Spearhead	Organisation	Date	Reporting Period
SRHR	Netherlands Embassy Maputo, Mozambique	27-June-2013	1st Jan - 31st Dec 2012

Activity Number	Implementing Organisations	Implementation Channel	Actual Expenditure 2012
24256	ProSaude-4	GOV	8.000.000
24740	TA Facility preparation	PRIV	14.000
24255	MAP-PSI-4	NGO	2.516.000
24255	MAP-PSI-4 + nutrition (DC w/Danida)	NGO	
24255	MAP-PSI-4 + talent centres (Tico Tico)	NGO	
20064	NAFEZA	NGO	142.000
24399	AGIR (N'weti, Lambda, WLSA)	NGO	987.971
24398	INAS	GOV	988.000
24398	INAS top-up (1 MEuro)	NGO	
23708	Policy Response to Poverty (Analysis)	PRIV	30.000

Result area 1	Young people are better informed and are thus able to make healthier choices regarding their sexuality					
Question 1a: To what extent are young people better informed? What evidence is there that they are making healthier choices regarding their sexuality?	The recent Demographic Health Survey showed that the Total Fertility Rate (TFR = average family size) has increased since last measured in 2003 from 5,5 to 5,9. This phenomena is contrary to trends in other Sub Sahara African Countries where the TFR follows reducing Child Mortality. Teenage pregnancy remains common and few channels have been accessed to effectively reach youth. Schools are not a safe environment for Reproductive and Sexual education with many girls thinking it to be normal to share sexual favors with teachers to obtain better grades for themselves and their siblings.					
disaggregate information by male/female, if possible	**Baseline**	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Percentage using condoms at last high-risk sex, by age group (MDG indicator 6.2) (15-24 yr f/m as %)	2003: 29/33	NA	38/41			DHS
Percentage of young people (15-24) with comprehensive correct knowledge of HIV/aids (MDG indicator 6.3) (f/m as %)	2009: 36/34	NA	30/52			INSIDA 2009 DHS 2011
Question 1b: With which results has your programme contributed to comprehensive sexuality education for young people in and outside of school *On third indicator below: previous : *Number of young people being counselled for HIV/STI/contraception and/or tested for HIV/STIs aged 15-24 yrs. f/m by PSI* - indicator was revised since the principal target group of the project are teachers in two schools, Matola Secondary School and Chimundo Secundary School. However, we will also reach a total of 3,515 (2013 projection) through peer education activities on harrassment and sexual abuse, and provide referrals to students for VCT, STI diagnosis and treatment and FP counseling and services, including emergency contraception.	PSI has started a programme to discuss SRHR issues with teachers, parents and pupils at schools. Schools are not the most effective channel to advance on SRHR Information, Eductaion and Communication. A Knowledge Attitude Practice (KAP) survey showed a complex interplay of teachers acting immorally, girls playing teachers, despondent HIV+ youth: "I'm not going to die alone", etc. The Minister of Health has halted the expansion of specific Youth Friendly Clinics in favour of more integrated sevices. We are hopeful to re-activitate Geracão Biz nationwide youth programme. With Embassy of the Kingdom of the Netherlands support through AGIR programme, N'weti has started to implement an interactive radio program targeting young people (age group 15-24) with the objective to inform and transform atititudes and practices towards sexual and reproductive health. The questions received through SMS shows the interest of the target group eager to learn more about pregnancy, homosexuality, abortion, etc.					
Optional indicators	**Baseline**	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Number (or %) of youth-friendly (health) centres	244 (2008)	NA	???			MoH
Adolescents and Youngsters tested for HIV at health facilties (%)	NA	33% ('14)	57%			MoH
** Number of school teacher being tested for HIV/STI and referred for FP services by PSI*	0 recorded (2011)	159 ('13)	/			PSI, no data yet
Number of school teachers capacitated to identify and report on cases of sexual abuse by PSI	0 recorded (2011)	159 ('13)	/			PSI, progr. start delayed no data yet
Number of school management capacitated to identify and report on cases of sexual abuse by PSI	0 recorded (2011)	2 ('13)	/			PSI, progr. start delayed no data yet
Number of student leaders capacitated to report on cases of sexual abuse by PSI	0 recorded (2011)	120 ('13)	/			PSI, progr. start delayed no data yet
Number of schools (/pupils) that adopt (/receive) comprehensive sexuality education (Mozambique from Grade 6-7)	all	all	all	all		MINED
Question 1c: With which results has your programme contributed to opportunities for young people to have their voice heard and stand up for their rights?	Our Embassy supports a NGO-advocacy sub-granting platform via OXFAM-NOVIB to reach out to NGO's active in the field of LGTBI, youth, Gender Based Violence and SRHR advocacy in general.					
Assessment of results achieved across the entire result area, Dutch contribution	**C**					
A. Results achieved better than planned **B. Results achieved as planned** **C. Results achieved poorer than planned** **D. Results achieved much poorer than planned**	**Reasons for results achieved:** although progress is being made by partners such as PSI and N'weti, we have not managed to open nation-wide effective communication channels to reach out specifically to youth.					
Implications for planning						
The Swedish development agency SIDA, UNFPA and PSI are positive about plans to reactivate the nationwide Youth Organisation Geracao Biz, we epect this activity to take off by the end of the year. With support from the Regional Programme for HIV/aids and SRHR the cash transfer programmes for healthier and more responsible SRHR of youth will be started this year in Mozambique. With additional support to PSI we have started to help role model talent support centres organised by a famous football player Tico Tico. These centres reach youth through sport and simultaneously they learn more about living healthier and responsible lives, improved nutrition for young children (micronutrients) and family planning to reduce teenage pregnancies.						

