REPRODUCTIVE HEALTH *at a* GLANCE

MOZAMBIQUE

April 2011

Country Context

Between 1996 and 2008, Mozambique's economy has grown at an average of eight percent annually, among the highest growth rates in all of Africa.[1] As a result, more than three million people were lifted out of poverty over the same period. Mozambique made substantial progress in achieving some milestones towards the Millennium Development Goals (MDGs).[2,3] Yet, three-quarters of the population subsists on less than US $1.25 per day.[4]

Mozambique's large share of youth population (44 percent of the country population is younger than 15 years old[4]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[5] In Mozambique, the literacy rate among females ages 15 and above is 40 percent.[4] Fewer girls are enrolled in secondary schools compared to boys with a 75 percent ratio of female to male secondary enrollment.[4] 86 percent of adult women participate in the labor force[4] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Mozambique ranks 150 of 157 countries in the Gender-related Development Index.[6]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[6]

Mozambique: MDG 5 Status

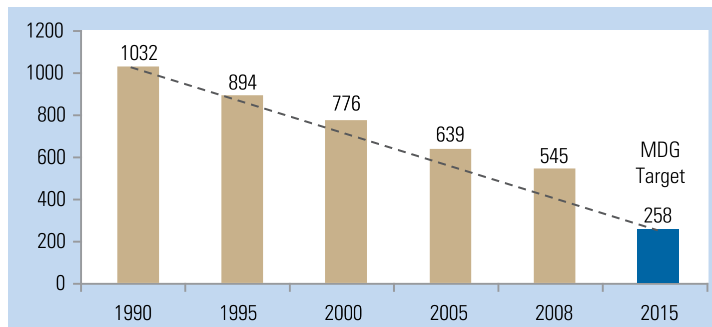
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	545
Births attended by skilled health personnel (percent)	47.7
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	16.5
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	179
Antenatal care with health personnel (percent)	98.2
Unmet need for family planning (percent)	18.4

Source: Table compiled from multiple sources.
[a]The 2005 DHS estimated maternal mortality ratio between 327 to 492.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Mozambique has been making progress over the past two decades on maternal health but it is not yet on track to achieve its 2015 targets.[7]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Mozambique

The Bank's current ***Country Partnership Strategy*** is for fiscal years 2008 to 2011.

Current Projects:
P099930 MZ-Health Service Delivery SIL (FY09) ($44.6m)

Pipeline Project: None

Previous Health Project: P078053 MZ-HIV/AIDS Response SIL (FY03)

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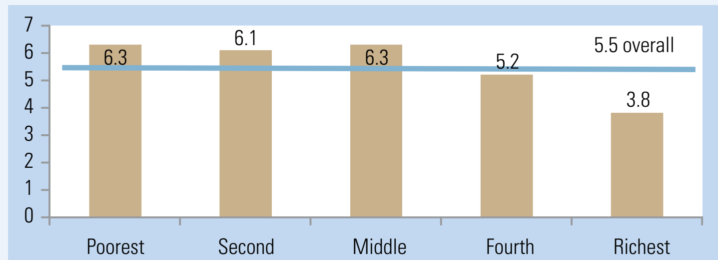
Key Challenges

High fertility

Fertility remains high. Total fertility rate (TFR) fell from 6.2 births per woman in 1990 to 5.5 in 2003.[4, 8] TFR is very high (over 6) among women in the lower three wealth quintiles (Figure 2).[8] Disparities exist between women in rural areas at 6.1 births per woman compared to 4.4 for those in urban areas, and vary by education levels at 6.3 births per woman with no education, and 2.9 with secondary education or higher.

Figure 2 ▪ Total fertility rate by wealth quintile

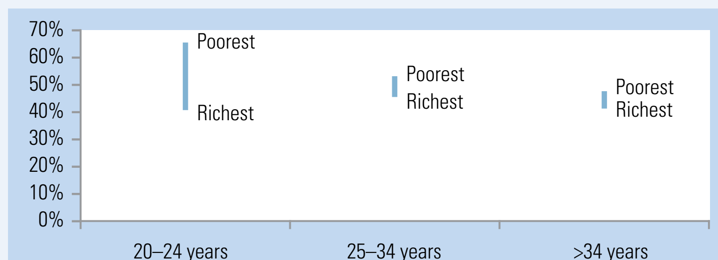


Source: DHS Final Report, Mozambique 2003.

