FAMILY PLANNING

Strengthening Mozambique’s Family Planning Market: A Way Forward
Greetings,

Providing quality family planning is a priority for the government of Mozambique. We have a strong focus on youth, and are committed to improving the services offered in our health system. We also want to stimulate an increase in demand for modern contraception and overall use. Three strategies guide our work: the National Family Planning and Contraceptive Strategy, the Global Financing Facility (GFF) Strategy, and Mozambique’s Family Planning 2020 (FP2020) Commitments.

Our goals are ambitious and we are proud of progress made to date. There is still work to be done, especially reaching youth and women in rural and peri-urban communities. Success will require a multi-sectoral approach and a strategic shift in modern contraceptive promotion. Public-private partnerships are needed to improve distribution and increase the number of providers and facilities that can support youth and women in their reproductive health decision-making. These strategies will require the support of religious and community leaders, our partners, and strengthened coordination between the public and private sectors.

This report is the product of a family planning technical working group (TWG) meeting in June 2017. It reflects a larger effort between the government and our partners to provide a range of safe and effective methods to help women plan the families they desire and curb population growth. The TWG took a critical look at the health of Mozambique’s family planning market and areas where the market is failing. Using this kind of approach will help us make the most efficient use of existing resources and delivery points within our health system, and ultimately move us toward a healthier, more prosperous country and population.

Sincerely,

XXXXXXX

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Family Planning in Mozambique

Mozambique’s future will be largely influenced by fertility trends. If fertility remains high — at 5.4 children per woman — the population could grow from 20.6 million in 2007 to 67.9 million in 2050, more than tripling in size. High fertility is associated with increases in maternal mortality and morbidity, and has broader consequences on the health and well-being of all Mozambicans. Continued and rapid population growth could compromise the quality of health services, strain the education system, decrease employment opportunities, and compromise food security across the country.\(^2\)

High fertility is more common in rural Mozambique than urban areas. According to the latest national survey, the total fertility rate (TFR) in rural areas was 6.1 compared to 3.6 in urban areas. TFR has remained mostly stable between 1997 and 2015 (range = 5.2 to 5.9), although there was a slight decline between 2011 and 2015 (from 5.9 to 5.3, respectively).\(^3\)

Sexual activity and childbearing begins at a young age in Mozambique. There is pressure on youth to enter stable unions early, which constitutes the beginning of frequent sexual intercourse and low contraceptive use. The mean age at first union is 16 years for girls and 18 for boys,\(^1\) and pregnancy and childbearing are expected and desirable events within the context of these unions.\(^2\)

Nearly half of all Mozambican women have a child or become pregnant when they are 15–19 years old.\(^6\)

In addition, a high percentage of 15-19 and 20-24 year olds have reported trying to abort unplanned pregnancies (40% and 32%, respectively).\(^5\) For several years, the government has prioritized family planning (FP) for youth because of the risk that accompanies early pregnancy and abortion: medical complications, maternal mortality, prematurity birth, low birthweight among newborns, and social consequences, like reduced educational and employment opportunities for women.\(^4\)

With 47% of all Mozambican women in their reproductive age, quality FP services, including access to modern methods, are essential for decreasing TFR. Among women aged 15-49, only 25% report using a modern method. The most commonly used method is injections (13%), followed by oral contraceptives and implants (6% and 2%, respectively). Contraceptive use peaks in women aged 30-34 years (32%), but is very low among 15-19 year olds (19%) and 20-24 year olds (26%). Use also varies by residence (34% urban vs. 22% rural) and wealth. Modern contraceptive use is highest among the wealthiest women and lowest among the poorest (43% in quintile 5 vs. 17% use in quintile 1).\(^3\)

Much remains to be done to generate demand for FP and provide women the services they need, particularly youth. The National Health Service provides free FP services, including to youth aged 10-24 through a Teen and Youth-Friendly Services initiative. There are challenges, however, and youth report that providers in Sanitary Units are rarely youth friendly and they sometimes refuse to provide modern contraception to girls who have never had a child. Male and female youth report a lack of confidentiality and stigma associated with seeking public services, and when they turn to private sector services, they are too expensive. Additionally, when girls do not have access to other forms of contraception, they try to use condoms, but their partners often refuse, which results in no method being used.\(^10\)

