HEALTH CLUSTER

MOZAMBIQUE

The Minimum Initial Service Package for Sexual and Reproductive Health

IMPLEMENTATION EVALUATION

JUNE 2025

Summary

The implementation of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Mozambique's Cabo Delgado province is challenged by insecurity, displacement, and funding cuts. Coordination among SRH actors is strong, but service delivery suffers from gaps in supplies, infrastructure, and provider training. Maternal care, HIV prevention, and GBV response are available but uneven, and the MISP is often used as a development rather than an emergency tool. Greater integration and resources are urgently needed for equitable SRH services.

What is the MISP?

The **Minimum Initial Service Package (MISP) for SRH in Crisis Situations**, developed by the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG), comprises the *minimum*, lifesaving sexual and reproductive health needs that humanitarians must address at the onset of an emergency (within 48 hours wherever possible). It includes six key objectives: 1) coordination, 2) preventing sexual violence, 3) reducing HIV/STI transmission, 4) preventing unintended pregnancies, 5) ensuring safe childbirth, and 6) planning for comprehensive SRH services. The MISP provides a roadmap for communities to deliver critical care in crisis while laying a foundation to transition to a more comprehensive suite of SRH services (ideally within 3 to 6 months) as communities recover.

Priority Actions

- Advocate for the MISP to be better integrated within emergency or disaster planning (including budgeting and annual planning) via engagement with key Government entities (such as INGD) to reduce the MISP's role as a development tool (rather than an emergency response tool).
- Assist the Mozambican health sector with coordination and planning to secure alternative and more sustainable funding (principally with the loss of USAID funding).
- Advocate for better alignment, training, oversight, and general maintenance to alleviate the cost of health services for end-users.
- Promote workshops or other training sessions that involve principal stakeholders (namely, Government entities) in a concrete and actionable way (i.e., to change "theoretical" understanding of the MISP into a more "practical and ready-to-implement" understanding).
- Engage Government entities to standardize kits in a way that makes them more affordable and more aligned with the local needs or classifications of health centers.
- Reinforce coordination efforts by ensuring cross-specialty collaboration between the SRH, GBV, and HIV sectors (i.e., not only within each specialty).
- Continue to offer training to frontline staff to ensure that updated knowledge is consistently transferred and implemented.

This work was conducted on behalf of the Global Health Cluster Sexual and Reproductive Health Task Team (GHC SRH TT). The authors extend their gratitude to the task team members, national SRH Working Group members, and additional reviewers for their valuable contributions.

Evaluation Background and Methodology

The MISP has been delivered in Mozambique's northernmost Province of Cabo Delgado since 2019. Facing a protracted humanitarian crisis that has been defined by violent attacks from armed non-state groups, severe climate events, and a long history of poverty and exclusion, as many as 1,028,743 people have been displaced one or more times in the Province over the past seven years.

To conduct this qualitative and quantitative Process Evaluation, a team of evaluators was deployed in June 2025 to four Districts (Mueda, Chiúre, Namuno, and Metuge) in Cabo Delgado. The Evaluation's methodology included seven health facility assessments (HFAs) across these Districts, 23 surveys with SRH providers, 13 key informant interviews (KIIs) and six focus group discussions (FGDs) with community members. The Evaluation received Global Ethical Approval from the International Rescue Committee's internal ethical approval board as well as from the Mozambican National Bioethical Committee for Health (CNBS).

Health Facility Assessments

Assessments were conducted in seven facilities to establish the context in which SRH and gender-based violence (GBV) services are offered. To facilitate analysis, each observed condition was assigned a qualitative ranking by a member of the Evaluation team across four categories: **encouraging, average, suboptimal, and poor**.

Encouraging

- **Access to laboratory space:** 71% (five of seven facilities) reported having access to laboratory space for conducting blood and screening tests (with smaller facilities reporting no on-site access).
- **Signage at facilities:** While signage indicating operational hours was uncommon (observed in 29%), all the facilities (100%) were observed to have patient education materials about family planning, institutional birth / post-partum practices, and newborn health. Furthermore, 86% had signage about GBV and pregnancy care, while 29% displayed education materials about sexually transmitted infections (STIs) / HIV.
- **Affordability of services (encouraging, according to facility Directors, but disputed by FGD participants):** No facilities reported having a registration fee for services, although all reported having a consultation fee of 1 Metical (USD$0.02) to receive services. Pregnant women, children, and the elderly were exempt from the fee in most facilities, IDPs were exempt in 3 (43%), and disabled people were exempt in 2 (29%). The reason for this lack of standardization was not identified. While all facility directors reported that patients would still be attended to even if they did not pay the fee, some community members disputed this in FGDs. Furthermore, all facilities reported a fee for pharmaceuticals, which ranges between 1 and 5 Meticals (USD$0.02 – $0.08), with exemptions for ARVs and malaria medications. All but one facility reported that medication will still be given to a patient even if they cannot afford the fee.

