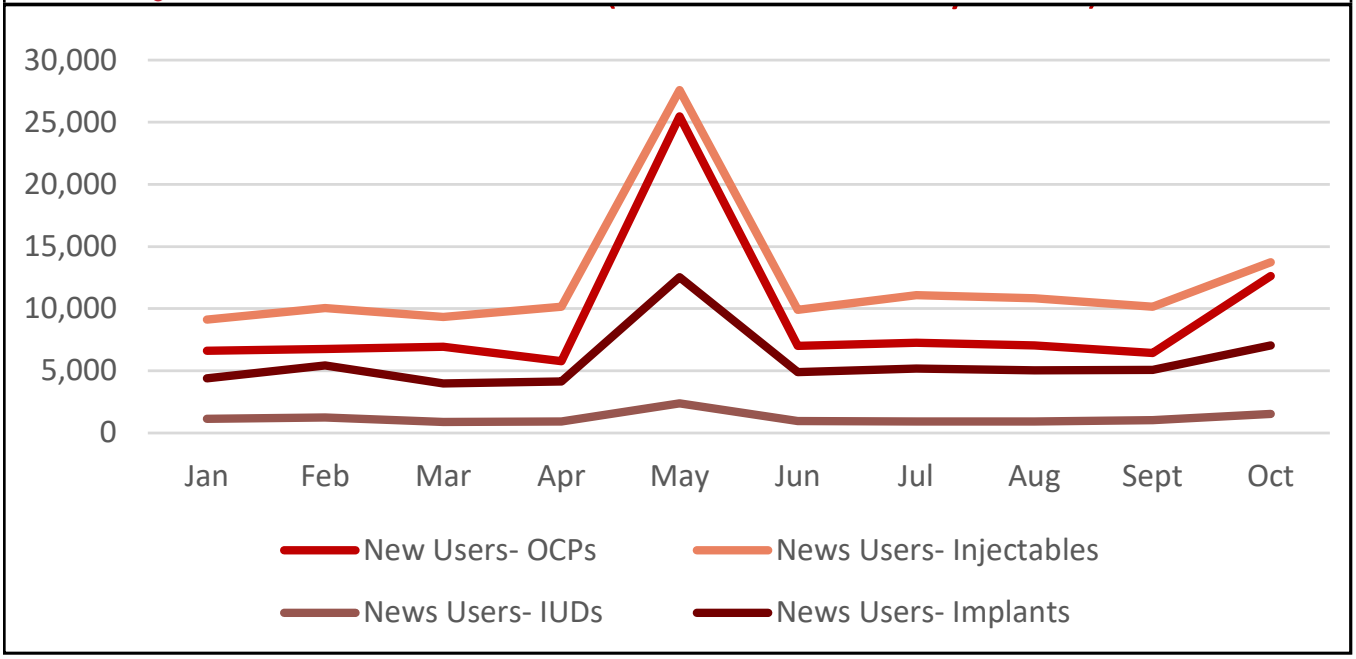
Pathfinder International provided contraceptive service delivery data from SISMA for all 159 health units in Sofala province from January to October 2019. The dataset included all MCH activities, including contraceptive activities, performed at the health units and mobile units; however, it did not include contraceptive service delivery activities performed by APEs or by the burgeoning national integrated health service program. The data shows a relatively static trend in new contraceptive users during this 10-month period, other than a dramatic increase in new users in May. Overall, all contraceptive indicators collected by SISMA for Sofala followed this general trend. This increase in May—one month following the cyclone—corresponds with MISAU's "Semana Nacional de Saúde," or National Health Week, which promoted basic health services, including vaccination, ANC, and contraceptive services, including by distributing client cards for contraceptive services. This maternal and child health campaign was implemented in all health units at the national level and at the community level with APEs and mobile brigades.

Figure 1: New Contraceptive Clients by Month, Sofala Province (January-October 2019)



Data on new contraceptive users by method shows that throughout this time period, the most popular new methods are injectables, followed closely by OCPs, and then implants. IUDs were the least popular of the four methods tracked.

Figure 2. New Contraceptive Users by Method, Sofala Province (January-October 2019)



VI. Findings from Health Facility Assessments

Health facilities assessed

The WRC study team conducted facility assessments in five health facilities: one rural hospital, one urban health center, two rural health centers, and one mobile health unit (Table 2). Per national policy, both rural and urban health centers should offer short- and long-acting methods. Mobile health units should offer implants and short-acting methods. Rural hospitals and rural and urban health centers should operate 24 hours per day, seven days per week (24/7), and offer PAC services. All facilities assessed were government facilities, but all facilities were supported by NGOs.

Table 2: Health facilities assessed			
Facility name	**Location**	**Agencies supporting***	**Type of facility**
Rural hospital – Buzi	Buzi	Pathfinder International, Health Alliance International (HAI), ABT Associates, Clinton Health Access Initiative (CHAI)	Rural hospital
Urban health center – Dondo	Dondo	Pathfinder International, Population Services International (PSI), UNFPA, HAI, DKT, AMODEFA, ABT Associates, ECHO	Urban health center
Rural health center – Macharute	Dondo	Jhpiego, Pathfinder International, UNFPA, ECHO	Rural health center
Rural health center - Mutua Maternidade	Dondo	Pathfinder International, DKT, Jhpiego, PSI	Rural health center
Mobile health unit – Mandruzi Resettlement Center	Dondo	AMODEFA, Pathfinder International	Mobile health unit

** Support was not necessarily specific to SRH services.*

General infrastructure

Four of the five facilities assessed—the rural hospital and the urban and rural health units—operated 24/7. However, in both rural health units, it was not clear that the staff person available on nights and weekends was trained to provide PAC. The rural hospital and the urban health post had functioning power and water supply. Both rural health units sustained significant damage in the cyclone and at the time of the assessment, both were undergoing repairs and providing services out of tents. The mobile health unit was a dedicated tent in the resettlement center.

Table 3: General infrastructure			
	Rural hospital (n=1)	**Urban/rural health unit (n=3)**	**Mobile health unit (n=1)**
At least 1 qualified health provider available 24/7	1	3	N/A
Functioning power supply	1	1	N/A
Functioning water supply	1	1	1
Minimum infection prevention supplies*	0	0	0

** Minimum infection prevention supplies include a washing station with soap, gloves (sterile or non-sterile), regular trash bin, antiseptics; sharps must be separated from other waste and there must be an appropriate disposal method for medical waste.*

None of the facilities assessed had minimum infection prevention supplies. Only one facility had an appropriate disposal method for medical waste. Two facilities that did not have appropriate disposal methods for medical waste had all other measures in place. One facility did not have a washing station in the consultation or procedure rooms, but all other measures were in place. One facility did not have soap in the consultation or procedure rooms, but all other measures—excepting an appropriate disposal method for medical waste—were in place. One facility did not have a washing station, soap, gloves, antiseptics, or an appropriate disposal method for medical waste.

A waste disposal pit at one of the assessed facilities in Dondo. All five facilities assessed did not meet the minimum infection prevention supplies. Photo credit: Katherine Gambir/WRC

Contraception

None of the facilities assessed qualified as a functioning contraceptive service delivery point, defined in this study as having skilled staff present, the equipment and supplies required to provide a minimum method mix—IUDs, implants, OCPs, injectables, condoms, and emergency contraceptive pills (ECPs)—and having provided contraceptive services in the three months prior to the assessment.

To able to provide a method to an acceptable standard of quality–and therefore to be included in tables 4 and 5 below–a facility must have provided the method in the preceding three months, have skilled staff providing the method, and have all the supplies and equipment required to provide the method with an acceptable standard of quality, including counseling materials. A detailed breakdown of facilities' ability to provide each method, including availability of supplies and equipment, is included in **Appendix B** (page 49). For the purposes of this study, a minimum method mix is defined as IUDs, implants, OCPs, injectables, condoms, and ECPs.

Table 4: Able to provide a minimum method mix	
	Health facility (n=5)
Counseling materials available	**4**
IUDs (n=4*)	**1**
Implants	**3**
OCPs	**3**
Injectable contraceptives	**3**
Condoms	**4**
ECPs	**1**
Able to provide a minimum method mix	**0**

**One facility was not authorized to provide IUDs.*

Again, for the purposes of this study, a functioning contraceptive service delivery point is defined as having skilled staff present, the equipment and supplies required to provide a minimum method mix, and having provided contraceptive services in the three months prior to the assessment.