Generating demand for FP and providing a range of modern contraceptive options and quality services will be key to slowing population growth in Mozambique. Such investments would allow Mozambique to focus on complementary areas of development, like improving overall healthcare, guaranteeing universal education, expanding employment opportunities, and attaining food security. If strategically implemented, these measures could catalyze progress toward a healthier, more prosperous country and population.\(^11\)

Policy

In response to these needs, Mozambique has joined 38 other nations in making FP2020 commitments,\(^12\) joined the effort to meet Millennium Development Goals (MDGs) 4 and 5,\(^13\) and implemented its own National Family Planning and Contraceptives Strategy.\(^4\) It has also committed to a Global Financing Facility (GFF) Strategy.\(^15\)

Commitments stress the importance of covering contraceptive needs, increasing access to long-acting and permanent methods (LAPMs), and increasing the modern contraceptive prevalence rate (mCPR) to 34% in 2020 through the following mechanisms:

- Demand generation targeted at rural and peri-urban communities and community-based distribution of modern contraception. The government will enlist the participation of communities, health agents, traditional midwives, non-governmental organizations, and mobile clinics in these efforts. There is also commitment to working with religious leaders and community leaders to educate and advocate for FP.
- Supply-side efforts focused on increasing the number of facilities that offer at least three contraceptive methods and increasing the number of providers who can provide post-partum and post-abortion counseling. The government will continue to provide cost-free, integrated sexual and reproductive health services and commodities in all health facilities, and will ensure that existing laws pertaining to sexual and reproductive health are known and implemented at all levels.
- Public-private partnerships to improve the distribution of contraceptive commodities and strengthening the coordination between partners.
- Use of an electronic stock management system to better manage the supply chain for commodities, including contraceptives, by 2020.\(^16\)

KEY TO MOZAMBIQUE’S COMMITMENTS IN THE FOCUS ON YOUTH

Since 2012, the government has prioritized revitalizing FP information, services, and outreach for youth. At the time of the TMA workshop, the government intended to renew these commitments and strengthen the focus on youth by:

- Increasing the use of modern contraceptive methods among all married/in union youth aged 15-19 from 14% (2015) to 19% in 2020
- Increasing the use of modern contraceptive methods for all unmarried sexually active youth aged 15-19 from 27% (2011) to 50% in 2020
- Providing sexual and reproductive health services (information and contraceptives) in all secondary schools by 2020

1.\(^{\text{PhD 2007, UNDP 2017}}\)
2.\(^{\text{MISAU 2016}}\)
3.\(^{\text{IMASIDA 2016}}\)
4.\(^{\text{WHO 2016}}\)
5.\(^{\text{UNFPA 2015}}\)
6.\(^{\text{MISAU 2001}}\)
7.\(^{\text{Health Policy Project for the Government of Mozambique 2015}}\)
8.\(^{\text{MISAU 2015}}\)
9.\(^{\text{WHO 2016}}\)
10.\(^{\text{UNFPA 2015; PSI 2016a}}\)
11.\(^{\text{IMASIDA 2016}}\)
12.\(^{\text{MISAU 2001}}\)
13.\(^{\text{IMASIDA 2016}}\)
14.\(^{\text{UNFPA 2015; PSI 2016a}}\)
15.\(^{\text{Health Policy Project for the Government of Mozambique 2015}}\)
16.\(^{\text{Health Policy Project for the Government of Mozambique 2015}}\)
The Total Market Approach

The public health community has recently focused on improving the health of market systems to better serve consumers. The Total Market Approach (TMA) for FP is about making the most efficient use of existing resources and delivery points in the health system to generate demand for FP and ensure all consumers can access the products and services they want.