Average

- **Availability of services:** Hours of attendance generally ranged between 7 AM and 3 PM, with the exception of a 24-hour secondary-level facility; despite protocols, FGD participants disrupted the reliability of on-call providers during closed hours.
- **Accessibility of services:** None of the facilities reported offering transportation subsidies for people who are located far from the facilities, although the Rural Hospital of Mueda did report partnering with Doctors without Borders to support its most vulnerable patients with transportation to receive higher-level care.
- **Access to on-site pharmacies with SRH supplies:** 100% of facilities reported having access to pharmacies that have SRH supplies. Nevertheless, beliefs about the adequacy of those supplies were mixed: only one facility (14%) reported that they always have adequate SRH supplies, compared to three (43%) that reported *they sometimes have adequate SRH supplies*, and three (43%) that reported they mostly have adequate SRH supplies.

Suboptimal

- **Access to water and electricity:** Access to water is inconsistent throughout the facilities, with 2 (29%) reporting that they *always* have access to water, 2 (29%) reporting that they *frequently* have access to water, and 3 (43%) reporting that they *sometimes or rarely* have access to water. Five facilities (71%) reported experiencing frequent power outages, with three of these having some source of grid-supplied energy and two having solar energy.
- **Security:** Four facilities (57%) reported that they do not have a security guard, and four facilities (57%) reported that they do not have sufficient external lighting. Nevertheless, 100% of facilities reported having access to private and secure rooms for conducting physical examinations.

Poor

- **Access to bathrooms:** Only 3 of the facilities (43%) were observed to have functional bathrooms specifically for providers, none of which were gender-segregated, and only 1 of which had a lock and an adjacent handwashing station. For the facilities that did not have provider bathrooms, providers reported using bathrooms in nearby homes. Six facilities (86%) were observed to have functional bathrooms for patients and visitors, half of which were gender-segregated and none of which had a lock, adjacent handwashing stations, or available water at the time of visit. Patient and visitor bathrooms were also observed to lack accessibility conditions for people with disabilities. The Evaluation team also reported a general lack of hygienic conditions, including trash, nearby open defecation, and a shortage of hygiene products.

Altogether, these findings from the HFAs highlight that while health centers are the primary sites for receiving SRH services, certain features of health centers—namely, bathrooms and other supporting infrastructure—require improvement to promote optimal service delivery. These infrastructure gaps were associated with negative patient experiences and compromised care, as reported by both providers and community members. Improving bathrooms, water, and electricity infrastructure is recommended to directly enhance service delivery and patient outcomes.

In addition, the following key findings from this Evaluation include the following, organized by each of the MISP's objectives:

OBJECTIVE 1

Ensure the Health Sector / Cluster identifies an organization to lead implementation of the MISP

Overall, awareness about and experiences with the MISP are suboptimal among key informants and providers. However, this finding appears to be more a branding issue than a lack of effort to coordinate or work on key MISP-related topics.[1] **Key informants strongly believe that coordination is taking place and that efforts have been made to meet key needs since the conflict intensified in 2020.**

This belief is supported by the reported planning and resource-sharing meetings per specialty (i.e., HIV, GBV, and SRH). Coordination meetings were generally described as being organized, evidence-based, and inclusive, which has led to less duplication of services, better programming and stronger partnerships with key Government actors. As one Specialist described,

> *"In these meetings... the goal... is to avoid duplication of efforts. It's in these meetings where we map out each partner's actions, where each partner explains where they are [working], what they are doing, and who their beneficiaries are. Then based on this, we can distribute support to each partner or support at the Provincial level... We [also] share the needs and challenges we face... [for example] with this forum, we determine which organization can support us with resolving stockouts [per geographic location]."*
>
> **SRH SPECIALIST**

Notably, the use of WhatsApp chat groups and checklists, along with the involvement of focal points, was considered a crucial tool to support such coordination.

> **Coordination meetings were generally described as being organized, evidence-based, and inclusive.**

Early in the conflict, staff mobilization (particularly of community health workers), various forms of stock reserves, and logistical planning were prioritized efforts. From those efforts, 86% (6 out of 7) of health facility directors surveyed believe that SRH supplies are easily accessible. As the conflict has continued, coordination within the GBV, HIV, and SRH working groups has also continued (albeit with less frequency). However, some key informants spoke of a lack of strategic (rather than needs-based) coordination, especially at the health center level, and there was reported room for improvement regarding how specialty areas coordinate *with each other* (as opposed to internally). Furthermore, new funding cuts and changes have led to significant coordination gaps in supplies and service delivery, including for HIV programming. As described by one partner, "*The US Government withdrew 30% of the program's support. So this year, we are reinventing ourselves… With the lack of funding, it is chaos… Even if we have medicines here in the Province, how do we get them [to the Districts] … Many partners also left*" (HIV Specialist).

OBJECTIVE 2

Prevent sexual violence and respond to the needs of survivors

In general, facility directors and key informants described **encouraging implementation efforts for GBV prevention and response**. The volume of sexual violence within communities appears to be manageable, which allows for additional resource availability, provider training and community engagement (especially for vulnerable groups like adolescents and for men).