Table 5: Functioning contraceptive service delivery point	
	Health facility (n=5)
Skilled staff present	**5**
Contraceptive services provided in preceding three months	**5**
Able to provide a minimum method mix*	**0**
Functioning contraceptive service delivery point	**0**

**One facility was not authorized to provide IUDs.*

One facility reported providing all methods in the three months preceding the assessment. However, they did not have any counseling materials available, which is required for a facility to meet the criteria to provide contraception with an acceptable standard of quality. Additionally, while the facility had all the equipment and supplies required to provide implants, OCPs, injectables, condoms, and ECPs, they did not have the supplies and equipment to provide IUDs to an acceptable standard of care.

Two other facilities also reported providing IUDs in the three months prior to the assessment, but lacked the equipment and supplies required to provide the service to an acceptable standard of care.

Three facilities were stocked out of dedicated ECPs at the time of the assessment. One facility reported that the stockout had been ongoing for three months, and was using the Copper IUD and the Yuzpe method to provide EC; one facility also reported using the Yuzpe method.

One facility reported providing OCPs, injectables, and implants in the three months prior to the assessment, but lacked the supplies and equipment required to provide the services to an acceptable standard of care.

Detailed tables can be found in **Appendix B**.

All facilities used the standard register provided by MISAU for contraceptive services. The registers included spaces specifically for new clients, clients changing methods, referrals from other services provided in the facility, and complications from contraceptive procedures.

Post-abortion care

None of the facilities authorized to provide PAC (n=4) qualified as a functioning PAC service delivery point, defined as having skilled staff providing PAC services, PAC services available 24/7, offering contraception to all post-abortion clients, and the equipment and supplies required to provide PAC with MVA or misoprostol. PAC is an essential emergency service, and must be available 24/7.

Table 6: Provision of PAC to an acceptable standard

	Health facility (n=4)
Post-abortion contraception is offered to all PAC clients	4
Skilled staff trained to provide PAC	3
PAC services available 24/7	2
Equipment and supplies to provide PAC with MVA	0
Supplies to provide PAC with misoprostol	3
Functioning PAC service delivery point	**0**

Notably, one facility reported providing PAC in the three months preceding the assessment, but indicated that no providers had been trained to provide PAC. Accordingly, it was not possible to say definitively whether PAC was available 24/7 in this facility, although the facility was reportedly open 24/7, with two mid-level providers present during nights and weekends.

One other facility also reported providing PAC in the three months preceding the assessment, but indicated that no providers were trained to provide PAC; however, a review of the knowledge and attitudes questionnaire completed by the provider present at the facility at the time of the assessment revealed that she reported being trained to provide PAC with MVA and misoprostol. It was therefore not possible to determine if trained providers were on staff, or how many. Similarly, it was not possible to confirm that PAC was available 24/7 in this facility. The facility was reportedly open 24/7, with two mid-level providers present during nights and weekends. However, it was not possible to determine if at least one trained provider was available at all times.

Two facilities reported providing PAC with MVA in the three months preceding the assessment, but lacked the equipment required to provide the service to an acceptable standard of quality.

One facility was stocked out of misoprostol at the time of the assessment, but did report providing PAC in the three months preceding the assessment.

All facilities reported PAC data in the standard gynecology register provided by MISAU, which includes spaces for diagnosis and/or complications, treatment provided/method used, and post-abortion contraceptive method accepted.

Pharmacy and drug storage

Six of the seven facilities had pharmacies on site. The remaining facility was waiting for the installation of electricity before establishing a full pharmacy. All the pharmacies had registers, could explain the mechanism in place for ensuring that expired medications and supplies were not distributed, and made requests for pharmaceuticals (including contraceptives), supplies, and equipment at regular intervals (monthly or weekly). Furthermore, all pharmacies either used First Expired, First Out (FEFO) or a combination of FEFO and First In, First Out (FIFO) for their stock management system.

Three of the six facilities reported stockouts in the last three months, although only two of these were reports of contraceptive stockouts. The two reports of stockouts of contraceptives were reported as the result of a stockout at the "supplier" (e.g., UNFPA or SMOH).

Only two of the facilities assessed had proper storage conditions. The remaining facilities did not have climate control in place, did not use shelving or slates, and had little to no ventilation in the room. Additionally, there was a security incident in which a purse was stolen out of one pharmacy while WRC staff was present at the facility, implying that the space was not secure. Furthermore, only three of the pharmacies appeared clean (e.g., free of dirt, dust, and cobwebs).

Table 7: Pharmacy and stock management

	Rural hospital (n=1)	Urban/rural health unit (n=3)	Mobile health unit (n=1)
Stockout reported in the last three months*	1	3	1
Pharmacy available 24/7	1	3	N/A
Drugs properly stored†	1	1	N/A
Pharmacy room was clean‡	1	1	N/A

**Stockout of any contraceptive method reported in the last three months.*
†Properly stored means the pharmaceuticals were secured and protected from moisture, heat, and infestation (e.g., placed on shelves or slats, ventilated).
‡ Clean means the pharmacy was tidy and free of dirt, dust, and cobwebs.
ʃ In one facility, there was not a pharmacy, but drugs were available 24/7 in a bin inside the health tent where contraceptive services were provided.

The mobile health unit did not provide services on a 24/7 basis. Two facilities were operating entirely out of tents due to damage sustained in the cyclone. In one facility, drugs were stored in bins or boxes in the same tents where services were provided. In that facility, the tents were kept tidy and reasonably clean, and providers were able to access drugs on a 24/7 basis. In the other facility, providers were using a separate building constructed after the cyclone as a pharmacy. Drugs were organized and placed on shelves, but were not adequately protected from moisture, heat, and infestation. Providers were able to access drugs on a 24/7 basis.

In some facilities, commodities were stored in a haphazard manner, while in others, they were well organized.
Photo credit: Katherine Gambir/WRC

Data use

Table 8: Data use at assessed facilities

	Health facilities (n=5)
Contraceptive services graphs displayed in facility	2
Provider could describe trends in contraceptive data	2
Data review meeting held in the three months preceding the assessment	5
Provider could describe actions taken as a result of data	4

Contraceptive services graphs were displayed in two of five facilities, but in one facility, the graphs displayed were from 2017-2018. In both facilities, providers were able to describe trends in the data displayed. Notably, in two facilities where data were not displayed, providers reported reviewing the registers to monitor data over time. In all four facilities, providers were able to describe actions taken as a result of data. All facilities reported data through national systems, and meetings to review data were convened monthly at the district, provincial, and national levels.

Knowledge and attitudes of service providers

Ten health workers across five facilities completed knowledge and attitudes assessments. Detailed tables with responses can be found in **Appendix C** (page 62).

Table 9: Professional classification of respondents (n=10)	
Professional classification	**Number**
Maternal and Infant Health Nurse	4
Preventative Medicine Technician	1
Maternal and Infant Health Nurse and Medical Technician	4
Maternal Health Supervisor Nurse	1

All 10 respondents reported providing contraceptive counseling in the past three months. Over half (7/10) reported having provided an IUD in the past three months, although only 5/10 reported having ever had received instruction or training to provide this service. Fifty percent (5/10) of respondents reported having inserted a post-partum IUD in the past three months. Almost all (9/10) reported having provided an implant in the past three months. Seven respondents reported having provided DMPA-SC and seven respondents reported they had provided emergency contraception in the past three months.

A slightly higher number of respondents reported having provided MVA (5/10) and misoprostol (4/10) for PAC, though fewer reported having ever received instruction or training to provide these services (3/10 and 2/10, respectively). Over half of respondents (7/10) reported having provided post-abortion family planning counselling in the past three months.

Provider knowledge

The tool included 10 questions to assess providers' technical knowledge of contraceptive services and PAC. Respondents demonstrated a strong overall level of knowledge of contraceptive services, with a mean score of 5 out of 6 **(Appendix C, Table 15)**. However, only 3 of 10 respondents were able to correctly identify the common changes in a women's menstrual period following the insertion of an IUD. This gap in knowledge corresponds with only half of respondents (5/10) having ever received instruction or training on how to insert an IUD. Given 7/10 respondents reported having inserted an IUD in the past three months, this has potential negative implications for counseling women about IUDs and preparing them for initial heavy bleeding, especially for first-time IUD users.

Knowledge of PAC was very low, with a mean score of 1.1 out of 4 **(Appendix C, Table 16)**. Only two respondents were able to correctly identify the recommended dosage of misoprostol to treat an incomplete abortion or when a woman's fertility returns. None of the respondents were able to correctly identify until what point, based on uterine size, MVA and misoprostol can be used to treat an incomplete abortion. Over half of respondents (7/10) knew that they should inform the PAC client on when she will be able to conceive again, provide contraception or referral for contraception, and explain the consequences of an unsafe abortion.