There are four main questions to answer when using TMA:

1) **Who is the market failing?**
   Consider potential consumers (total NEED for a product or service) and actual consumers (total USE of a product or service) in a market. Analysis of this gap through equity lenses such as age, gender, geography, wealth quintile and risk behaviors help determine who the market is failing among non-users and users.

2) **How is the market failing?**
   Conduct a market mapping and landscape exercise to identify key market players, the functions they perform, and how the enabling environment influences their capacities and incentives to perform.

3) **Where can improvements be made?**
   Determine how market players are best positioned to improve the market, and design interventions to improve overall market performance.

4) **How will we get there?**
   Identify steps to achieve the interventions’ goal and the metrics to track progress.

“There are times when the supplier doesn’t have any product, and then we don’t have it either. For example, Oralcon F is a pill that (consumers) prefer and sometimes it disappears from the market. Consumption is high and the quantities they send from the central level aren’t enough.”

— Urban distributor, FP Market Landscaping

**A healthy market, includes the following:**

- Sufficient demand among consumers so high quality and appropriate products and services are sought and used
- Robust supply, including a strong supply chain, sufficient delivery points, a diverse range of products and growing market volume and value
- Supportive functions, such as coordination across market players, quality assurance, appropriate labor capacity, and a financing mechanism for the poor and vulnerable
- Supportive policy and regulatory environment
Methods

To improve coordination of the FP market and alignment amongst partners, MISAU led a TMA workshop with UNFPA, social marketers, the TWG, and private sector representatives in June 2017. Participants came from a total of 12 agencies and used a participatory process to produce the findings and recommendations highlighted in this report. MSIs Impact2 tool was used to generate method mix scenarios, mCPR, and CYPs. Unintended pregnancies were calculated based on Impact2 outputs and Trussel’s 2011 publication on failure rates.¹⁰

Input for the workshop was collected through an extensive consultation process with beneficiaries as well as public and private actors across the information and service delivery chain. Donors, implementing organizations, and MISAU were interviewed on FP service and policies, financing, and TMA using both close-ended (statements that were rated on a scale of 1-10 indicating no agreement to total agreement), and open-ended questions.¹ⁱ

During the TMA workshop, participants used data to identify who the FP market was failing and how. They then worked together to identify priority improvements and steps for achieving the goal of a healthier FP market that is responsive to consumers and in line with national priorities.

Figure 1. TMA workshop participants were from the following organizations:

- MISAU
- CNCS
- FNUAP
-ONUSIDA
- USAID
- DKT
- GHSC-PSM
- ICRH – Moçambique
- INJ
- MCSP/Jhpiego
- NPCS - Maputo Cidade
- Pathfinder
- PSI

TMA workshop participants were from the following organizations:

1 interview with MISAU
9 focus groups with women of reproductive age
7 interviews with NGOs
4 interviews with private sector providers
16 interviews with public sector providers
15 interviews with private pharmacists
14 interviews with retailers
12 interviews with importers/wholesalers/distributors
5 interviews with donors

75 TOTAL CONSULTATIONS

Figure 2 shows the process for estimating modern contraceptive use and need among all women of reproductive age (WRA), the first step in identifying who the market is failing. Moving from the top of the figure to the bottom, one sees how WRA are divided into those who are married (left) and unmarried (right), their sexual activity, fertility intentions, and contraceptive use. Those using modern contraception (orange boxes) and those in need of modern contraception (blue boxes plus orange boxes) constitute what marketers call “use/need.”

Depicting data in numbers, rather than just percentages, makes it possible to understand the size of the potential and actual market for modern contraception.

Sources: IMASIDA 2016 and 2007 Mozambique census population projections
Who is the Market Failing?

**USE/NEED**

Figure 3 depicts use/need for married and sexually active unmarried women over time: when national surveys were completed (2011 and 2015), present day (2017), and when national FP2020 commitments should be met (2020).

In 2011, the potential market was smallest (1.7 million) and the majority of women fell within the use/need gap (1.1 million). Just over half a million women were using modern contraception.