All observed health facilities (n=7, 100%) reported offering clinical care for sexual assault survivors via numerous services (see Figure 1). In addition, all facilities reported having standard operating procedures for both treating and referring sexual assault survivors. For vulnerable groups in particular, all facilities offer sexual violence and/or other GBV treatment services to adolescents. At the same time, 6 (86%) reported that they make additional accommodations to provide sexual violence treatment and other GBV services for members of vulnerable groups (such as sex workers and members of the LGBTQ community).

Data from provider surveys show that only 60% of providers have received training on clinical and pharmaceutical response to sexual violence. This gap is reflected in the observed variability in the quality of care, as highlighted by community feedback in FGDs, which disputes the consistency of non-judgmental and high-quality services. Therefore, additional provider training is recommended to directly address these gaps and ensure that all survivors receive consistent, high-quality care, as evidenced by both provider and community reports.

> **Male and female FGD respondents reported that the police and health centers are both important reporting resources that work together for survivors.**

Health facilities currently act as key links within the sexual assault case management chain due to their involvement in referrals. Male and female FGD respondents reported that the police and health centers are both important reporting resources that work together for survivors.

FIGURE 1

Availability of GBV services at the sampled facilities, (n=7)

Key informants described referral pathways as having improved since the start of the conflict, specifically attributing this progress to additional training for GBV focal points and enhanced collaboration among NGOs. For example, community members reported being well-informed about GBV referrals through health centers and mobile clinics, indicating that training interventions have led to more effective case management and survivor follow-through.

Despite these findings, integrating GBV services to promote more effective case management should be prioritized, as noted by key informants.

For respondents who believe such coordination is effective, some **cited coordination with schools, the use of mobile clinics, and overall communication between different GBV organizations** as being strengths. As one respondent described:

> *We had some projects [from 4-5 organizations] in the same [geographical] areas... to respond to GBV. So we had one organization work specifically in the area of mental health, another in awareness-raising, and another on economic empowerment. So all of these combined [services]... gave us a greater response"*
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> **GBV SPECIALIST**

On the other hand, **insufficient integration of services and partners working in a silo** were cited as justifications for why coordination is not effective. One key informant said:

> *The challenges that remain are a lack of one place for a survivor to access all services. Because they have to go to the health center, they have to leave and go to the police, leave and go to the Social Action Department. This makes the process exhausting because she has to go around to a lot of places and the probability of her giving up is very high. So we still need a central attending unit."*
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> **GBV SPECIALIST**

OBJECTIVE 3

Prevent the transmission of / reduce morbidity and mortality due to HIV and other STIs

Overall, **STI and HIV prevention and treatment trends are encouraging in Cabo Delgado** despite the conflict. Six facilities (86%) reported having Standard Operating Procedures or protocols for referring patients with STIs. All sampled facilities (n=7, 100%) offer ARVs to continuing users, work with ARV protocols, offer ARVs to mothers and babies in maternity wards, offer co-trimoxazole prophylaxis to HIV-infected patients to fight opportunistic infections, and provide syndromic management of STIs. With regards to vulnerable groups seeking HIV or STI treatment services, all facilities (n=7, 100%) reported that they offer such treatment services to adolescents; however, all of them require parent consent to access such services (i.e., for end-users below the age of 18).

The clinical management of HIV was cited as a strength of the health system- particularly the availability of self-testing & pre-exposure prophylactic treatment, and the suppression of viral loads & vertical transmission. As many as 74% of providers (n=17) reported that they have administered ARVs to prevent mother-to-child transmission of HIV (PMTCT) within the past 3 months. Furthermore, 91% of providers (n=21) believe (1) that it is critical to test pregnant women for HIV (and initiate ARV treatment if positive), regardless of the woman's marital status and (2) that mothers should breastfeed their babies if they are on ARV treatment. These findings further emphasize the perceived importance and effectiveness of PMTCT methods. Nevertheless, only 48% of providers (n=11) reported receiving training about PMTCT over the past three years; this finding should be improved to ensure that updated protocols or treatment guidelines are followed with quality for this sensitive population.

Providers and facility directors were generally confident about their ability to treat STIs and HIV, as well as their access to key supplies. In addition, 87% of providers (n=20) believe that pre-exposure prophylaxis treatment should be available or offered to all people regardless of their sexual orientation or lifestyle choices. Of note, the most commonly cited barrier for HIV programming, according to key informants, is the ability to track or follow up with patients.