Provider attitudes

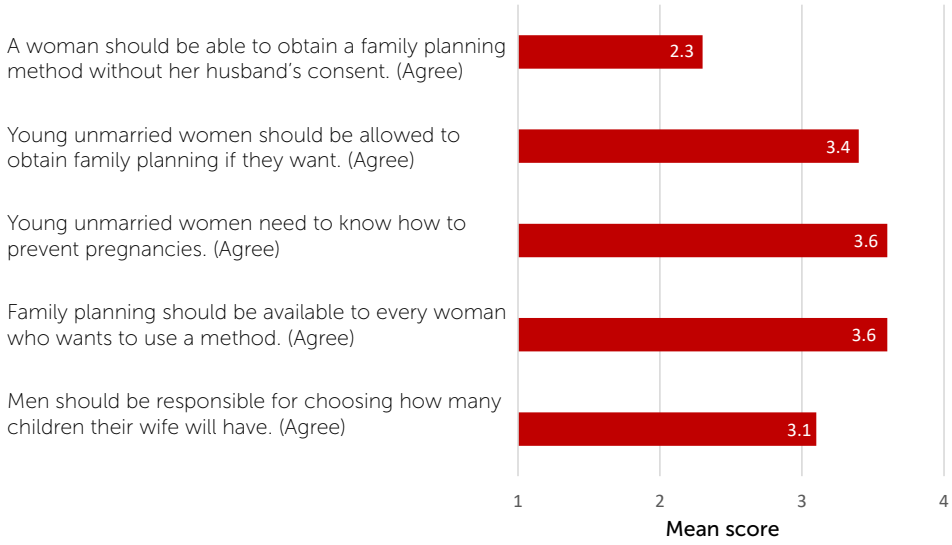
Results from the section of the questionnaire measuring provider attitudes are presented as mean scores ranging from one to four for each statement. All scores are based on Likert scale responses

to each statement: strongly agree (4), agree (3), disagree (2), and strongly disagree (1). Some statements were reverse coded so that high means always signal attitudes that promote equitable and good quality contraceptive and post-abortion care.

Responses indicated generally favorable attitudes toward access to contraceptive services. The statement "Family planning should be available to every woman who wants to use a method" had a mean score of 3.6/4. Attitudes towards young unmarried women's access to contraceptive information was equally high, with a mean score of 3.6/4 for the statement "Young unmarried women need to know how to prevent pregnancies." However, attitudes toward young unmarried women's access to contraceptive services was slightly lower. The statement "Young unmarried women should be allowed to obtain family planning if they want" had a mean score of 3.4/4.

Respondents expressed less favorable attitudes toward women's autonomy and decision-making about childbearing and contraceptive use. The mean score for the statement "Men should be responsible for choosing how many children their wife will have" was 3.1. The mean score for the statement "A woman should be able to obtain a family planning method without her husband's consent" was 2.3.

Figure 3: Provider attitudes toward contraceptive services (n=10)



Provider attitudes towards PAC were generally favorable. Almost all respondents believed that "PAC is an important medical service for reducing maternal mortality and morbidity" (mean score: 3.7).

VII. Findings from the Community

Eleven FGDs were held with 112 community members; five discussions were held in a resettlement center in Dondo and six were held in a hospital in Buzi. As previously noted, FGDs were conducted in locations with ongoing contraceptive and PAC service provision and participants may thus have been more knowledgeable or express more positive beliefs about contraceptive services, compared to participants from communities without similar access. Additionally, NGOs supporting SRH service provision led recruitment efforts, and participants may have been more likely to provide positive responses about contraceptive services if they associated the FGD facilitators with the NGO.

Table 10: Focus group discussion composition (n=112 participants)

Group	Location	Number of participants
Adolescent girls (15–19 years)	Dondo	12
Adolescent girls (15–19 years)	Buzi	9
Women (20–24 years)	Dondo	11
Women (20–24 years)	Buzi	9
Women (25–45 years)	Dondo	11
Women (25–45 years)	Buzi	13
Men (25–45 years)	Dondo	13
Men (20–29 years)	Buzi	12
Men (30-45 years)	Buzi	5
Adolescent boys (15–19 years)	Dondo	12
Adolescent boys (15–19 years)	Buzi	7

Practices and norms related to pregnancy and marriage

Child, early, and forced marriage

There was consensus across focus groups that it was not uncommon for adolescent girls to become married, but some participants expressed the belief that the incidence of early marriage was decreasing. An adolescent girl in Buzi said, "The practice of marrying girls early is diminishing lately, because there are activists going to schools and giving lectures about premature marriage." One adolescent boy in Buzi noted that while early marriage was "almost over" in Buzi, it was still common in smaller or rural communities. Boys in the same focus group discussion linked early marriage to poverty, an observation that was echoed by adolescent girls in Dondo.

Pregnancy

Across focus groups in both Dondo and Buzi, participants reported that sexual relationships and pregnancy were very commonplace among adolescents and young people. Participants across focus groups reported that unmarried adolescent girls and young women who became pregnant were largely viewed poorly by their communities. Multiple participants across focus groups cited the disruption to girls' education as a key negative outcome of pregnancy.

Participants across focus groups reported that, in many cases, pregnancy resulted in child, early, and forced marriage and informal unions. When queried as to what happened after an adolescent girl or unmarried woman or girl became pregnant, respondents across focus group discussions (Women

26-45, Buzi; Women 26-45, Dondo; Men 20-45, Buzi; Women 20-25, Buzi; Women 20-26, Dondo) made references to boys and men being asked if they will "take responsibility," or the girl or woman being "sent to [the boy or man's] house." A woman in Dondo (20-26) reported that some parents "force the girl to go to the boy's home," and a woman in Buzi (20-25) stated that "some 'confused' parents of our community send their daughters away with the fellow who impregnated them. They suffer in their [new] homes because of that."

Post-cyclone

Multiple participants across focus groups reported that early marriage increased following the cyclone, although other participants reported that they had not observed changes in the incidence of early marriage following the cyclone. One adolescent boy in Buzi reported that "[they had] not seen many marriages" following the cyclone, and expressed concern about adolescent girls becoming pregnant prior to or outside of marriage. A man in Buzi (30-45) also reported a decrease in marriages, and stated that there were more pregnant adolescent girls in the Guara resettlement center as compared to Buzi.

Participants explicitly linked resource scarcity and transactional sex with early marriage after the cyclone. An adolescent boy in Dondo said, "Marital practices have changed in the community after Cyclone Idai, but for the worse. As crisis settled in the community, girls are harassed, and they end up with older men in exchange for food." A man in Buzi (20-29) expressed a similar opinion, and said, "There are a lot of marriages happening because of the lack of food in the communities. Girls give their bodies in exchange for food. The floods only worsened the misery." However, multiple participants reported community mobilization activities addressing early marriage continued following the cyclone.

More broadly, participants reported that the cyclone disrupted existent marriages, noting that some men have left to seek work; some participants reported an increase in divorces following the cyclone. Others discussed challenges like food and housing posed by displacement. One woman in Buzi (26-45) said:

> "Yes, life has changed. Now we are sleeping outdoors, and my husband keeps wondering, why are we sleeping outside? We also need to think about food, soap, school supplies, clothes for the kids, and also think about finding a job. When I talk to him, he insults me because he gets stressed out by all the things we have been through. All of this was brought by the cyclone Idai and the floods, because we had a healthy relationship back in the day—despite being made of grass, we at least had a house to sleep in."

Another woman in Dondo (26-45) said, "Things changed, because we no longer live where we used to before. Some men just receive the food in the camp and go to sell it to drink. Women have to look for their own."

Awareness of contraceptive methods and availability

There was widespread awareness of contraception and its benefits across focus groups, including of short- and long-acting methods. Of LARCs, participants across focus groups reported having greater familiarity with implants as compared to IUDs. This corresponds to the relative popularity of implants as compared to IUDs among women in the community using long-acting methods reported by participants across FGDs.

There was also widespread awareness of the dual protection offered by condoms. However, there was very low awareness of EC across FGDs, with the overwhelming majority of participants reporting no prior knowledge of EC.

When queried as to whether awareness of contraception changed in the aftermath of the cyclone, some participants reported that awareness of contraception was high prior to the cyclone, citing community mobilization activities—specifically "lectures." However, participants also reported that these activities continued or increased in the aftermath of the cyclone, and some described awareness of contraception increasing as a result.