In 2015, more women expressed a need for modern contraception and the market grew to 2.5 million. Use increased and mCPR among married women was 25%; however the use/need gap was still 1.2 million women, an untapped FP market.

Present day, the market continues to grow (2.6 million) but just over half of women in need of modern contraception are using a method (1.4 million).

If need and use continue at the same rate, by 2020, the potential market will grow to 2.9 million women, but there will still be a significant gap between the number of women in need of modern contraception and those actually using a method (1.4 million).

**Figure 3.** Contraceptive use and need over time for married and sexually active unmarried women of reproductive age

**Figure 4.** Examining the gap (2017)

When examining the gap between use and need is apparent that most women report being married and live in rural areas.

Of 1,257,913 women:

- 887,185 married women
- 372,176 unmarried women

Of 1,090,779 married women:

- 796,908 from poorest quintiles
- 294,541 from middle quintiles

Of 167,135 unmarried women:

- 90,278 from poorest quintiles
- 77,634 from middle quintiles

A closer look reveals that married women in rural areas are the largest potential market. Most women are also under 34 years old and among them, most are aged 15-24. Women in the poorest two quintiles also constitute a potential market: they are less served by the current market than women from wealthier quintiles. Among unmarried women, the largest potential market is those living in rural areas.

**Marital Status**

- Married
- Unmarried

**Location**

- Rural
- Urban

**Economic Status**

- Poorest
- Poor
- Middle
- Rich
- Richest

**Age**

- 15 - 24
- 25 - 34
- 35 - 49

Sources: IMASIDA 2016 and 2007 Mozambique census population projections
METHOD MIX

When all married and sexually active unmarried women are considered together, the market dominance of short-acting methods is apparent, especially for injectables and oral contraceptives: nearly half of women use injectables (48%), 25% use oral contraceptives, and 13% use male condoms. Implants have only 6% market share and other modern methods have a negligible presence on the market.

A market dominated by short-acting methods is less impactful and efficient than one offering a mix of methods. When considering method failure and misuse by consumers, the current method mix will result in approximately 77,190 unintended pregnancies in 2017. With this method mix, 1.2 million couple years of protection (CYPs) are achieved by reaching 1.4 million women with 30 million methods. The cost per CYP is $3.21. Shifting more women in need to long-acting methods would make the market more impactful and cost effective.

Breaking method mix down by demographics shows how the market differs across women. The majority of married women in rural areas report using injectables (63%). Married urban women rely on a mix of injectables and oral contraceptives (38% vs. 33%). Male condoms are approximately 10% of the FP market for urban married women and 3% of the rural market.

There is low market presence for LAPMs: implants are more common than other methods, but make up only a small part of the market (6% rural, 9% urban). Very few married women use IUDs (3% in both rural and urban), and rates of sterilization are negligible (range = 0 to 2%).

The FP market among youth aged 15-24 is similar to other age categories. Married youth tend to use injectables (48%) and oral contraceptives (29%). They rely more heavily on condoms than other groups (8% vs. 5% and 6%, respectively), and when they use LAPMs, they are most likely to use implants (7%).

Short-acting methods also dominate the FP market for unmarried women. Those in rural areas rely on injectables (41%), oral contraceptives (29%), and male condoms (16%). Their urban counterparts rely more heavily on male condoms (51%), followed by injectables and oral contraceptives (20% each).

Among LAPMs, implants are, again, more common than other methods, but only a small part of the market (6% rural, 5% urban). Very few unmarried women use IUDs (4% rural, 1% urban), and rates of sterilization are negligible (range = 0 to 1%).