Adolescent fertility rate is high (179 reported births per 1,000 women aged 15–19 years) affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[5, 9]

Early childbearing is high and more frequent among the poor. 65 percent of the poorest 20–24 years old women have had a child before reaching 18, and 40 percent of their richer counterparts did (Figure 3). Furthermore, younger cohorts of girls in the poorest quintiles are more likely to have a child early in life now than their older counterparts.

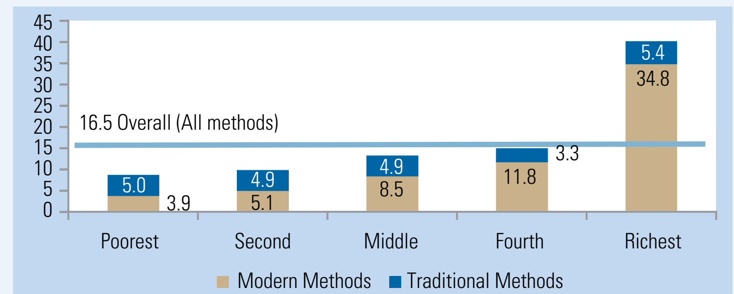
Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile



Source: DHS Final Report, Mozambique 2003 (author's calculation).

Less than a fifth of women use contraception. Current use of contraception among married women was 17 percent in 2003 and more married women use modern contraceptive methods than traditional methods (12 percent and 5 percent).[8] Injectables and the pill are the most commonly used method among married women at 5 percent each. Use of long-term methods such as intrauterine device and implants are negligible. There are socio-economic differences in the use of modern contraception among women: it is 35 percent among women in the highest wealth quintile and 4 percent among those in the poorest quintile (Figure 4). Similarly, just 5 percent of women with no education use modern contraception as compared to 47 percent of women with secondary education or higher, and 7 percent for rural women versus 23 percent for urban women.

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS Final Report, Mozambique 2003.

Unmet need for contraception is high at 18 percent indicating that women may not be achieving their desired family size.[10]

Wanting more children and infertility are the predominant reasons women do not intend to use modern contraceptives in future. Forty-nine percent of women not intending to use contraception indicated they want more children as the main reason while 20 percent indicated they are unable to conceive and 10 percent expressed opposition to use, primarily by themselves, their husband, or due to their religion. Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

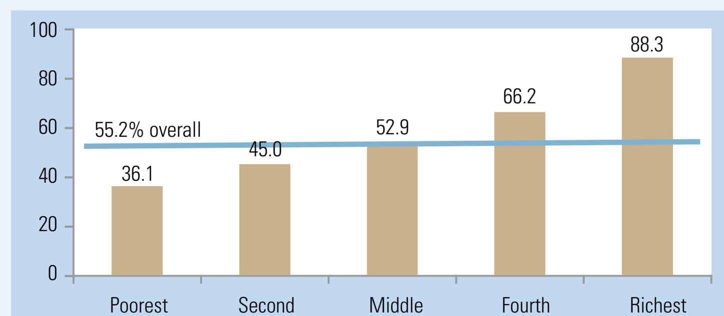
The forthcoming Mozambique DHS 2010 will provide recent information on the reasons women do not use contraception.

Poor Pregnancy Outcomes

While majority of pregnant women use antenatal care, institutional deliveries are less common. Nearly all pregnant women receive antenatal care from skilled medical personnel (doctor, nurse. or midwife).[11] However, a smaller proportion, 55.2 percent deliver with the assistance of skilled medical personnel. While 88 percent of women in the wealthiest quintile delivered with skilled health personnel, only 36 percent of women in the poorest quintile obtained such assistance (Figure 5).[11] Additionally, 41 percent of women with no education delivered with skilled health personnel as compared to 89 percent of women with secondary education or higher. Further, 52 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[12] The forthcoming Mozambique DHS 2010 will

provide information on women's perception on the barriers to accessing health care.

Figure 5 ▪ Birth assisted by health personnel (percentage) by wealth quintile



Source: MICS3 Final Report, Mozambique 2008.