Sources of information on contraceptive methods and services

When asked about the primary sources of information on contraception in their communities, participants across focus group discussions, including adolescents, overwhelmingly cited health facilities. Participants across focus groups reported "lectures" disseminating information about contraception. "Lectures" referred to information sessions conducted by APEs and other advocates and volunteers; in some instances, participants seemed to use "lecture" as a general term to describe community mobilization activities. Girls and women in Buzi (20-25) and boys in Dondo reported information on contraception being disseminated in schools. Finally, one man in Dondo (20-45) reported receiving information about contraception via the radio.

Women in Dondo and men in Buzi also reported sharing information on contraception through informal networks. When asked if participants recommended contraceptive services to their friends, one woman in Dondo (26-45) acknowledged that while "some women do not accept advice, we still talk about it in many places – when we go to [get] water, in the market, [and] when talking with our neighbors and friends." Similarly, when participants were asked about their experience seeking contraceptive services at the health facility, a man in Buzi (30-45) responded that "it was a good consultation and [he had] already invited a couple of friends to go there." One woman in Dondo emphasized the importance of women speaking with their daughters about preventing unintended and early pregnancies, and supporting girls to access contraceptives (26-45).

Reasons for contraceptive use, and positive attitudes toward contraceptive use

Across focus group discussions, participants expressed generally positive attitudes toward contraception. When queried as to why women and girls in their communities used contraception, participants discussed the importance of preventing unintended pregnancies and the benefits of child spacing for women's and children's health.

Participants across focus groups also expressed the importance of spacing and limiting births to ensure families could care for their children, with multiple participants expressing that this was particularly true given the social and economic impact of the cyclone. One woman in Dondo

(26-45) said, "Nowadays, it's not good to have many children. Life is difficult, especially after what happened. Families are vulnerable without a home, without a job.... So, sisters, let's use planning to avoid our children growing up in the conditions we are living in now."

Participants across focus groups reported their perception that injectables and implants were the most commonly used contraceptive methods in their communities. Regarding method selection, women in Buzi and Dondo expressed that women have different needs, and there is not one method that will meet the needs of all contraceptive users. Women and adolescent girls in Buzi and Dondo discussed negative side effects and their impact on method selection; side effects discussed included bleeding, irregular menstruation or the cessation of menstruation, headaches, decreases in sexual desire, weight loss, and specifically regarding implants, arm pain and/or pain at the insertion site. However, participants did not cite side effects as a barrier to contraceptive use.

Participants across FGDs, including men and boys, discussed the benefits of LARCs—specifically, implants—and emphasized the advantages of multi-year protection. Boys in Dondo and men in Buzi and Dondo all noted that that LARCs ensure that women and girls do not have to visit the health facility on a regular basis, with one man in Buzi (30-45) noting ,"It helps a lot for those families where women are far away and can't go to the hospital all the time."

An adolescent girl in Dondo discussed her decision to switch from OCPs to the implant, emphasizing the benefits of not needing to routinely take a pill. She said:

> "For me, [the implant] is a good thing, as I can avoid getting pregnant. I used to have pills, which I forgot to take often. Now, I'm safer. I've been with the implant for four years now, and my [child] is also four. As soon as it expires, I'll go put a new one. Right now, I'm studying and I have a boyfriend. If it wasn't for the implant, I would be pregnant already. Thanks for existing, implant!"

Negative attitudes and misconceptions about contraceptives and contraceptive use

Although participants across FGDs voiced largely positive attitudes toward contraceptive use, some expressed and many acknowledged misinformation and misperceptions about contraceptives. The most commonly cited misperceptions were that the use of contraception could damage women's fertility, particularly if used for long periods of time, and that it is not appropriate for women who have not yet had children to use contraception. The misperception that contraception could damage fertility seemed to be most commonly associated with the use of LARCs.

Although many participants contradicted the belief that contraception damaged women's fertility, women in Dondo (20-26) expressed that it would take longer for a woman to become pregnant if she had been using contraception. Men in Buzi (20-29) and Dondo (20-45) and women in Buzi (20-25) reported hearing of incidents in which women became pregnant while using the implant.

Women in Buzi (20-25) reported misperceptions that the implant could "roam" a woman's body, and concerns that the IUD could "[leave] its place." It is not clear if participants were describing a similar misperception that the IUD could "roam" the body, or if they were referring to incidents in which an IUD becomes displaced in the uterus. An adolescent boy reported a similar concern, stating that he had heard someone say that an implant had "disappeared inside the arm."

Participants expressed or described more negative attitudes toward IUDs compared to implants,

noting that they were not widely used in their communities, and that they lacked knowledge about IUDs. In Buzi, one woman (26-45) who had a positive experience using an IUD said, "It didn't do me any harm like people said it would." Another woman (26-45) added, "They say that it's no good. That's why women in the community don't like to use it." Men in Dondo (20-45) and women in Buzi (20-25; 26-45) noted concerns that the IUD could cause pain for men during sex, and an adolescent boy in Buzi reported that IUDs "[would not] kill your sperm"—that they were not effective.

Stigma as a barrier to contraceptive use

Participants, particularly adolescent girls, acknowledged encountering stigma as a result of seeking contraceptive services, and stigma negatively impacting uptake of contraceptives in their communities. When asked whether adolescent girls use contraceptives in their community, one adolescent girl in Buzi said, "Not many, because they say that planning is only done after having children." Another girl concurred, saying, "I agree with her, and they even say it spoils the woman's uterus."

Girls reported encountering mixed attitudes from their peers after seeking contraceptive services, with one participant stating that "Some say good things about it and support it," while another added, "Others rebuke you, saying [using contraception is] bad at our age." Girls in Dondo reported similar experiences, with one participant stating that "we are insulted, [and it is] even worse when you don't get pregnant quickly after quitting family planning."

Women in Buzi (20-25) echoed these concerns. One woman reported that "some friends say that I won't be able to have more babies, that I killed my uterus." However, she added, "After a while, when you get pregnant, they're surprised and embarrassed." Another participant reported stigma associated with the cultural valuation of childbearing.

Factors influencing contraceptive use

Male partners, parents, and decision-making about contraceptive use

When asked about decision-making regarding the number of children a couple would have and contraceptive use, participants described a range of experiences, perceptions, and opinions. Men largely expressed that married women should obtain permission from their partners. One man in Dondo (20-45) said, "It must be the couple's decision. If the wife wants to do the planning, she must ask her husband first." One man in Buzi (30-45) said, "Usually, as the name says itself, it's 'family' planning. You can only go alone, without your partner, if you're [unmarried]."

Another man in the same FGD added, "As much as women want it, they need to ask their husbands, to avoid divorces and trouble in the future."

Younger men (aged 20 to 29) in Buzi discussed decision-making at greater length. Several men reported that some couples made the decision jointly. However, one participant said, "In the community, when you gather a sample, the majority of those decisions—regarding women using family planning - are made by their men." Another participant agreed.

Another man noted that his wife did not consult him prior to obtaining a method, saying:

> "When she returned home, she just said to me that she had decided to put on [contraception] because she didn't want to have children now, as she is currently studying."

However, another participant commented on his experience, "the decision should be made by the couple, to avoid raising trouble at home."

Women across focus groups reported that in some cases, couples decided jointly whether to use contraception. However, women acknowledged that men were often the primary decision makers regarding the use of contraception, and that men could accordingly pose a barrier to contraceptive use. For example, one woman (Dondo 26-45) said:

> "We may not even want to have more kids, but our husbands tell us that they want eight children. We have to accept that, as we have no other choices—otherwise, we'll lose our homes."

One woman (Buzi 20-25) reported that "some husbands force their wives to quit the planning."

However, some women expressed that women made decisions about contraceptive use independently, sometimes discreetly, from their husbands and partners (Dondo 20-26, Buzi 20-25). Per one woman (Buzi 20-25), "We decide it by ourselves. These husbands of ours don't like to know that their wives are doing any planning."

Women reported that it was common for women to secretly use contraception. One woman in Buzi (26-45) said, "Here in the community, some women do it behind their husbands' backs, because they threaten them, saying that the planning will end their marriages." Another woman added, "Some husbands beat their wives when they find out."

However, women also noted instances of male partners supporting contraceptive use. A woman in Buzi (26-45) reported that although some men opposed the use of contraceptives, others "accept and even say 'look, my wife is going to do planning.'"

Participants also reported that parents of adolescent girls played a role in decision-making about contraceptive use. An adolescent boy in Buzi reported that his father "forced" his sister to have an implant inserted because she was "showing negative behavior in [the eyes of] the family." One adolescent boy in Dondo said, "Currently, parents themselves are asking their daughters to go through family planning, as they're afraid of ending up with a pregnant daughter."