Result area 2	**A growing number of people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health**
Question 2a: To what extent do more people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health?	In general access to contraceptives is low and only slowly improving. PSI is the main distributor of condoms (m/f) and oral anticontraceptives using private sector channels. The Public procurement supply management (PSM) is very poor especially for non-medical goods such as contraceptives. Although relatively high and still improving access to Anti Retroviral Therapy, it is still very dependent on targeted support by the US and the Global Fund to Fight Aids, Tb and Malaria (GFATM). Sustained follow-up to treatment beyond the first year remains a challenge. Unmet need for Family Planning has increased from 18.4 % in 2003 to 23.9% in 2011 (DHS). Unfortunately the Maternal Mortality (408/100.000 lb) and Neonatal Mortality (34/1.000 lb) remained virtually stagnant and high, in contrast to the other child mortality rates. (DHS '11).

	Baseline (year)	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Contraceptive Prevalence Rate - modern methods- all women15-49 (MDG indicator 5.3)	2003: 14.2%	34%	12.1%			DHS 2011
	2009: 13.9%		23.0%			SIS
Unmet need for family planning (per age group, where available and relevant)(MDG indicator 5.6) age group: 15-49	2003: 18.4%		23.9%			INSIDA 2010
Proportion of population with advanced HIV infection (according to CD4) with access to antiretroviral drugs (MDG indicator 6.5) (>15 years of treatment as in national protocol)	2006: 7.4%		45.5%			GARPR from DHS-INSIDA

Question 2b: With which results has your programme contributed to a greater choice in and sufficient availability of contraceptives/medicines?	The total resource envelope available for health, SRHR & HIV/Aids (public including NGOs on & off budget) is approximately US $ 800 million, thus our contribution is estimated to be about 1,25% annually. This contribution is fully on-budget, on-account and discretionary to the Minister of Health (MoH), sustaining the health systems ability to provide amongst others HIV/Aids and SRHR services. MoH is by far the biggest HIV/Aids & SRHR service provider in Mozambique. Our funding to PSI (2012: 17,6% PSI total funding) is also core-funding and non-prescriptive since our agendas nearly fully overlap. Close ongoing dialogue, also during planning, ensures close alignment and greater aid efficiency (more results for our respective Euro). Through PSI, DKT is instrumental in promoting long term female contraception such as IUD and AC-implant.

Optional indicators	**Baseline (year)**	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Type of new, user-friendly products / medicines on the market for improved sexual and reproductive health			Cupid Female Condom			
Number of couples protected by various contraceptives (Couple Year Protection (CYP))						
Number of CYPs provided by all methods (Intra Uterine Device & Implant) through social marketing by DKT through PSI. (9 clinics)	26.355 (6 months 2012)		26.364			PSI DKT
Number of CYPs provided by long-term methods (Intra Uterine Device & Implant) through social marketing by DKT through PSI. (9 clinics)	4.845 (6 months 2012)		4.670			PSI DKT
Number of people being treated with anti-retroviral drugs. (Paediatric/adult)	23.035 + 250.508 = 273.543 (2011)	39.743 + 360.257 = 400.000 (2014)	25.597 + 297.801 = 323.398			MoH ACA
HIV-infected pregnant women who received antiretroviral (ARV) combination therapy for PMTCT to prevent vertical HIV-transmission for mother to child (%)	66% (2011)		115,4%*			MoH ACA

** data quality problem, possible double counting, to be corrected*

Question 2c: With which results has your programme contributed to addressing sociocultural barriers preventing women from using contraceptives?	IEC through MoH and PSI does specifically address such obstacles. We work actively within the condoms working group of the National AIDS Council (CNCS) to promote that socio-cultural aspects are included in activities promoting the use of both female and male condoms. Our support to PSI and DKT for the introduction of the female condom focusses on women's empowerment.