Human resources for maternal health are limited with only 0.027 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.308 per 1,000 population.[4]

The high maternal mortality ratio at 545 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[7]

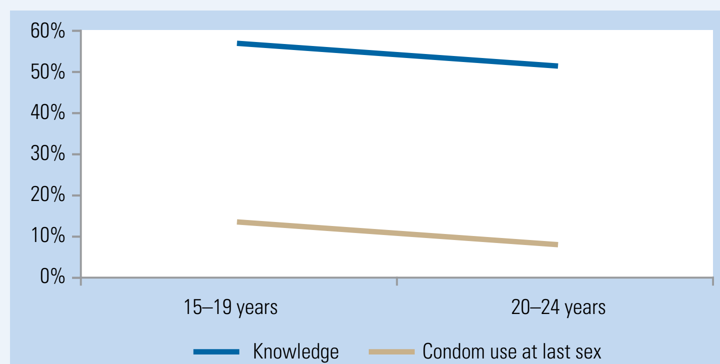
STIs/HIV/AIDS is a public health concern

The adult population that has HIV is estimated at 12.5 percent. This high HIV/AIDS prevalence is reversing the country's efforts for increasing life expectancy.

The forthcoming Mozambique DHS 2010 will provide recent information on HIV/AIDS-related knowledge, attitudes, and sexual behaviour

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While 57 percent of young women are aware that using a condom in every intercourse prevents HIV, only 14 percent of them report having used condom at last intercourse (Figure 6). This gap remains constant among older aged women.

Figure 6 ▪ Knowledge behavior gap in HIV prevention among young women



Source: DHS Final Report, Mozambique 2003 (author's calculation).

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups and emphasize community-based distribution.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including longterm methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.

Reducing maternal mortality

- During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.
- Promote institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Lower the incidence of HIV infections by strengthening Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.

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MOZAMBIQUE REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2003	5.5	Population, total (million)	2008	22.4
Adolescent fertility rate (births per 1,000 women ages 15–19)	2003	179	Population growth (annual %)	2008	2.3
Contraceptive prevalence (% of married women ages 15–49)	2003	16.5	Population ages 0–14 (% of total)	2008	44.1
Unmet need for contraceptives (%)	2006	18.4	Population ages 15–64 (% of total)	2008	52.7
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	3.2
Median age at marriage (years)	—	—	Age dependency ratio (% of working-age population)	2008	89.8
Mean ideal number of children for all women	2003	5.3	Urban population (% of total)	2008	36.8
Antenatal care with health personnel (%)	2008	98.2	Mean size of households	—	—
Births attended by skilled health personnel (%)	2008	55.2	GNI per capita, Atlas method (current US$)	2008	380
Proportion of pregnant women with hemoglobin <110 g/L	2008	52.4	GDP per capita (current US$)	2008	440
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	1000	GDP growth (annual %)	2008	6.8
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	890	Population living below US$1.25 per day	2003	74.7
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	780	Labor force participation rate, female (% of female population ages 15–64)	2008	85.7
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	640	Literacy rate, adult female (% of females ages 15 and above)	2006	40.1
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	550	Total enrollment, primary (% net)	2008	79.9
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	260	Ratio of female to male primary enrollment (%)	2007	88
Infant mortality rate (per 1,000 live births)	2008	90	Ratio of female to male secondary enrollment (%)	2007	74.8
Newborns protected against tetanus (%)	2008	83	Gender Development Index (GDI)	2008	150
DPT3 immunization coverage (% by age 1)	2008	71.6	Health expenditure, total (% of GDP)	2007	4.9
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	5.7	Health expenditure, public (% of GDP)	2007	3.5
Prevalence of HIV, total (% of population ages 15–49)	2007	12.5	Health expenditure per capita (current US$)	2007	18.1
Female adults with HIV (% of population ages 15+ with HIV)	2007	57.9	Physicians (per 1,000 population)	2007	0.027
Prevalence of HIV, female (% ages 15–24)	2007	8.5	Nurses and midwives (per 1,000 population)	2006	0.308

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2003	6.3	6.1	6.3	5.2	3.8	5.5	2.5	1.7
Current use of contraception (Modern method)	DHS	2003	3.9	5.1	8.5	11.8	34.8	11.7	–30.9	0.1
Current use of contraception (Any method)	DHS	2003	8.9	10.0	13.4	15.1	40.2	16.5	–31.3	0.2
Unmet need for family planning (Total)	DHS	2003	16.6	18.1	18.4	21.1	18.7	18.4	–2.1	0.9
Births attended by skilled health personnel (percent)	MICS3	2008	36.1	45.0	52.9	66.2	88.3	55.2	–52.2	0.4