Stock distribution and maintenance were considered to be a challenge, and **access to STI treatment was reported to be inconsistent** for end-users (especially men). FGD participants commonly cited limitations to accessing treatment, namely (1) the cost of STI treatments (and, rarely, ARVs), (2) documentation that proves displacement status to unlock free treatments, (3) the quality of providers, and (4) medication being in stock. As with other services associated with other objectives, both male and female FGD participants indicated that health workers provide treatments outside of health centers as a way of supplementing their individual incomes, which is a significant challenge for stock maintenance. Of note, men were more likely to cite barriers to STI treatment than their female counterparts, as described by one community member:

> *"When you go to a health center suffering from HIV, you will have access to ARVs instantly, but for infections like gonorrhea, you will have difficulties in accessing that without money. Those treatments will cost you between Mt300-500 [USD$4.69-$7.82]. [If you don't pay], you need to bring that woman from the street [who you had sex with] and you don't even know where to find her."*
>
> **MALE RESPONDENT**

A range of HIV response solutions has been tested and proven valuable, especially various forms of community engagement; however, new approaches are needed to amplify and sustain those efforts. HIV Specialists widely reported HIV service lapses due to the reduced availability of technical staff, the diversion of resources to meet internally displaced people's (IDP) needs (resulting in the neglect of host community members' needs), frequent (re)displacement of IDPs resulting in lost patients, loss or robbery of key stock, and shame with having to re-present for services. As a result, a series of challenges for HIV+ people (and their sexual partners) in Cabo Delgado were cited, particularly their capacity to manage the risk of infection. Finally, the most commonly cited challenges for acquiring key supplies for HIV service provision include the financial constraints on purchasing and distributing stock (which have been exacerbated by recent cuts from the US Government), as well as the ability to track stock effectively. As one respondent clearly summarized:

> *Economic power [is already a challenge]- and logistics are expensive because [health centers] are distant. And then the recipient is also not managing stock well, much less reporting [what really happens with stock]? Management and logistics are a big problem."*
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> **HIV SPECIALIST**

OBJECTIVE 4

Prevent excess maternal and newborn morbidity and mortality

Support for institutional birth was very high amongst community members, SRH Specialists, and health system representatives alike, as highlighted by the following illustrative quotes:

> *In the hospital, it is better [to give birth]. I say this because there, we will get treatment. Those who go there to have their baby go and return with their baby in their hands. They are well attended to without complications."*
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> **FEMALE RESPONDENT**

> *To have the baby in the hospital is better because when you have a baby at home, it is risky. There are no people who are trained for that work. You can run the risk of losing the baby's life or the mother's."*
>
> **FEMALE RESPONDENT**

> *When they go to the health center for birth, I am very satisfied because the women are treated well. The baby and the mother stay healthy."*
>
> **MALE RESPONDENT**

When birth does occur outside of a health center, FGD respondents most frequently explained that this is because women go into labor at night (with suboptimal after-hours support) or because they do not have sufficient financial means to pay for transportation to the health center.

> **Support for institutional birth was very high amongst community members, SRH Specialists, and health system representatives alike.**

Training rates for lifesaving maternal and infant services among providers ranged from 48% to 52%, with half of the sampled services delivered by providers who had not received training in the last two years. This gap is reflected in the recorded outcome of 38 newborn deaths (including stillbirths) across seven facilities in the previous three months, and qualitative feedback from facility directors citing insufficient equipment and training as contributing factors. Therefore, updating provider training and improving equipment are recommended to address these observed negative outcomes.

Nevertheless, when looking at maternal and child death data per sampled health facility, only one maternal death was recorded (and zero deaths related to unsafe abortion were recorded) in the previous 3 months.[2] On the other hand, 38 newborn deaths (including stillbirths) were recorded across the seven facilities within the previous 3 months.[3] Qualitatively, two facility directors reported insufficient equipment for facilitating newborn care (such as cribs and incubators) as contributing to this outcome. As one director described, *"Providers need an incubator in the maternity ward because there are cases of premature newborns who must be sent to Pemba [the Provincial capital of Cabo Delgado] and they arrive in critical condition because of the distance"* (Health Facility Director).[4]

Identified trends in SRH outcomes that have been worsened by the security situation most commonly included **(1) reduced access to obstetric treatment / institutional birth, and (2) reduced flow of supplies and trained staff.** According to key informants, reduced access to supplies, particularly in the context of the COVID-19 pandemic, has resulted in increased service lapses (especially for vulnerable groups, such as adolescents), the loss of evening services, and insufficient materials to facilitate good birth outcomes. On the other hand, key informants described increased coordination (even with non-traditional partners) as a solution that has emerged to address logistical and staffing challenges, which is an encouraging finding. As one respondent explained:

> *The supply chain for the non-conflict zones is smooth and flows normally. But for the conflict zones, we have the support of the Ministry of the Interior [which oversees the police]... and some organizations like Doctors without Borders also support us with shipments."*
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> **SRH SPECIALIST**

With regards to safe abortion care, male FGD participants were evenly divided between two options: going to a health center to terminate the pregnancy or taking herbs with a traditional healer to terminate the pregnancy. Of note, several men cited that the traditional option for pregnancy termination can be more commonly utilized if women do not have the financial means to pay for a safe abortion at the health center. As one respondent described:

> *She has to arrange means to approach a health center to do the abortion. If she cannot manage to do so, she will go to community elders to access traditional roots."*
>
> **MALE RESPONDENT**

On the other hand, women most commonly reported that pregnant women will continue with the pregnancy (with two women citing attempted or successful infanticide that has occurred in their communities directly after birth). **Few women reported that going to a health center for an abortion is an option**, and even fewer women admitted to any knowledge of traditional abortion methods. As one woman briefly commented:

> *There is no option. [The pregnancy already] happened."*
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> **FEMALE RESPONDENT**

These findings are supported by data from the provider surveys, which indicate that providers have been trained about safe abortion care more often than they have recently applied it.