“Nurses sometimes say that a woman who doesn’t have a child can’t use injection methods or that teenagers can only use condoms and pills... [These young women] should never accept an injectable device or IUD.”
— Woman with children, FP Market Consultation

Data disaggregated by age were not available for unmarried women.
Trussel 2011
UNFPA 2017
MOSI 2016
Measure Evaluation 2017

Figure 5a. Method mix for married and sexually active unmarried women (2017)

2017 by the numbers:

- 29,904,134 estimated number of methods...
- 1,385,924 married and sexually active unmarried women:
- 1,242,963 estimated number of CYPs
- 77,190 estimated number of unintended pregnancies
- $3.21 cost per CYP

Source: IMASIDA 2016
Figure 5b. Method mix for married and unmarried women by residence and age (2017)

Of 1,090,779 married women:
- 796,908 are from rural areas
- 294,541 are from urban areas
  - 402,581 are 15-24
  - 362,866 are 25-34
  - 326,016 are 35-49

Of 267,124 unmarried women:
- 90,278 are from rural areas
- 77,634 are from urban areas
  - 326,016 are 35-49
The public sector has been the main supplier of modern methods, with distribution focused on oral contraceptives and injectables between 2011 and 2016. The public sector also provided the greatest number of IUDs and started distributing implants in 2014. Implant distribution started later in the public than private sector and remains low relative to other modern methods. In 2015, the public sector surpassed the private sector to become the main supplier of implants.

Two social marketing agencies distribute commodities and provide services in the private sector (DKT and PSI). They offer FP services for oral contraceptives, injectables, implants, and IUDs. The private sector made up 11-18% of the market for oral contraceptives, implants, and IUDs. The growth of the private sector year on year suggests an increased willingness to pay and women’s decision to seek services outside of the public sector. While this trend in the private sector is promising for urban and peri-urban areas, rural women will still depend heavily on public sector health units and community health workers. In urban areas, the private sector could expand services and relieve the burden on the public sector.

Converting volumes to CYPs shows the estimated contraceptive protection provided by the market during a one-year period. Public sector CYPs increased between 2011 and 2016, mostly due to large-scale distribution of oral contraceptives and injectables. Despite lower distribution, social marketing CYPs started to climb in 2015 with greater focus on implants, and in 2016 with greater distribution of IUDs. Both methods provide a longer period of contraceptive protection and are more effective offerings on the market.

Data are not available for the commercial sector, but estimated market share is small, approximately 10% for oral contraceptives and negligible volumes for other methods. Sources: MISAU, DKT, and PSI 2016 and 2017.
How Would a Healthier Market Look?!

In addition to fixing the market to increase access and uptake of current offerings, it is important to consider how Mozambique’s FP market could be more impactful and cost effective over time. Below are the three scenarios that show how the market would look if it were to continue as is, or if there were a more ambitious shift to long-acting methods. Strategic market-level decisions will mean the difference between the country reaching its commitments or falling short of its goals.

Figure 7. Scenarios

Current method mix

### Scenario 1. Stay the Course: Keep method mix and distribution consistent through 2020

Mozambique would not reach its FP2020 commitment or grow CYPs. The cost per CYP would hold constant. The burden of unintended pregnancies would increase.

<table>
<thead>
<tr>
<th>2017</th>
<th>2020</th>
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<tbody>
<tr>
<td>Number of methods</td>
<td>12,580,934</td>
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<tr>
<td>Women</td>
<td>1,302,360</td>
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<td>CYPs</td>
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<td>Cost/CYP</td>
<td>$2.52</td>
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<td>mCPR 25% Among married women</td>
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Between 2014 and 2016, MISAU and its partners more than doubled implant distribution as illustrated in Figure 6 above (from 62,714 to 153,680). The effects of that effort can be seen in this modeled scenario where more married women are using and will continue to use implants and IUDs over time. If distribution were to stay the same, by the end of 2020, mCPR among married women would be 32%. The same number of methods would be distributed, and CYPs would hold steady at 1.5 million. The number of women using modern methods would increase by 230,972 over time because of continued use of implants and IUDs. The cost per CYP would hold constant at $2.52.1

### Scenario 2. Increase implant and IUD distribution 7.5% each year and decrease OCs and injectables by 1.75%

Mozambique would meet its FP2020 commitment and grow CYPs by more than 10% over current levels. There would be a stronger FP market and the cost per CYP would decrease. The burden of unintended pregnancies would decrease.