He also reported knowledge of adolescent girls using contraception secretly, without their parents' knowledge, which he linked to improved availability of information in the aftermath of the cyclone, citing the "many lectures" on early marriage and "premature pregnancy."

Religious beliefs and leaders

Participants across focus group discussions reported that religious leaders did not frequently discuss contraception within their communities. Women across focus groups in Dondo and Buzi reported that religious and community leaders did not discuss contraception, although women in Dondo (26-45) and Buzi (26-45) reported that religion in their community considered contraceptive use to be a "sin." One woman in Buzi (26-45), when queried as to whether priests or other religious leader addressed contraception, said, "Never. They say it's a sin." Another added, "They say '[be fruitful] and multiple.' It's not talked about during mass, but instead in mother's groups."

Men across focus groups in Dondo and Buzi concurred that religious leaders in their communities did not discuss contraception on a regular basis, although one participant in Buzi (20-29) noted that while he did not regularly attend church, "[he] once heard the [community leader] talking about family planning and marriage." One participant in Buzi (30-45) said that while there was religious guidance in the community, "[it was] not very in depth." Accordingly, it may be that religious leaders

were more likely to address contraception with men, even infrequently, as compared to women.

Facilitators and recommendations identified by participants

Participants across focus groups cited community mobilization as an important driver supporting positive attitudes toward contraception and contraceptive use. As previously noted, participants across focus groups cited lectures as key sources of information about contraception and early marriage. When queried as to what activities would support contraceptive use in their communities, participants across focus groups advocated for the continuation of these "lectures." Women (26-45), men (30-45), and boys in Buzi all emphasized the importance of reaching rural and isolated communities with community mobilization activities. One man in Buzi (30-45) described the focus group participants as a "well-informed minority," and said, "Information like this should be everywhere, in the areas where a lot of young girls are having babies and thinking that having children and getting married are all there is for their lives." Additionally, women in Buzi (20-25) recommended targeted mobilization activities with men.

Participants recommended a number of community mobilization activities in addition to lectures, including having permanent activists in the community (Boys, Dondo; Men 30-45 Buzi), increasing advertising and promotion about contraceptive services (Boys, Dondo), community theater (Men 20-45, Dondo; Men 30-45, Buzi), and discussions with youth groups (Men 30-45, Buzi).

Participants also discussed the potential for family members and peers to serve as facilitators, especially for young people. One adolescent boy in Buzi expressed the need for community leaders and parents to discuss contraception with their children. Additionally, women in Dondo (26-45) and Buzi (26-45) expressed that they could serve as resources for their daughters, and support girls to learn about and access contraceptives. One woman in Buzi (26-45) said:

> "Mothers should be friends with their daughters. Approach them to know what is going on in their heads, to avoid the kind of situation where she gets pregnant and we don't know about it. Our own daughter cannot see us as a lion! We have to talk and explain the reality to them. [To] reach the age of 20 without getting pregnant—that will be good for them and for us, parents."

Finally, adolescent girls in Dondo and Buzi reported that they did not have a place to go to access adolescent-friendly contraceptive services, and voiced a desire for a youth center in their community, asserting that this would support access to contraception for young people.

Availability and accessibility of services

Availability and accessibility of contraceptive services

Participants across all groups agreed that contraceptive services were available. Participants in Dondo cited the mobile health unit located within the resettlement site and the urban health unit located outside the resettlement site as the two key service delivery points for contraceptive services that were available to them. All participants in Buzi cited the hospital as the key service delivery point for contraceptive services. However, five men in Buzi (20-29) explicitly noted that contraceptive services were not available in their respective communities. Men in Dondo (20-25) and Buzi (30-45) and adolescent boys in Buzi all cited distance to the health facility as a barrier to contraceptive services that some community members face. Men in Dondo (20-45) reported that "people living in places where there are no health services" may have the most difficulty accessing contraceptive services. Boys in Buzi suggested that contraceptive uptake mobilization activities should go to the "farthest communities," so these community members understand the importance of contraceptives and have information about

where to access services. Women and girls in Buzi confirmed that contraceptive services were available at the hospital but did not mention services being located outside their communities.

Notably, participants across groups confirmed that everyone could access contraceptive services at health facilities. When probed whether teenagers and single people had access to these services, a man (Buzi 30-45) clearly stated "Services are available to anyone that needs them." Participants across all groups noted that adolescents can obtain contraceptive services alone. Adolescent boys in both groups shared that they obtained condoms at the clinic. A boy from Buzi noted that he obtained condoms at the pharmacy, and said, "I felt 'at ease' going to the pharmacy and asking for condoms. I was very well taken care of by the pharmacist, who said that this condom I was taking with me was not meant to give away to children for them to make balls."

An adolescent girl in Buzi confirmed that girls in her community can obtain contraceptive services by themselves; however, she emphasized that not many adolescents use contraceptives due to misconceptions about contraceptives.

In addition, one man in Buzi (30-45) noted that people with disabilities may have heightened difficulty obtaining contraceptive services.

Post-cyclone

All groups of women commented that contraceptive services were not affected by the cyclone; however, all groups of men reported that contraceptive services were negatively affected. One man in Dondo (30-45) mentioned that contraceptive services were affected by the cyclone because the hospital was flooded, so community members "spent many days without going to the hospital. When the first response came, it was only for more critical situations." Similarly, a man from Buzi (20-29) stated that contraceptive services stopped because the hospital was flooded.

A selection of short and long acting contraceptive supplies in one of the assessed facilities.
Photo credit: Arturo Sanabria

Despite key informants reported delays in the availability of contraceptive services in the aftermath of the cyclone, several adolescent boys in Dondo, adolescent girls in Buzi, and men in Buzi (20-29) noted that access to contraceptive information improved after the Cyclone due to community mobilization efforts. One adolescent boy from Buzi explained, "Family planning changed a lot after the cyclone. We had several talks on how to prevent the diseases and about premature marriage."

Adolescent girls in Dondo reported that contraceptive services and information did not change following the cyclone.

Quality of services

Across all groups, participants expressed overall positive views about the quality of services delivered at health facilities. Participants across groups seemed to be satisfied with the quality of services delivered at health facilities, citing professional and trained health facility staff, treatment by health staff, confidentiality, and convenience as primary reasons that they obtain services from a particular health facility. One man in Buzi (30-45) shared his experience at the health facility: "When we arrived at the appointment, the nurse showed us the available methods and explained their advantages. We chose the implant and it was inserted."

Although several men in Buzi (20-29; 30-45) commented that they had to wait a long time before being seen by a health provider, all groups reported that the health facilities were open during convenient hours. Several women (26-45) and girls in Buzi stated that the reason they seek contraceptive services from the particular health facility is because "it is nearby" and "there is no other hospital to go to," respectively.

However, several women in Buzi (26-45) described negative experiences related to treatment by health providers—specifically, incidents of health providers denying contraceptive removal. One woman (26-45) stated:

> "The problem is when you put it [the implant] on and don't have a husband. If you happen to find someone after two years, and want to have children, the nurses at the hospital refuse taking it off. And sometimes they say there are no scalpels to do so."

Providers' attitudes

All participant groups reported that they were treated well by health providers at the health facility, excepting adolescent boys in Dondo, who did not address treatment by providers. One man from Dondo (20-45) explained why community members obtain services at a particular health facility: "We go there because we want to do family planning. The nurse is attentive toward us and explains everything that has to do with family planning."

However, several women from Buzi (20-25 and 26-45) shared negative experiences and perceptions of providers, including the aforementioned denial of removal services by providers.

Cost

When probed about the cost of contraceptive services at the health facility, all participants acknowledged that services, including contraceptive commodities, were free. Men (20-45 Dondo) specifically cited that the free cost of services was a factor they liked about contraceptive services.

Stockouts

Women (26-45) in Buzi raised commodity stockouts as a barrier. One woman cited that commodity

stockouts were not uncommon: "The only thing we don't like is when we want to take the planning away and the nurses tell us some story, asking us to go back 'tomorrow.' That tomorrow never arrives."

Post-abortion care

Participants across groups demonstrated awareness that women and girls who experience complications from abortions should seek medical attention. All groups, except for boys in Dondo, discussed that health providers are the only individuals who can help girls and women resolve post-abortion complications. However, one man in Buzi (30-45) expressed the belief that there may be a lack of knowledge about the availability of PAC services at the hospital, and that fear of stigma may prevent women and girls from seeking care, stating:

> "I'm sure women don't know about that [post-abortion care services at the health facility], because when they have an abortion and it goes wrong, they don't go immediately to the hospital, as they're afraid of any backlash that may have."