Finally, SRH Specialists were asked about the key characteristics that have defined SRH during the conflict, as well as the predominant features of SRH response or service delivery. Overall, **access to specialized maternal and child health care as well as access to safe abortion were described as two of the predominant SRH challenges for women** in Cabo Delgado. Several SRH Specialists described this as a human resource-related limitation, with one key informant explaining:

> *Illegal charges are requested. Because abortion is free at the health center, but they know people are desperate. They don't want [patients] to know [that the service is free]. So if a nurse tells them she could solve their problem, they end up going there... [and] they end up paying. Or they go to the community to have an unsafe abortion."*
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> **SRH SPECIALIST**

Another specialist described:

> *Currently, nurseries are... only available in large hospitals, but premature babies aren't only born in large hospitals... So the management of these babies leaves a lot to be desired. Let me just say, we are only doing 10% of what the baby needs... In all of Cabo Delgado, we only have two pediatric specialists."*
>
> **SRH SPECIALIST**

Notably, providers are highly supportive of training community health workers to deliver essential maternal and neonatal health and family planning interventions (83%, n=19).

OBJECTIVE 5

Prevent unintended pregnancies

Overall, the **availability of and access to family planning are inconsistent**, and provider training is suboptimal, particularly regarding long-term methods. Male community members' access to family planning methods like condoms is affected by illicit schemes from certain SRH providers and the inadequate stock that results from these actions. Youth engagement in family planning also requires additional attention, as does awareness-building about emergency contraception.

The volume of distributed family planning methods varied significantly between health facilities, depending on the method (with emergency contraception and long-term methods such as the IUD and the implant serving as the least common methods and injections and male condoms serving as the most common methods). The following graph highlights the average number of users per method across the sampled facilities.

All family planning methods are available to adolescents in 5 out of 7 facilities (71%), with IUDs not available in the remaining two facilities.[5] Additionally, parental consent is required at five facilities (71%) for adolescents to access any family planning methods. Notably, providers are supportive of educating young people about SRH topics (96%, n=22), and 100% of providers reported feeling comfortable doing so.

As with the previous objectives, **family planning services are considered to be accessible** to disabled end-users in 4 facilities (57%). In addition, engagement via trained maternal and child health nurses has been recent (i.e., conducted within the previous two months) across all seven facilities (100%); outreach topics included presentations on the benefits of long-term methods, correct usage of specific methods, and the advantages and disadvantages of various methods.

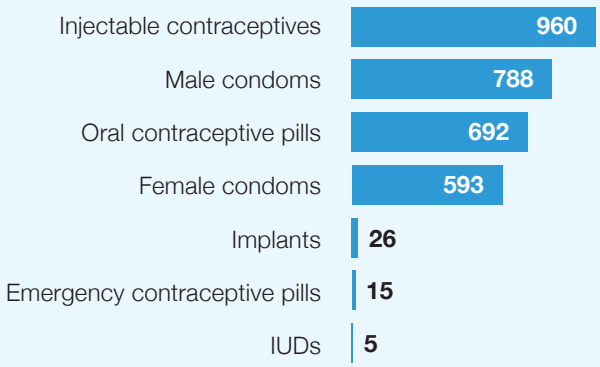
Provider surveys and the desk review indicate that training and experience with IUDs and implant insertion/removal are the lowest among family planning methods. This is reflected in the low average number of patients using IUDs (five per facility) and implants (26 per facility), as well as FGD participants reporting difficulties accessing these methods. Strengthening provider training in these areas is recommended to improve access and usage rates, as evidenced by both provider and community feedback.

Most providers expressed that family planning methods should be available to every woman who wants them (87% agreement, n=20) and that women should be able to choose the method they prefer (91% agreement, n=21).

faFGD participants were asked about the most common methods used in their communities, as well as their perceived level of difficulty in accessing these methods. Male respondents were most likely to cite condoms, the implant, and the injection, while female respondents primarily spoke about pills and the injection. Men were highly divided regarding their perception of ease of access (with frequent disagreements about which methods are difficult to access based on respondent location); female respondents generally coalesced around the idea that access to family planning was not very difficult (except for some women who reported difficulties when they wanted to have their implant removed). Overall, these findings indicate that access to specific methods is highly variable, especially for men. Finally, FGD participants were asked specifically about their awareness of emergency contraception. Out of the entire FGD sample, only one female respondent had heard about this method.