Assessment of results achieved across the entire result area, Dutch contribution	**B**
A. Results achieved better than planned **B. Results achieved as planned** **C. Results achieved poorer than planned** **D. Results achieved much poorer than planned**	**Reasons for results achieved:** PSI has developed strong alternative distribution for RH commodities. Simultaneously slow progress is being achieved in the public procurement and supply management system. The socially marketed female condom has been launched. The Aids Council CSNS is now faced with problems to guarantee distribution and availability of the publically available "free" female condom.

Implications for planning
Continue to support MoH to improve its logistical supply. Recent improvement is encouraging. In parallel we stimulate PSI to expand innovative modalities to use private distribution channels.

Result area 3	**Public and private clinics provide better sexual and reproductive healthcare services, which more and more people are using**					
Question 3a: To what extent has the use of sexual and reproductive healthcare services in the public and private sector changed?	Access to services provided by the public sector has gradually improved over the years. Ministry of Health is by far the biggest hiv/aids & SRHR service provider in Mozambique. At the same time the private sector has expanded its services primarily in the major urban areas. This includes access to SRHR services. There are large diparities in accessing SRHR services between the wealthier and poorest groups: 30-90%. No data are available on private sector service provision.					
	Baseline (year)	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Antenatal care coverage (at least one visit and at least four visits = >0/>3 as %) (MDG indicator 5.5)	2003: 84/53	NA	91/51			DHS
Proportion of births attended by skilled health personnel (MDG indicator 5.2)	2003: 47.6%	NA	54.3%			DHS 2011, incl. TBA
Instutional deliveries	2005: 49%	62,8%	63,0%			SIS
Percentage of HIV-positive pregnant women receiving treatment to prevent mother-to-child transmission of HIV	2011: 66%	NA	115.4%			MoH ACA
Question 3b: With which results has your programme contributed to improved cooperation between public and private healthcare services?	Currently, the health expert of the embassy is actively participating in a Health Financing working group to contribute to considerations such as health insurances. Discussions have progressed with involvement of ACHMEA, Pharmaccess and the Association for Sugar Mills in Mozambique. Embassy of the Kingdom of the Netherlands advocay at MoH for clear public-private separation, to avoid the perverse public-to-private subsidies/leaks, through uncontrolled use of staff, equipment and other public resources. RNE is also exploring options to better understand and consider for Social Impact Bonds. Only in the private sector is there some insurance. Experience with Performance Based Finance is being considered for upscaling. (US Government with strong NL know-how)					
Question 3c: With which results has your programme contributed to making sexual and reproductive health care more affordable?	Sexual and reproductive health services are free at point of delivery. Yet we have supported incentive systems to support women to cover the cost to reach a clinic and stay at a mothershelter awaiting delivery. Health services and medicines are free for the elderly. However it is expensive to travel to hospitals. With the cash received from the cash transfer program they are able to improve their access to the hospital.					
Optional indicators	**Baseline (year)**	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Number of households benefiting from cash tranfer programme	217.683	400.000	310.305			INAS
Question 3d: With which results has your programme contributed to improved obstetric care?						
Optional indicators	**Baseline (year)**	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Number of doctors, nurses and midwives per 1000 inhabitants	0,67 (2011)	0,69 ('14)	0,682			MoH, HRD
Compliance with the most recent safe abortion guidelines						
Access to basic emergency obstetric care (BeMOC) per 500,000 population						
Health Centers per 500.000 inhabitants offering BEOC (N)	2005: 1,23 2011: 2,2		2,3			MoH-ACA
Health Centre with maternity and with mothershelters (%)	2011: 54,7%		50%			MoH-ACA
Pregnant women who receive at least 2 doses of preventative prenatal Antimalarial treatment (%)	2009: 66.9% 2011: 19,3%	60% ('14)	36%			MoH-ACA
Pregnant women who receive longlasting insecticide treated mosquitoenet prenatal (%)	2009: 76,6% 2011: 92,0%	>95%	75%			MoH-ACA

Assessment of results achieved across the entire result area, Dutch contribution	B
A. Results achieved better than planned	**Reasons for results achieved:** Gradually access to basic obsterical services is improving, thanks to stimulation of demand, reducing barriers and increasing physical access.
B. Results achieved as planned	
C. Results achieved poorer than planned	
D. Results achieved much poorer than planned	