Participants across groups reported knowledge of unsafe abortion in their communities, particularly among unmarried and adolescent girls. Notably, girls and women from Buzi (20-25) reported that unsafe abortions at home have led to maternal mortality among girls, stating explicitly that "many [girls] end up losing their lives by doing home abortions[.]" (Women 20-25, Buzi).

VIII. Discussion

Findings from the KIIs suggest that there were delays in the availability of contraceptive services, particularly for LARCs, in the immediate aftermath of Cyclone Idai. Respondents reported conflicting information as to when contraceptive services were made available, with some reporting that contraceptive services were available immediately, and other respondents reporting delays of a month for short-acting methods, and three months for LARCs.

Several key informants reported that contraceptive supplies and services were not prioritized in the initial response, with one respondent reporting that the availability of LARCs in particular was delayed due to the perception among some MISAU staff engaged in the response that contraception was not lifesaving. This perception reportedly also affected the prioritization of contraceptive supplies for transport to cyclone-affected areas.

Respondents reported that awareness of the MISP, including management of the IARH kits, was generally low among both MISAU staff and health providers at the outset of the response. However, both UNFPA and IPPF reportedly provided MISP training to partners delivering SRH services early in the humanitarian response.

Gaps in the availability of contraceptive and PAC services evidently persisted, even as the situation stabilized; at the time of data collection, nine months after Cyclone Idai, none of the assessed facilities qualified as functioning contraceptive or PAC service delivery points. However, all five facilities reported providing short-acting methods, and four of five facilities reported providing LARCs in the three months preceding the facility assessment. Four facilities reported providing PAC in the three months preceding the assessment.

FGD participants, including boys and men, demonstrated high awareness of contraceptive methods, including implants, and the benefits of contraceptive use. This may reflect that FGDs were conducted in locations where NGOs had ongoing contraceptive service delivery and community mobilization activities. Participants across focus groups cited the influence of community mobilization activities, specifically "lectures," in building awareness of and support for contraceptive use in their communities, but acknowledged that barriers persist, particularly for adolescents. Partner opposition was reportedly a key barrier for married women and girls. Participants across focus groups were aware of the importance of post-abortion care; participants consistently reported high incidence of unsafe abortion, particularly among adolescent girls.

Long-acting reversible contraceptives

Compared to short-acting methods, LARCs appeared to be less available to affected communities. As previously noted, respondents reported that LARCs were first made available three months after the cyclone, reportedly in part because some MISAU staff did not view contraceptive service delivery as a lifesaving activity.

Participants demonstrated high awareness of a range of contraceptive methods, including implants. However, participants reported comparably less knowledge of IUDs, noting that they were unpopular among women and girls in the community. Participants unanimously reported that health facilities were the most important source for contraceptive information and services.

However, health facility assessments revealed particular barriers to provision of LARCs, particularly IUDs. Three of the four facilities authorized to provide IUDs lacked the necessary supplies and equipment to provide IUDs with an acceptable standard of quality. Two of the five facilities authorized to provide implants lacked the equipment and supplies required to provide implants with an acceptable standard of quality.

Analysis of provider knowledge and attitude assessments revealed gaps in training on provision of IUDs. Although seven of ten respondents reported having provided an IUD in the past three months, five reported never having received instruction or training to provide IUDs, and only three were able to correctly identify the common changes in a woman's menstrual period following the insertion of an IUD.

Notably, one woman in Buzi (26-45 Buzi) reported awareness of instances in which nurses denied implant removals to unmarried women who desired it. It is critical that providers and facilities be equipped to offer a full range of methods to ensure that women and girls can select the method that best meets their needs. It is equally important that providers are trained on all elements of quality service provision, including the fundamental principle of client choice in selecting, using, and discontinuing a method.

Moreover, community members' relative lack of familiarity with IUDs indicates a need for community mobilization activities to include targeted information on and address misinformation surrounding IUDs.

Emergency contraception

Respondents provided conflicting information as to whether ECPs were made available when short-acting methods and male condoms became available, or with LARCs and female condoms after a period of three months. Multiple key informants reported experiencing stockouts of ECPs over the course of the humanitarian response. At the time of data collection, three facilities were stocked out of ECPs, including the mobile health unit. When queried as to their referral mechanism, providers

at the mobile health unit indicated that they were not able to support transportation to the health facility outside of emergencies, and that they did not follow up with the health facility or the client to determine if referred clients successfully reached the facility to receive services. One facility reported that the stockout of ECPs had been ongoing for three months. A provider in that facility reported using the copper IUD and the Yuzpe method to provide EC; one key informant also reported their organization's providers relied on copper IUDs and the Yuzpe method in the event of ECP stockouts.

Participants across FGDs reported extremely low knowledge of EC. In order for women and girls to successfully use EC, they must be familiar with the method, know where to access it, and be able to reach a service delivery point as quickly as possible. Multiple key informants and participants across FGDs also reported increases in GBV and transactional sex in the aftermath of the cyclone. EC is a critical component of clinical management of rape, and it is essential that all women who experience an incident of unprotected sex are able to access EC in a timely fashion.

It is essential that community mobilization activities disseminate information about EC and its use, and that EC is made available in all service delivery points and in community-based service delivery mechanisms.

Post-abortion care

Participants across focus groups reported that unsafe abortion, and associated maternal deaths, were commonplace in their communities. Post-abortion care is an essential, lifesaving service for women and girls. Although participants were aware of the importance of seeking medical attention in the event of post-abortion complications, data collected over the course of the case study suggest gaps in the availability of PAC. None of the four facilities assessed that were authorized to provide PAC qualified as a functioning service delivery point.

Moreover, only three and two out of ten providers reported having ever been trained to provide PAC with MVA and PAC with misoprostol, respectively. Knowledge of PAC was very low, with a mean score of 1.1 out of 4 **(Appendix C, Table 16)**. Only two out of 10 respondents were able to correctly identify the recommended dosage of misoprostol to treat an incomplete abortion or when a woman's fertility returns after abortion, and no respondents were able to correctly identify until what point, based on uterine size, MVA and misoprostol can be used to treat an incomplete abortion.

Mobile health units were not authorized to provide PAC services, and the providers in the mobile health unit assessed indicated that the referral mechanism for PAC clients was relatively weak. While the conditions in the mobile unit were not conducive to the provision of PAC with MVA, PAC with misoprostol can be safely administered in settings with restricted resources where there is a functioning referral system in the event of complications.

Stockouts and supply chain management

Supply chain management and commodity availability posed challenges for contraceptive and PAC service delivery over the course of the humanitarian response. In addition to contraceptive commodities reportedly being deprioritized, key informants reported challenges with IARH kit management, wastage, quantification, and widespread and frequent stockouts. At the time of data collection, all five facilities assessed reported experiencing a stockout of at least one method in the preceding three months. Supply chain management and commodity security is essential for an effective humanitarian response.

Challenges, effective strategies, and opportunities for contraceptive uptake

Data quality and supply chain management

Case study findings suggest there were challenges with the use of MISAU's national health information system, "SISMA," in the aftermath of the cyclone. Although SISMA has been implemented at the national level since 2016, key informants reported that disparate implementation across the health system persists. Key informants and all health facilities referenced and demonstrated the use of paper-based client cards, stock cards, and registers rather than cloud-based automatic data collection. Key informants and health workers reported that client cards were lost and destroyed due to the cyclone. Similarly, key informants and health workers reported that registers were destroyed by the cyclone and, therefore, health facility service utilization data for at least 47 facilities in March 2019 are unknown. As such, there is no health service utilization data in SISMA for health facilities in Buzi and Cheringoma in March 2019. Without data on contraceptive uptake and stock levels, it is impossible for health workers and supply chain managers to understand demand for contraceptives during a crisis and manage commodity stocks, and therefore meet the need for contraceptives.

In a notable effort to resolve these challenges, all health units in Mozambique are transitioning to a new cloud-based Logistics Management Information System for health facilities, SIGLUS. SIGLUS includes an Android application that captures health facility-level information and activities, such as stock management, automated requisition orders, and alerts for stock levels and expired commodities. SIGLUS also includes a web portal where decision-makers can access facility-level data for reporting, visualization, and analysis. With adequate training on the software, SIGLUS has the potential to greatly improve data quality for supply chain management, and ultimately contribute

Family planning and consultation tent in a rural health center in Dondo, Sofala Province.
Photo credit Katherine Gambir/WRC

to the decline of the unmet need for contraceptives. Further, a cloud-based system that includes immediate electronic data collection ensures data are protected and not lost from future weather-related or other disastrous events.