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By the end of 2020, increasing yearly distribution of implants and IUDs by 7.5% and decreasing OCs and injectables by 1.75% would result in 34% mCPR among married women. Switching some women from short-acting to long-acting methods and increasing the number of women who start using LARCs means that 201,136 fewer methods would need to be distributed in 2020 than in 2017. The number of women using modern methods would increase by 302,816 and CYPs would increase by 120,432. The cost per CYP would be $2.40. Unintended pregnancies would decrease by 2,254 among married modern method users.

### Scenario 3. Increase implant and IUD distribution 10% each year, and decrease OCs and injectables by 2%

Mozambique would meet its FP2020 commitment and grow CYPs by more than 15% over current levels. There would be a stronger FP market and at the lowest cost per CYP. This scenario would have the most impact on unintended pregnancies.

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By the end of 2020, increasing yearly distribution of implants and IUDs by 10% and decreasing OCs and injectables by 2% would result in 34% mCPR among married women. Switching more women from short-acting to long-acting methods and increasing the number of women who start using LARCs means that 215,847 fewer methods would need to be distributed in 2020 than in 2017. The number of women using modern methods would increase by 339,142 and CYPs would increase by 178,459. The cost per CYP would be $2.38. Unintended pregnancies among married modern method users would decrease by 2,602.

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1 Scenarios were calculated for married women only and illustrate four paths Mozambique could use to reach its FP2020 commitment of 34% mCPR among married women. Baseline data came from IMASIDA’s 2015 survey. Method mixes use actual or projected distribution from MISAU, DKT, and PSI, not method use reported at the population level. The amount of product distributed to married women was calculated by applying the proportion of married women from the IMASIDA survey to distribution figures. Scenarios assume that all methods distributed reached married women and were used. No wastage was included, so actual figures would be lower. MISP Impact2 tool was used to generate method mix scenarios, mCPR, and CYPs. Unintended pregnancies were calculated based on Impact2 outputs and Trussel’s 2011 failure rates.

2 Costs were calculated based on 2017 prices in USD. No costs were included for female or male sterilization, LAM, or “other methods.” Costs were only for commodities and based on UNFPA’s costs/unit in 2017. Costs do not include additional investments, like service delivery, labor, infrastructure, or promotion.

3 Unintended pregnancies among women using modern contraception will increase when more women use methods. This will remain the case until enough women switch from short-acting to long-acting methods with lower failure rates.

Source: IMASIDA 2016
How is the Market Failing?

After identifying who the market is failing, MISAU and its partners used transcripts from focus groups and interviews, market data, background literature, and their combined years of experience to identify where and how the market is failing. Figure 7 contains the results of that analysis and illustrates challenges related to supply and demand, and the market supporting functions.

Figure 8.

- Overburdened public sector leads to poor service delivery and counseling
- Lack of youth-friendly providers limits choice for young people
- Private sector coverage is low and products and services are too expensive
- Lack of targeted FP promotion perpetuates myths and inaccurate information
- Poor accessibility to health units and providers, especially in rural areas
- Product stockouts are common and affect method choice
- Black market contraceptives compete with higher quality options
- Retailers and providers have poor understanding of government policy
- Fluctuations in currency decrease purchasing power

**Porters/Distributors/Wholesalers**
- Public sector hospitals and health centers, social franchising health centers, private sector clinics, community health workers (CHWs)

**Retailers**
- Private sector pharmacies, unofficial pharmacies

**Consumers**
- Women aged 15-49, their partners

An overburdened public sector leads to poor service delivery and counseling
- Wait times can average 1.4 hours from arrival to first examination and there is little patient follow up.
- Providers lack time to provide customized care and counsel consumers on the full range of methods available.
- Providers tend to recommend methods, especially short-term methods like oral contraceptives, that are easy to administer rather than what women prefer.
- Many providers lack the skills to provide effective counseling, especially for method side effects and post-abortion care.
- There is no mechanism for licensing and relicensing providers, or continuous training to improve skills.