Implications for planning

Continue to support the MoH to improve the supply of SRHR services, both static and mobile, and stimulate demand for SRHR services. In addition it is important to expand possibilities to expand access and use of SRHR services through the private sector: social marketing and health insurances. Greater control by MoH over Technical Assistance to be hired in support of the MoH for general systems strengthening will be attempted through the creation of a technical assistance pool. As new austerity measures (85% cashbudget limit for new commitments) in the Netherlands were announced and could lead to a reduction of the SRHR budget in Mozambique, a new activity such as the Tecnical Assistance Facility (TAF) has been cancelled. Alternatives for contracting by MoH are being explored. Options will be explored to pilot health insurance scheme(s) to improve access to affordable good quality SRHR services at community and health facility levels (i.e.: Polana Canico, part of Maputo): Public Private Partnerships. In close cooperation with the Ministry of Foreign Affairs in the Netherlands a mission of health insurance experts is considered. Cooperation is entertained with IFC in consultation with ELI-EVD. For access to social schemes such as Social Protection and Health Insurance civic registration is required: considering the austerity measures it is unlikely that we will be able to build on our past support to UNICEF to improve birth registration in Mozambique (no approved commitment).

Result area 4	**Greater respect for the sexual and reproductive rights of people to whom these rights are denied**					
Question 4a: What evidence is there of greater respect for the sexual and reproductive rights of women, young people, sexual minorities, sex workers and intravenous drug users?	The organisation for LGTB (LAMBDA) is allowed to function publically without restrictions although the same organisation fails to register as an NGO. About a quarter of the 15-24 old girls and boys (girls earlier than boys) have sexual intercourse before the age of 15 years (GARPR (2004-2008) based on DHS, INSIDA surveys). Abortions are technically illegal in Mozambique. Even though the laws are no longer enforced and abortion related penalties have been removed from the penal code by the Council of Ministers, medical standards have yet to catch up, especially in rural areas where patients find less sterile, riskier procedures. Mozambique's Parliament is likely to approve decriminalizing abortion this year (2013).					
indicators that illustrate the compliance with the law - choose the issues relevant to local context	**Baseline (year)**	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Percentage of girls (aged 15-24y) married before age 18						
Percentage of girls aged 20-24 yrs who had given birth before the age of 20 yrs.	68% (2003)					DHS
Median age at first sexual intercourse (25-49) F/M (yr)	16.1/18.0 (2003)		16,1F/ 17,1M			DHS
Percentage of female genital mutilation	Minimal		Minimal			
Female empowerment: Number of female condoms sold through social marketing	10.000 (4 mths May-Aug 2012)		62.057 (incl. 39.979 free)			PSI
Percentage of women/men that would be in favour of abandoning FGM						
Percentage of women that think it is normal to be punished / beaten if they refuse sex			9%			DHS
Percentage of unsafe abortion						
others						
Question 4b: With which results has your programme contributed to the identification of or changes in legal and policy barriers for the sexual and reproductive health of women, young people, sexual minorities, intravenous drug users and sex workers?	On the margins our partners work on removing barriers of healthier behaviour for vulnerable groups, but mostly do so in big cities such as Maputo and Nampula. This has led to the provison of specially designed lubricants and tailored (outreach) services. (PSI) Lambda organises youth groups to discuss and share sexual and gender preferences and other issues amongst Lesbians, Gays, Bi- and Trans-Sexuals (LGBT). Lambda does involve family members ansd also trains health staff to provide non-discriminatiory support to LGBT. WLSA (Woman and Law in Southern Africa) has been very active in bringing forward cases of rape against children, demanding the full implementation of the law against domestic violence. The work of WLSA with the judicial system, health care professionals and ministry of interior has helped to increase awareness and to overcome socio-cultural barriers that influence the way those professionals react to cases of gender based violence. Additionally WLSA is doing a research about initiation rites in order to understand how they influence female and male socialization, adressing issues such as early marriage, sexual practices, etc.					
optional indicators- choose the issues relevant to local context	**Baseline (year)**	**Objective (2015)**	**Result (2012)**	**Result (2013)**	**Result (2014)**	**Source**
Number of organisations active to come up for the rights and needs of	nr					
Sexworkers						
LGBT	1		2			CSO report
unmarried - young people						
intravenous drug users						
Number of organisations active to advocate for abandoning harmful practices such as	nr					
child marriages			2			CSO report
Number of communities / local leaders that have denounced.	nr					
child marriages						
Number of LGBT reported to be assaulted / imprisoned (i.e. via E/M technology)	nr					
Question 4c: With which results has your programme contributed to improving the access of people and these specific groups to sexual and reproductive health services and commodities?						
Assessment of results achieved across the entire result area, Dutch contribution	**C**					
A. Results achieved better than planned	**Reasons for results achieved:** The results are still insufficient, since we only reach limited numbers.					
B. Results achieved as planned						
C. Results achieved poorer than planned						
D. Results achieved much poorer than planned						
Implications for planning						
We need to engage more actively with these organisations. So far we have not identified non-alcohol drug abuse. We continue to monitor.						