Community mobilization and SRHR

Community members and key informants commented that "last mile" health service delivery was a structural barrier to contraceptive uptake. Key informants attributed lack of transportation and funding as barriers to reaching remote communities with contraceptive services. Despite these challenges, community members and key informants lauded community mobilization as a key facilitator of contraceptive awareness. With sufficient funding and adequate transportation, community mobilization has the potential to expand contraceptive access, including to remote communities.

However, lack of contraceptive decision-making power among girls and women was a key barrier to contraceptive uptake that must be addressed as part of community mobilization efforts. Community members across groups asserted that women and girls needed their partners' permission, while girls also needed their parents' permission, to access contraceptives. Women and girls' lack of contraceptive decision-making power is not only a violation of human rights, but results in unsafe abortions leading to morbidity and mortality. Many women and adolescent girls shared experiences about their unintended pregnancies and participants across groups recognized that unsafe abortions, many of them deadly, were very common in their communities. Health provider surveys also demonstrated extremely unfavorable attitudes toward women-led contraceptive decision-making.

Community mobilization efforts have the potential to engage community members, including men and boys, with important SRHR information that supports girl- and woman-led contraceptive decision-making.

Task shifting and task sharing

Despite WHO's global recommendations and guidelines on task shifting that support community health worker provision of ECPs, injectables, and OCPs, we received conflicting information as to whether APEs were authorized to provide these essential health services. Key informants and community members emphasized the integral role that community mobilization, including APEs, played in increasing awareness about the importance of contraceptives. With sufficient policy and training support, APEs could be leveraged further to offer women a wider range of contraceptive methods.

Similarly, mobile health units deployed during the cyclone response were not permitted to provide PAC. Although the mobile units did not have the conditions, equipment, and supplies to provide PAC with MVA, it is possible to provide PAC with misoprostol in more restricted settings, provided there is a strong, functional referral mechanism in the event of complications.

Pathfinder International and MISAU informants noted that Pathfinder is training diverse health providers to provide contraceptive services as part of an integrative health service delivery approach; this data will be captured by SIGLUS. Integrative service delivery has the potential to increase contraceptive uptake by expanding access to quality provision of contraceptive methods by mid-level providers outside of health facilities. Integrative service delivery can expand access to contraceptive services, particularly to communities that do not have access to static health facilities due to distance and/or transportation costs. To effectively disseminate contraceptive information and services to community members, especially those with increased barriers to facility-based care, integrative health service delivery must include trusted health workers at the community level, such as APEs, midwives, TBAs, and community activists, not only facility-based providers.

Adolescent-friendly services

Adolescent contraceptive use is critically important to curb adolescent maternal morbidity and mortality, especially given community members' discussions of high rates of adolescent pregnancy and child marriage, and reported increases in transactional sex among adolescent girls post-cyclone. However, adolescent and adult community members reported that gaps in adolescent-friendly services remain. Given that community and health provider stigma was a key barrier for adolescents in accessing contraceptive services, adolescent-friendly services may reduce stigma faced by adolescents, and therefore increase contraceptive uptake.

Notably, MISAU has established "Serviços de Aconselhamento e Acompanhamento dos Jovens," or SAAJs—dedicated facilities for adolescents and young people aged ten to 24 to increase their access to adolescent-friendly health services, including contraception. According to respondents, SAAJs, and other adolescent-targeted strategies, have been successful in increasing adolescents' access to these services. Adolescent-friendly services, such as SAAJs, should be expanded to other communities affected by the cyclone, including in accommodation centers, to improve adolescents' access to contraceptives and further engage them with lifesaving SRHR information and contraceptive services. Other effective adolescent SRH strategies, such as age-appropriate comprehensive sexuality education that includes gender and power dynamics, should be expanded across schools.

IX. Recommendations

Based on the case study, recommendations for all partners providing SRH services in Cyclone Idai-affected areas were identified. Although many components of the Cyclone Idai humanitarian response have concluded, humanitarian needs remain vast. In June 2020, UN OCHA issued a flash appeal to support the response to COVID-19 response in Mozambique, and reported that over the preceding year, droughts, violence in Cabo Delgado province, cyclones, and flooding have left an estimated 2.5 million people across the county in urgent need of humanitarian assistance, and a projected 2 million people at risk of food insecurity. COVID-19 will only compound the current crisis.[40] Moreover, given the country's vulnerabilities to recurring crises and the role that climate change plays in increasing the frequency of and exacerbating disasters on a global scale[41], it is critical to undertake preparedness measures to fortify the health system and improve its capacity to provide contraceptive services in response to future emergencies.

It is essential that the government of Mozambique and its partners maintain their efforts to deliver SRH services to affected populations and those who may be impacted by future disasters, including the most remote or isolated communities, and meet demand and need for contraceptive services, preventing mortality and morbidity and fulfilling fundamental human rights. Many recommendations are focused on emergency preparedness, which is essential to ensure MISAU and partners are prepared to implement the MISP for SRH, including contraceptive services and PAC, in an emergency response at national, provincial, district, and community levels, inclusive of often marginalized populations.

The government of Mozambique and MISAU should:

- **continue to expand its integrated model for contraceptive service delivery and task-sharing policies** by ensuring all providers are trained, stocked, and supported to provide the full range of methods that they are authorized to provide. In particular, the MISAU should ensure that

midwives and traditional birth attendants are trained, stocked, and supported to deliver the full-range of contraceptive methods, and that Agentes Polivalents Elementares are trained, stocked, and supported to provide ECPs;

- **expand the availability and accessibility of contraceptive services in remote and isolated areas** by authorizing health providers and pharmacists to distribute OCPs, DMPA-SC, and ECPs in multi-month supplies;
- **authorize women to self-inject DMPA-SC,** and ensure health providers and pharmacists are equipped to train and support women to self-inject;
- **expand the availability of PAC services for women and girls residing in resettlement centers** by strengthening the referral mechanism from mobile health units to static facilities, training staff on safe provision of PAC with misoprostol, and authorizing the provision of PAC with misoprostol by trained providers in mobile health units;
- **ensure that the MISP for SRH services, including contraceptive services, are included in national and sub-national emergency preparedness and disaster risk management** for health policies and activities;[42]
- **strengthen preparedness efforts by continuing to identify implementing partners,** including and prioritizing local partners, who will be positioned to support SRH service delivery at the onset of an emergency;[43] and
- **ensure that all products included in the IARH kits are registered in country and included in the national essential medicines list** to support timely and cost-effective procurement in the event of an emergency.[44]

All SRH partners should:

Strengthen preparedness for SRH by:

- **identifying gaps in knowledge and capacity for MISP for SRH implementation, i**ncluding IARH kit management, and continuing to deliver MISP for SRH trainings to all relevant staff and providers;
- **ensuring all relevant staff are familiar with emergency preparedness and disaster risk management policies and procedures at the national and sub-national levels, and with humanitarian coordination mechanisms** (i.e., the cluster system) that may be activated in the event of a crisis; and
- **continuing and expanding measures to train providers, pharmacists, and supply chain managers** on supply chain management, including effective distribution, stock management, and the use of the SIGLUS system, including during a humanitarian response.

Support quality contraceptive and PAC service provision by:

- **continuing to train diverse providers on integrated contraceptive service delivery**, including through regular refresher trainings, and supportive supervision and on the job training (OJT);
- **continuing to expand measures to strengthen the capacity of providers to deliver a full range of contraceptive methods,** particularly EC, IUDs and LARC removals, through training, regular refresher trainings, and supportive supervision and OJT;
- **strengthening the capacity of providers to provide PAC services** through training, regular refresher trainings, supportive supervision and OJT;

- **addressing providers' attitudes around partner permission for contraceptive services and woman-led decision-making around contraceptive use** by providing values clarification and attitudes transformation (VCAT) trainings; and
- **strengthening accessibility and availability of adolescent-friendly contraceptive and SRH services for youth** by conducting training on adolescent-friendly service delivery and VCAT.

