Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights Mozambique’s investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE
The Republic of Mozambique’s national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the Family Planning Contraception Strategy 2010–2015, the National Plan for Development and Human Resources for Health 2008–2015, and the Health Sector Strategic Plan 2014–2019. In this latter document, the country offers integrated RH services in all facilities throughout the country in order to increase access (FP2020, 2016).

Legal Status on Abortion
In Mozambique, abortion is legal for women in the first 12 weeks of pregnancy. In the case of rape or incest, abortions are legal up to 16 weeks, while in cases of fetal anomaly, abortion is legal up to 24 weeks (Ipas, 2014).

PAC TRAINING AND STANDARDS
DKT International the United Nations Population Fund (UNFPA) collaborated to train healthcare providers in the public and private sectors in order to increase access to FP. Since 2011, 511 public sector and 28 private sector providers have completed training in the promotion and distribution of contraceptive methods (including oral contraceptives and condoms) at the community level (FP2020, 2014).

Further, the Mozambican Ministry of Health developed an intervention to provide training in PAC and manual vacuum aspiration to improve PAC services in public sector facilities. Master trainers provided training on all PAC elements outlined in the USAID model, including pain management, counseling, and postabortion contraceptive provision (Gallo, Gebreselassie, Victorino, et al, 2005).
The country’s medical school curricula also provides additional training resources for physicians and maternal and child health nurses. Pre-service or in-service training curricula include comprehensive PAC, emphasizing surgical treatment for complications with manual vacuum aspiration and medical treatment with misoprostol (Gallo, Gebreselassie, Victorino, et al, 2005).

**STRENGTHENING SERVICE DELIVERY**

Mozambique has been offering FP counseling and a broad range of voluntary methods (except intrauterine devices) throughout communities via mobile brigades and national healthcare weeks (FP2020, 2014). As a result of district-level trainings for community health agents, 3,232 community health agents have been actively promoting voluntary FP methods and distributing oral contraceptives and condoms in communities since 2013 (FP2020, 2014). In 2014, 89% of healthcare centers were offering at least three different contraceptive methods (FP2020, 2014).

**BARRIERS TO PAC**

Women in Mozambique face multiple barriers to accessing PAC and FP services. The primary obstacle that women face is the stigma related to discussing sex and RH, which leads to negative behaviors and attitudes. Additional challenges, including a lack of human resources, further limit access to PAC and FP services, especially in rural and remote areas of the country (FP2020, 2014).

**FINANCING MECHANISMS**

In Mozambique, international donors contribute more than 50% of the government’s total health budget (Curtin et al, 2012). In the public sector, FP services are free, but universal health coverage has not yet been fully implemented (Curtin et al, 2012).
### MOZAMBIQUE

#### Country population
- **Country population**: 29,668,834
- **Year**: 2017
- **Source**: World Bank

#### Total fertility rate
- **Total fertility rate**: 5.2
- **Source**: Demographic and Health Survey, 2011

#### Age at first birth
- **Age at first birth**: 19.4

#### Maternal mortality per 100,000 live births
- **Maternal mortality per 100,000 live births**: 408
- **Source**: Demographic and Health Survey, 2011

#### Newborn mortality per 1,000 live births
- **Newborn mortality per 1,000 live births**: 30
- **Source**: Demographic and Health Survey, 2011

#### Infant mortality per 1,000 live births
- **Infant mortality per 1,000 live births**: 64
- **Source**: Demographic and Health Survey, 2011

#### Under-five child mortality per 1,000 live births
- **Under-five child mortality per 1,000 live births**: 97
- **Source**: Demographic and Health Survey, 2011

#### Facility-based deliveries
- **Facility-based deliveries**: 55.0%
- **Source**: Demographic and Health Survey, 2011

#### Proportion of women who attended at least one antenatal visit
- **Proportion of women who attended at least one antenatal visit**: 89.7%
- **Source**: Demographic and Health Survey, 2011

### Abortion and FP-related indicators

#### Number of abortions
- **Number of abortions**: 2,300
- **Source**: International Women’s Health Coalition

#### Proportion of women that report ever having terminated a pregnancy
- **Proportion of women that report ever having terminated a pregnancy**: 9%
- **Source**: Dickson et al.

#### Number of unintended pregnancies
- **Number of unintended pregnancies**: 297,000
- **Source**: FP2020 Core Indicator 2017–18 Summary Sheet

#### Number of unintended pregnancies averted due to use of modern contraceptive methods
- **Number of unintended pregnancies averted due to use of modern contraceptive methods**: 816,000
- **Source**: FP2020 Core Indicator 2017–18 Summary Sheet

#### Number of unsafe abortions averted due to use of modern contraceptive methods
- **Number of unsafe abortions averted due to use of modern contraceptive methods**: 179,000
- **Source**: FP2020 Core Indicator 2017–18 Summary Sheet

#### Number of maternal deaths averted due to use of modern contraceptive methods
- **Number of maternal deaths averted due to use of modern contraceptive methods**: 3,100
- **Source**: FP2020 Core Indicator 2017–18 Summary Sheet

#### Modern method contraceptive prevalence rate, all women of reproductive age (WRA)
- **Modern method contraceptive prevalence rate, all WRA**: 32.6%
- **Source**: Demographic and Health Survey, 2011

#### Knowledge of FP, all WRA
- **Knowledge of FP, all WRA**: 96%
- **Source**: Demographic and Health Survey, 2011

### Contraceptive use by type

#### Long-acting and permanent methods
- **Sterilization (female)**: 1.7%
- **Sterilization (male)**: 0.0%
- **Intrauterine device**: 1.7%
- **Implant**: 0.0%
- **Source**: FP2020 Core Indicator 2017–18 Summary Sheet

#### Short-acting methods
- **Injection (intramuscular and subcutaneous)**: 35.5%
- **Pill**: 35.5%
- **Condom (male)**: 24.0%
- **Condom (female)**: 0.0%
- **Other modern methods (e.g., cycle beads, and lactational amenorrhea method)**: 1.6%
- **Source**: FP2020 Core Indicator 2017–18 Summary Sheet

#### Unmet need for FP
- **Unmet need for FP**: 29.0%
- **Source**: Demographic and Health Survey, 2015–16

#### Unmet need for spacing
- **Unmet need for spacing**: 16.0%

#### Unmet need for limiting
- **Unmet need for limiting**: 13.0%

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2. Based on analysis of Mozambique DHS 2011.
3. Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.
REFERENCES