FIGURE 2

Average number of users per method (across the facilities that currently offer the method)



OBJECTIVE 6

Plan for comprehensive SRH services that are integrated into primary health care as soon as possible with Health Sector / Cluster partners to address the six health system blocks

There is an inherent challenge for Objective 6 in Mozambique: **the state of the health system prior to the onset of the conflict was already sub-optimal**. It is challenging to restore a health system to its pre-conflict state of operation when that operational capacity was already significantly deficient in terms of the health system's building blocks. This ultimately begs the question of how the MISP can and should be effective for crisis response in a setting like Mozambique (versus how it can be used as a development tool). One key informant summarized this objective by saying:

> *During the MISP's implementation, you plan for integration into the National Health Service… The MISP isn't a standalone process, where you implement [it] and stop doing other activities. We are in a…widespread crisis…whenever a situation arises, we implement the basic or initial services and as we recover, we integrate other services… We really consider integration within the response as a goal."*
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> **SRH SPECIALIST**

In general, it was difficult for key informants to distinguish what the MISP is specifically doing to achieve its objectives versus what is being done generally in SRH. Despite Mozambique's various emergencies, emergency response appears to be frequently reinvented to meet the direct needs caused by each emergency. This strategy is especially catered to natural disasters (instead of man-made disasters) as described by one key informant:

> *The Ministry of Health requires that year-end logistics be tailored to the diseases of that period- for example, the number of diarrheal disease cases [or] the number of malaria cases…. So [Districts] have to take care… [to be able to] respond to emergency situations [caused by]… natural disasters."*
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> **SRH SPECIALIST**

Continuously updating the response strategy leaves the MISP objectives at risk of not being implemented (so that other priorities can be addressed first). Nevertheless, the strength of coordination and the protracted experience of the conflict in Cabo Delgado have brought improvements to areas such as logistics. Altogether, these features are encouraging for Objective 6; however, prioritizing the additional embedding of MISP objectives within disaster planning committees is recommended.

Key informants were generally mixed in their opinions about the adequacy of MISP kits for addressing SRH needs as planned. On the one hand, kits were described as being diverse and being accompanied by *"training… information… [and] supervision to accompany how [they] are used"* (SRH Specialist). On the other hand, some specialists described the kits as lacking key solutions according to what the Ministry of Health has defined as their needs, and as not adhering to national standards or local needs. As one respondent explained:

> *They send materials to some… areas and don't comply with the Ministry's requirements…. We are finding vancomycin in [lower-tiered] health centers…. [and] the kits sent to the maternity ward don't have ophthalmic tetracycline. [Also] when oxytocin is given there, it's 10 vials. Ten vials are just for one woman."*
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> **SRH SPECIALIST**

Key informants were also divided about how sufficient training for healthcare professionals has been provided throughout the conflict. Some SRH Specialists explained that there are nurses who have received emergency-specific training, as well as technicians and other staff who have received training on how to work specifically with IDPs. Training areas that are considered lacking are psychosocial support to get end-users through the effects of the conflict, integrated case management in light of perceived increases in sexual assault, and how to work with youth through the conflict.

Regarding health information management, key informants generally believe that indicator reporting is being done well; however, there are some concerns regarding how data is collected and how it captures the experiences of IDPs. The primary challenges for SRH stock management were identified as (1) sufficient (and domestic) funding for key supplies and (2) the capacity to properly track or record supply movement.

SRH Specialists enthusiastically described effective community engagement strategies currently used to present SRH topics, including community lectures, the deployment of trained activists, pre-recorded radio dramas (novelas), engagement with religious leaders, mobile clinics, safe spaces, and health committees. Limitations to community engagement strategies were defined as lapses in coordination between various partners (including local partners like community leaders, health committees, and traditional birth attendants), and ownership or sustainability of community-based efforts.

When asked for their "wish lists" for their facilities, Directors shared a mix of **infrastructure needs** (such as dedicated youth service areas, improved or on-site water sources, newborn care areas, new bathrooms for visitors and providers, and improved electricity sources), **supplies and equipment** that will facilitate services (such as stretchers and beds or mattresses and sheets for the maternity ward, menstrual hygiene products for adolescents, additional safe delivery kits, additional medical and surgical supplies, privacy dividers for the delivery room, window screens, new cabinets, more patient-facing **pharmaceutical and medical supplies** (like gauze), and a long-term solution for **uninterrupted access to contraception** (especially increased access to the implant).

Moving forward with embedding HIV into integrated primary care, it is clear that due to the scale of HIV in Mozambique, Objective 6 is already relatively on course. To sustain this pattern, protected funding, improved condom distribution, planning for data protection in the event of health center destruction, and unwavering community-level engagement were all identified by key informants as priorities.

To embed GBV services into integrated primary care, consistent community engagement, accurate data collection or management, and widespread frontline training were all identified as priorities. In addition, Codes of Conduct at both the humanitarian level and at the community leader level were seen as critical components for empowering community members (which will, in turn, enable access to quality GBV services in the long term). Finally, for GBV services to be effective in the long term, case management that includes persistent follow-through and coordination between sectors should be prioritized.