Strengthen community mobilization efforts by:

- **expanding programming that supports attitudes and behavior change around SRHR,** including supporting women- and girl-led decision-making around contraceptive use;
- **conducting targeted efforts to increase awareness of the existence of ECPs and EC**, where to access them, and the importance of accessing them as soon as possible after an incident of unprotected sex;
- **conducting targeted efforts to increase awareness of where to access PAC services;**
- **expanding targeted efforts to reach adolescents;**
- **expanding targeted efforts to reach boys and men**; and
- **ensuring community mobilization efforts reach the most remote or isolated communities.**

X. Appendices

Appendix A: Data from key informant interviews

Table 11: Organizations and agencies interviewed (n=10)

Organization	Number of interviews
AMODEFA	1*
CUAMM	1
MISAU	4
Pathfinder International	3*
UNFPA	1*

**More than one representative present during the interview.*

Appendix B: Data from health facility assessments

Table 12: Facilities with essential components to provide contraception

	Rural hospital (n=1)	Rural/ urban health posts (n=3)	Mobile heath unit (n=1)
FP Information leaflets or flip chart	1	2	1
OCPs provided in last three months	1	3	1
Staff trained to provide short-acting methods	1	3	1
Blood pressure cuff	1	3	0
Stethoscope	1	3	0
Daily combined OCPs	1	3	1
Progestin-only contraceptive pills	1	3	1
Facility able to provide OCPs	1	2	0
Injectables provided in last three months	1	3	1
Staff trained to provide short-acting methods	1	3	1
Blood pressure cuff	1	3	0
Stethoscope	1	3	0
Injectable contraceptive (progestin-only)	1	3	1
Needles and syringes	1	3	1
Facility able to provide injectables	1	2	0
DMPA-SC	0	2	1
IUD insertion or removal performed in last three months	1	3	N/A
Staff trained to provide IUD	1	3	-
Sterile gloves	1	3	-
Graves speculum, medium	1	3	-
Uterine sound	1	0	-
Uterine tenaculum	1	2	-
Sponge forceps, straight	1	3	-
Mayo scissors, curved	1	3	-
Gauze/cotton	1	3	-
Antiseptics	1	3	-
IUD	1	3	-
Facility able to provide IUD	1	0	N/A
Implant insertion or removal performed in last three months	1	3	1
Staff trained to provide implants	1	3	1
Sponge forceps	1	3	ND

Table 12: Facilities with essential components to provide contraception

	Rural hospital (n=1)	Rural/ urban health posts (n=3)	Mobile heath unit (n=1)
Sterile gloves	1	3	ND
Needles and syringes	1	3	1
Antiseptics	1	3	0
Lidocaine	1	3	1
Gauze/cotton	1	3	1
Implant	1	3	1
Facility able to provide implant	1	2	0
Emergency contraceptive pills	0	2	0
Facility able to provide ECPs	0	1	0
Male condoms	1	3	1
Female condoms	1	2	0
Facility able to provide condoms	1	2	1

Table 13: Facilities with essential components to provide post-abortion care

	Rural hospital (n=1)	Rural/ urban health posts (n=3)	Mobile heath unit (n=1)
PAC performed in last three months using MVA	1	3	N/A
Staff trained to perform MVA	1	2	N/A
Vaginal speculum, graves medium	1	3	N/A
Sponge forceps	1	3	N/A
Uterine tenaculum	1	2	N/A
Uterine dilators, sizes 13–37 (French)	0	0	N/A
Vacuum aspirators/syringes	1	3	N/A
Flexible cannulae, 4–12 mm	1	3	N/A
Adapters	1	3	N/A
Kidney dishes	1	1	N/A
Antiseptic solution	1	3	N/A
Gloves (sterile or non-sterile)	1	3	N/A
Lidocaine	1	3	N/A

Table 13: Facilities with essential components to provide post-abortion care			
Paracetamol or ibuprofen	1	3	N/A
Oxytocin	1	3	N/A
Needles and syringes	1	3	N/A
Facility able to provide PAC using MVA	0	0	N/A
PAC performed in the last three months using misoprostol	1	2	N/A
Misoprostol 200 mcg tablets	1	2	N/A
Facility able to provide PAC using misoprostol	1	2	N/A

Appendix C: Provider knowledge and attitudes data

Table 14: Providers' provision of services and training

Service	Provided the service in the past three months (n=10)	Ever received instruction or training on how to provide this service (n=10)
Counsel women and girls about family planning	10	5
Insert an IUD	7	5
Insert a post-partum IUD (within 24 hours of delivery)	5	4
Insert an implant (e.g., Implanon, Jadelle)	9	7
Provide sub-cutaneous injectable contraception (DMPA-SC/Sayana Press)	7	4*
Provide emergency contraception	7	4*
Perform manual vacuum aspiration (MVA) for post-abortion care	5	3†
Provide post-abortion care using misoprostol	4	2†
Perform induced abortion using MVA	2	1†
Perform induced abortion using mifepristone and misoprostol combination pill	1	1†
Perform induced abortion using misoprostol	3	1†
Provide post-abortion family planning counselling	7	4*

** One participant responded yes and no.*

† One participant responded yes and no; one participant did not respond.

Table 15: Providers' knowledge: family planning

Family planning	n=10
The person responsible for deciding the FP method is the: a. healthcare provider **b. client** c. client's partner d. village elder	9*/10

Table 15: Providers' knowledge: family planning	
Family planning	**n=10**
The most important part of counseling is: **a. informing the client about all available methods and answering her concerns and questions about using contraceptives** b. making a good decision for the client c. using up all surplus supplies in the health facility d. making friends with the client	10/10
The most common side effect of Depo-Provera is: a. jaundice and liver damage b. increased facial hair c. reduced sexual desire **d. changes in the menstrual cycle**	8†/10
Most women experience changes in their menstrual cycles following the insertion of an IUD. You should explain to new IUD users that they can have: a. less bleeding than usual but more menstrual cramping during the first few periods following insertion b. more bleeding than usual and less menstrual cramping during the first few periods following insertion c. less bleeding than usual and no menstrual cramping during the first few periods following insertion d. m**ore bleeding than usual and more menstrual cramping and pain during the first few periods following insertion**	3/10
A mother who is less than six months post-partum and amenorrhoeic (her periods have not returned after delivery) is protected from pregnancy as long as she: a. breastfeeds her baby during the day and the baby sleeps at night **b. breastfeeds the baby on demand day and night** c. bottle feeds the baby d. breastfeeds the baby at night and bottle feeds during the day	10/10
Potential users of EC include: a. unmarried women b. young women c. women who smoke under the age of 35 **d. any woman who has had an episode of unprotected sex**	10/10
Total correct (mean)	**5/6**

Correct answers are marked in bold.

Table 16: Providers' knowledge: post-abortion care	
Post-abortion care	**n=10**
Both MVA and misoprostol are effective methods to treat an incomplete abortion if the uterine size is not greater than: 10 weeks 12 weeks **13 weeks** 16 weeks	0/10
Which one of the following is a WHO recommended regimen for misoprostol for treatment of an incomplete abortion and miscarriage? a. 400 mcg oral b. 600 mcg oral **c. 600 mcg sublingual** d. 800 mcg sublingual	2/10
After uterine evacuation for an incomplete abortion, a woman's fertility may return: a. after four weeks b. after her first menstrual period **c. within 7–11 days** d. after her first ovulation	2/10
What information do you give patients who were treated for an incomplete or unsafe abortion? a. About when a woman can conceive again b. Referral for FP or provide FP methods c. About the consequences of an unsafe abortion **d. All of the above**	7/10
Total correct (mean)	**1.1/4**

Correct answers are marked in bold.

Acronyms and Abbreviations

AMODEFA	Associação Moçambicana para Desenvolvimento da Família
CMR	Clinical management of rape
DMPA-SC	Depot medroxyprogesterone acetate, sub-cutaneous (brand name Sayana Press)
EC	Emergency contraception
ECPs	Emergency contraceptive pills
FEFO	First expired, first out
FGD	Focus group discussion
FP	Family planning
GBV	Gender-based violence
HMIS	Health information system
IARH kit	Inter-Agency Emergency Reproductive Health Kit
IAWG	Inter-agency Working Group for Reproductive Health in Crises
IDP	Internally displaced person
IEC	Information, education, and communication
IUD	Intrauterine device
KII	Key informant interview
LARC	Long-acting reversible contraception
MISP	Minimum Initial Service Package
MISAU	Mozambican Ministry of Health
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
OCP	Oral contraception pill
PAC	Post-abortion care
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund

Endnotes

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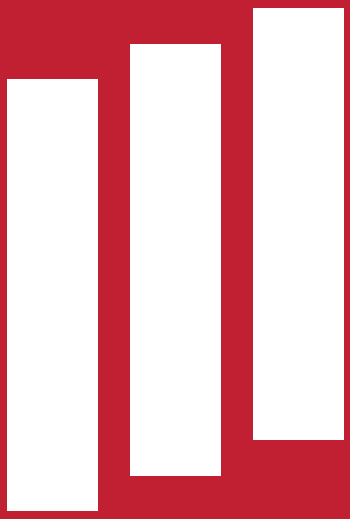

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