A lack of youth-friendly providers limits choice for young people
- Providers sometimes refuse services to youth, especially those under 18 whom they consider too young to be sexually active.
- Providers make FP decisions on behalf of youth and avoid providing long-acting methods to young women who have not yet had children.

Private Sector coverage is low and products and services are too expensive
- Private sector health services, including FP, are not available outside urban areas.
- Consumers suspect that private sector providers and pharmacists are purely profit driven and will push whichever method is most expensive (e.g., implants).
- Consumers believe the private sector offers the same products and services as the public sector, but at a much higher price.

There is a lack of targeted FP promotion, which perpetuates myths and inaccurate information
- In absence of centralized messaging and open discussions with parents about FP, youth rely on peers for information, which is often inaccurate.
- Myths and misperceptions abound, including which methods are appropriate for youth and that long-acting methods lead to infertility.
- Adolescent boys and young men have been overlooked in past campaigns and merit attention. They can undermine FP use among partners and often refuse to use condoms.

There is poor accessibility to health units and providers, especially in rural areas, which means that many consumers are unserved
- Mozambique has one of the lowest ratios of health workers to consumers globally and rural areas of Mozambique are particularly underserved: there are 176 health workers per 100,000 inhabitants in urban areas and only 65 in rural areas; there are 12 doctors per 100,000 inhabitants in urban areas and only 2 in rural areas.
- Public sector providers earn far less than their private sector counterparts. Many leave the public sector to work with donors, non-governmental organizations, or to work in private practices to increase their earnings.

Product stockouts are common and they affect method choice
- Mozambique has one of the lowest ratios of health workers to consumers globally and rural areas of Mozambique are particularly underserved: there are 176 health workers per 100,000 inhabitants in urban areas and only 65 in rural areas; there are 12 doctors per 100,000 inhabitants in urban areas and only 2 in rural areas.
- Public sector providers earn far less than their private sector counterparts. Many leave the public sector to work with donors, non-governmental organizations, or to work in private practices to increase their earnings.

Black Market contraceptives compete with higher quality options
- Contraceptives sold in informal markets compete directly with official pharmacies, but with much cheaper, non-quality assured products.

Retailers and providers have a poor understanding of government policy
- Providers make FP decisions on behalf of youth and avoid providing long-acting methods to young women who have not yet had children.

Fluctuations in currency decrease purchasing power
- Over the course of 2016, the metical declined 30%. Fluctuations in currency increased commodity prices and strained distributors’ cash flow.
- Distributors and wholesalers are reluctant to stock products that may not sell.
- Devaluation of the metical decreased consumer purchasing power.

No barriers were identified at the manufacturer level” and “Source: TMA workshop, June 2017
Where Can Improvements be Made?

Five priorities emerged during the TMA workshop to address market failures. By addressing these failures, the group aimed to make the FP market more responsive to consumers and increase method use, especially among youth and those living in rural areas. All priorities align with either the National Family Planning and Contraceptive Strategy, the GFF Strategy, or FP2020 Commitments. Following each priority are activities partners emphasized as important to address the current state of the Mozambican FP health market.

1) Increase the number of trained FP providers, especially youth-friendly providers

- Training on providing youth-friendly services that caters to the unique expectations, socio-cultural norms, and psychological needs of youth is especially important.
- Training is needed on the management of side effects to reduce discontinuation.
- Providers need to improve the quality of counseling, and offer women informed choice, including those who are young and do not yet have children.

2) Improve FP promotion for specific groups: female and male youth, and parents

- More targeted campaigns are needed to generate demand for FP among youth and their parents.
- Mozambican youth would benefit most from messages that challenge myths and misperceptions about methods, including how methods are administered and the fear of infertility associated with long-acting methods.
- Young men should be targeted with messages about condom use for dual protection; they should also support partners’ use of FP, including their method of choice.
- Mobile strategies are needed to generate demand in rural schools and efforts should be targeted at out-of-school youth.
- Implementing partners request faster approval and more meaningful feedback from MISAU to expedite campaign implementation.