Finally, **SRH is widely believed to be already embedded in traditional primary care services**. Key informants generally reported that Mozambique's laws and policies are supportive of SRH outcomes, which facilitate the MISP's objectives. Nevertheless, key informants were clear that a considerable range of national and international events has the capacity to influence SRH progress. For example, pending funding cuts from the US Government were commonly cited as a challenge that would affect the transportation of key materials, the availability of supplies, and human resources.[6] Additional awareness-building efforts about the MISP were suggested by several partners as a way to sustain progress despite these challenges and the range of emergencies that Mozambique has faced (and will continue to face). As one respondent explained:

> *"I don't know to what extent all these organizations that implement SRH and maternal & child health actions have benefited from training [about the MISP]. You need to ensure that all these organizations are trained about the MISP" (SRH Specialist). Another respondent explained, "GBV [for example]: violence doesn't only happen in conflict. It is exacerbated in conflict. So I think we could already have the [kits] regularly, have these training sessions, these meetings… and everything else to continue training communities and even have [a good response] in a 'normal' health unit."*
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> **SRH SPECIALIST**

Altogether, due to the characteristics of SRH, GBV, and HIV service delivery, Objective 6 is already underway in Cabo Delgado. Nevertheless, the baseline status of the primary care system in Mozambique has inherent challenges that must be addressed through additional investment in the health system's infrastructure.

Conclusion

Because the Mozambican health system frequently faces both man-made and climate-induced emergencies exacerbated by the precarious state of health sector funding, its historically challenging social and health-specific indicators, and its overall status as a developing health system, the MISP maintains its relevance. Nevertheless, this reality also makes establishing transition plans difficult (especially since another emergency could arise at any time). Additionally, the MISP is being utilized as a development tool rather than an emergency response tool in the Mozambican context. Accordingly, it is challenging for key informants to distinguish the MISP's approach as an acute response tool when the objectives it addresses essentially always require additional funding, training, and technical support.

Coordination is widely believed to be effective during the conflict, which is encouraging. This finding indicates that Objective 1 has been largely met. Objectives 2 and 5 appear to have ongoing acute needs (particularly regarding stock tracking and other maintenance). In contrast, parts of Objectives 3 and 4 are considered to be met by community members (but not necessarily by health professionals). Of note, a dual narrative clearly exists regarding the cost of services; community members (especially men) often report the need to pay (albeit off-the-record) for key supplies related to family planning, safe abortion, and STI treatment. At the same time, health sector representatives describe these services as being free. Finally, effective planning and existing structures associated with Objective 6 are on course, but "hand-over" efforts are consistently stunted by the volume of challenges that the local health system faces (both in non-emergency times and after each climate-induced and man-made emergency that Cabo Delgado has recently experienced).

Awareness about the MISP is largely theoretical among stakeholders and is therefore often confused with the objectives it aims to address. Accordingly, it is difficult to attribute key gains related to the objectives to MISP-specific interventions. Detailed descriptions about kit contents and/or MISP training were not common, nor were details about transition plans. Finally, reproductive health kits were described as generally helpful, but also too expensive and too standardized for the specific needs of individual health centers (and for the broader needs of the health system).

While the MISP remains relevant in Mozambique's crisis-affected Cabo Delgado province, its implementation is constrained by persistent emergencies, chronic underfunding, and systemic challenges within the health system. The package has served as a tool that enables strong coordination across system actors and maintains essential SRH, HIV, and GBV services. Still, gaps in resources, infrastructure, and integration dilute its impact. To maximize its value, the MISP must shift from a development-oriented tool to a more practical, well-resourced emergency response mechanism that is deployed to address the complex needs of vulnerable populations.

Recommendations

FGD participants generally requested **improved quality of services within health centers** (including more privacy and better service delivery for young people), increased availability of family planning methods (including fewer stock-outs and services that are actually free), and **additional community-based SRH services** (including services within the IDP camps and wider access to emergency contraception). The following quotes highlight these recommendations.

> *I would like to ask for a health center here in this community and more projects to support us in monetary ways so that we can buy the medications that are for sale at the health centers."*
>
> **MALE RESPONDENT**

> *I would like to ask for a more isolated consultation room with privacy where they can work with people who want to access family planning, denounce violence cases, and treat STIs."*
>
> **MALE RESPONDENT**

> *I would like them to bring those pills [we discussed]... to not get pregnant after an unprotected sexual encounter,"*
>
> **FEMALE RESPONDENT**

> *Like my colleague here said, [I would say] in the hospital, when we go, treat us well... When you arrive there... they get mad at you like you are a child,"*
>
> **FEMALE RESPONDENT**

While there is desk review-based evidence that the Government has adapted some of its plans and coordination efforts to include elements of the MISP, evidence of this engagement is not widespread. [7] For future results, the MISP needs to be better integrated into disaster planning through engagements with national authorities from the Disaster Preparation sector (INGD). These integration efforts should include embedding the MISP into health sector emergency budgeting and annual planning.

In addition, key stakeholders need to be better informed about the tangible interventions that the MISP has brought to the Mozambican Health sector. This awareness should be paramount among government stakeholders, given the established norms and tendencies of the Mozambican context. With this awareness, SRH stakeholders can be stronger advocates for the MISP if implementation continues in Mozambique. In addition, this type of advocacy can embed the MISP's objectives into strategic planning, which could return it to being an emergency response tool (instead of a development tool). One of the best solutions for doing this includes training on-the-ground providers, focal points, and Government authorities about the MISP.