3) Ensure sufficient providers to meet demand and achieve scale, including hiring more nurses and task shifting towards Community Health Workers (CHWs), especially in remote areas

- The Mozambican government’s National Plan for the Development of Human Resources for Health (PNDRHS) 2016-2025 outlines plans for meeting the goal of 113 health professionals per 100,000 inhabitants within the next ten years. As part of that plan, the government will retain and increase the number of public sector providers. Doing so will strengthen the entire health system, including FP.

4) Develop additional approaches to motivate and incentivize public sector providers

- Pay increases are needed to minimize attrition and prevent providers from going to higher paying private sector practices. The PNDRHS 2016-2025 outlines a plan to increase remuneration for public sector providers over the course of ten years.
- Pay-for-performance strategies could also be piloted in rural areas and taken to scale if successful.
- Fellowships might also motivate some public-sector providers to work in under-served areas.

5) Strengthen the supply chain for the public and private sector

- The Mozambican supply chain is compromised on several levels and ultimately decreases choice for consumers. Decentralizing distribution and implementing new initiatives, like partnerships with private sector distributors, offer promise for getting products to needed areas once record keeping is in order.
- There is also room to grow social marketing and make it more attractive for the commercial sector to enter the FP market. Growth in social marketing products year on year suggests an increased willingness to pay and women’s decision to seek FP outside of the public sector. While this sector will still require donor subsidy, it could relieve the burden on the public sector and help meet demand in the near-term. Also, using social marketers’ expertise to generate demand for FP will also entice commercial sector players to enter the market by demonstrating the potential of the market.

- Task shifting to CHWs in rural areas is a very promising strategy: they have the potential to provide nationwide access to FP products and services. With the right motivation and incentives, CHWs could have extraordinary reach.
- Hiring more nurses to provide counseling and deliver appropriate short-acting methods, implants, and IUDs is also a promising strategy.
- The PNDRHS 2016-2025 recognizes the importance of the private sector in increasing the number of health professionals to meet demand. Private sector FP providers could provide services in urban and peri-urban areas and raise quality standards since they have more time to customize counseling sessions to find the right method for each consumer. To do so, the private sector would need to overcome perceptions of high price and be very consumer focused, youth friendly and responsive to other women in need of FP. Donor funding or third party payment mechanisms would be required to expand social franchising services.
Looking Forward

Providing quality FP is a priority for the government of Mozambique and its partners. While there have been achievements against ambitious national targets and FP2020 commitments, work remains to be done, especially strengthening the FP market for youth and women in remote areas. A healthy market would generate sufficient demand for FP, ensure a robust and diverse supply of methods, capitalize on coordination across market players, and benefit from a supportive policy and regulatory environment. Generating demand for FP and providing a range of modern contraceptive options and quality services will be key to slowing population growth and ensuring a healthier, more prosperous country and population.

How Will We Get There?

Partners committed to programming against these five priorities and identified indicators to track progress. The biggest commitments are:

XXXXXX

Indicators will be tracked (identify mechanism) and reviewed at quarterly TWG meetings.

Figure 9. National Policy Checklist

<table>
<thead>
<tr>
<th>National Family Planning and Contraceptive Strategy</th>
<th>Global Financing Facility (GFF) Strategy</th>
<th>FP2020 Commitments</th>
<th>Indicators</th>
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<tbody>
<tr>
<td>Increase the number of youth-friendly providers</td>
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<td>Improve FP promotion for target groups</td>
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<tr>
<td>Ensure sufficient providers to meet demand</td>
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<td>Find strategies to encourage providers to work in the public sector</td>
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<tr>
<td>Strengthen the supply chain for the public and private sector</td>
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Sources


The Maternal and Child Health Integrated Program (MCHIP) and The Maternal and Child Survival Program (MCSP) 2013. Family Planning Needs during the First Two Years Postpartum in Mozambique. Available at: http://www.mcspprogram.org/resource/family-planning-needs-first-two-years-postpartum-mozambique/


PSI 2017a. PSI’s Market Development Approach Fact Sheet.


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