A parallel usage pattern has emerged amongst male and female FGD respondents in which men appear to be less engaged by health centers regarding SRH services; they are also more likely than their female counterparts to report barriers to accessing treatment or services. These trends manifest not only in lower usage rates, but also in more negative perceptions about how accessible SRH (and HIV) services are (and should therefore be reversed). While SRH usage rates for women are encouraging, the challenges with family planning stock maintenance are noticeable; stock manipulation and inappropriate distribution must be curtailed to protect the positive attitudes and beliefs that female community members have about SRH services. Accordingly, stock management plans, along with associated training and oversight, remain necessary.

Coordination is reportedly strong, according to key informants. Nevertheless, some key informants believe that coordination efforts have dwindled as the conflict continues. In addition, coordination *within* specialties (i.e., SRH groups) is more frequent and generally stronger than *between* specialties (i.e., SRH & GBV groups). These efforts should be consistently reinforced, particularly given the health sector's precarious financial situation.

Additional specific recommendations provided by respondents per objective

	Implementers	Health Cluster/ SRH Working Group	Donors	Ministry of Health & Government
Objective 1				
Engage youth and IDPs more effectively regarding SRH service delivery.	●	●		
Allocate additional funding to SRH, GBV, and HIV service delivery.			●	●
Promote strategic (rather than needs-based) coordination and follow-through (especially at the health center level).		●		
Objective 2				
Promote sexual assault response training amongst providers and ensure that such training will result in more inclusive attitudes towards married and unmarried individuals.	●	●		
Continue to share sexual assault messaging with community members to reduce stigma.	●			
Promote awareness-building about sexual violence laws.	●	●		●
Promote empowerment activities that address women's dependence on their abusers.	●	●		
Integrate GBV services more to make case management easier for survivors.	●	●		●
Continue to engage men to improve GBV, HIV, and SRH outcomes.	●	●		
Objective 3				
Update provider training in PMTCT.		●		●
Ensure that condoms are always available at health centers.	●	●		●
Ensure access to free and non-judgmental STI treatment.	●	●		●
Develop more effective follow-up systems for HIV patients.	●	●		●
Objective 4				
Offer transportation subsidies to expectant mothers and other distant health center users.	●			●
Concentrate efforts on reducing newborn mortality.	●	●		●
Update provider training on key safe delivery and infant health practices.	●			●
Improve access to after-hours support.	●			●
Counteract growing breastfeeding trends (in which mothers are breastfeeding for shorter periods).	●	●		●
Improve access to specialized maternal and child health care as well as to safe abortion.	●	●		●

Objective 5				
Improve the distribution of (and awareness about) emergency contraception.	●	●		●
Improve awareness about and experience with IUDs.	●	●		
Train more providers about implant insertion and removal.	●	●		●
Objective 6				
Encourage the development of SRH signage in local languages.		●		●
Improve access to electricity, water, and bathrooms (with handwashing stations) in health facilities.				●
Standardize the use of electronic medical records.	●			●
Encourage the use of grievance procedures, especially at health centers and through health committees.		●		
Fortify the SRH supply chain, especially by establishing funding for product movement and by standardizing ordering and tracking processes.		●		●
Establish more reliable and diversified funding mechanisms for the purchase and distribution of stock (especially in the absence of US Government funding).			●	●
Eliminate parental consent as a requirement for accessing SRH, GBV, and HIV services.	●			●
Continue to use mobile clinics effectively.	●			
Use digital platforms more effectively, especially social media for young people and radio-based messaging featuring religious leaders for adults.	●			
Capture the experience of IDPs in data collection.	●	●		
Encourage providers to maintain patient confidentiality more.	●	●		
Ensure that providers are aware of the scope of practice that CHWs have.	●	●		
Improve access to communication systems amongst providers.	●	●		●

In conclusion, a clear understanding of the work being done on MISP-related topics and the MISP itself is suboptimal, which is likely associated with the protracted nature of the Cabo Delgado conflict and the volume of needs that the health system generally faces. While the MISP is an emergency response tool, in Mozambique, it is one of many interventions required to address the vast needs of local populations.

Endnotes

1. Of the 10 organizations that were represented through key informant interviews, 7 (70%) had at least one colleague who had ever been trained in the MISP.
2. There was also 1 facility that reported that there have been known (but unrecorded) maternal deaths that have occurred outside of their facility (but within their catchment area) within the same timeframe.
3. Repeat previous footnote.
4. Distances can be longer than 80 km away (on average) on unpaved roads.
5. The reasons for this were (1) lack of demand and (2) shame due to how the method is inserted.
6. In addition, the COVID-19 Pandemic was cited as a major event that could have negatively impacted key outcomes, but instead, was generally believed to have shaped the health system positively due to the various lessons that it brought to health center operations.
7. The desk review highlighted how the Government has adapted its *National GBV Plan During Emergencies Package* to include references to the MISP, conducted a MISP Readiness Assessment, improved & participated in training and logistical preparations, developed a partnership between UNFPA and the National Institute for Disaster Management and Disaster Risk Reduction, and integrated the MISP's features into National Contingency Plans.

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