MOMENTUM

Integrated Health Resilience

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REPORT

LESSONS LEARNED FROM IMPLEMENTATION OF SRH EMERGENCY PREPAREDNESS ACTIVITIES IN CABO DELGADO, MOZAMBIQUE

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ACRONYMS

AI	Artificial Intelligence
APE	*Agentes Polivalentes Elementares* (community health worker)
CE	Community Engagement
CMC	Co-management Committee
DPS	*Direccao Provincial de Saude* (Provincial Directorate of Health)
EPR	Emergency Preparedness and Response
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-based Violence
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IDP	Internally Displaced Person
IFPI	Improved Family Planning Initiative
INGD	National Institute for Disaster Management
IPPF	International Planned Parenthood Federation
MIHR	MOMENTUM Integrated Health Resilience
MISP	Minimum Initial Services Package
MCH	Maternal and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
PSP	Professional Services Provider
RH	Reproductive Health
SAAJ	*Servicos Amigos de Adolescentes e Jovens* (Youth Friendly Services)
SDSMAS	District Services for Health, Women and Social Affairs
SRH	Sexual and Reproductive Health
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
YFS	Youth Friendly Services

EXECUTIVE SUMMARY

This report shares lessons from implementing sexual and reproductive health (SRH) emergency preparedness activities under MOMENTUM Integrated Health Resilience (MIHR) in Cabo Delgado, Mozambique, a region impacted by conflict and humanitarian crisis. This activity aimed to strengthen local capacity to sustain critical health services in emergencies and improve resilience to shocks.

Purpose

We share experiences and outcomes to inform future SRH resilience initiatives. Objectives include identifying facilitators and barriers to the Minimum Initial Service Package (MISP) for SRH readiness, assessing contributions to emergency SRH preparedness, and reflecting on participant perspectives.

Methods

The process evaluation combined qualitative and quantitative approaches:

- **Document Review**: Training reports, monitoring forms, and action plans.
- **Interviews**: Semi-structured interviews with health professionals, community leaders, and provincial and district health authorities.
- **Focus Group Discussions (FGDs)**: Discussions with co-management committees (CMCs) and community stakeholders.
- **Pre-Post Tests**: Participant knowledge assessments during MISP training sessions.

Key Findings

1. **Implementation Achievements**:
    - Trained 24 health professionals and 53 community stakeholders across three health facilities and multiple communities in Ancuabe district of Cabo Delgado, Mozambique.
    - Developed Emergency Preparedness and Response (EPR) and Community Engagement (CE) plans tailored to local needs.
    - Mobile brigades provided contraceptive methods and conducted health awareness talks in remote and underserved areas.
2. **Capacity Gains**:
    - Knowledge of SRH emergency preparedness improved significantly among MISP training participants, with post-training test scores increasing from 58.4% to 85.6%.
    - Health professionals reported enhanced ability to prioritize critical SRH needs in emergencies, such as family planning (FP) and gender-based violence (GBV) response.
3. **Community Impact**:
    - Co-management committees (CMCs) delivered educational sessions on FP, GBV prevention, and early marriage, despite cultural barriers and misinformation.
    - CE efforts strengthened referral systems for GBV survivors and increased awareness of the importance of facility-based births.
4. **Challenges Identified**:
    - **Time Constraints**: Compressed timelines affected the quality of planning and delivery of MISP training and EPR workshops.

- **Resource Gaps**: Limited supplies, infrastructure, and transport hindered complete EPR plan implementation.
- **Coordination Issues**: Delays in engaging health authorities, civil society partners, and other partners reduced the momentum for sustaining activities.
- **Confusion between district, facility, and community responsibilities**: EPR plans were drafted for districts but followed up at three health facilities, and Community Engagement plans were not included in EPR plan monitoring.

5. **Results by MISP Objectives**:
   - SRH Cluster of the Health Cluster resumed monthly meetings as a venue for reviewing EPR plan progress under the leadership of the Provincial Directorate of Health.
   - Improved response to GBV, including on-the-job training for health providers and the hiring of a psychologist by PEPFAR.
   - HIV was addressed through educational talks, but no changes were reported on preparedness for STI or HIV service delivery.
   - Expanded maternal and newborn health services, including mobile brigades and maternity ward upgrades.
   - FP promotion via community awareness campaigns, increasing access to FP methods.
   - Transition from MISP to comprehensive SRH services was not emphasized in MISP trainings or EPR workshops which focused on emergency preparedness and response.

Key Recommendations

1. **Enhance Coordination**: Engage provincial and district health authorities early to foster ownership and integration of plans into routine facility and community monitoring activities.
2. **Integrate EPR and Community Engagement plans**: Have a single plan per health district to guide implementation by district authorities. Clarify accountability mechanisms at district, facility, and community levels, including actions for preparedness, response, and recovery phases.
3. **Sustain Capacity Strengthening**: Increase the number of trained health providers and community actors, and ensure follow-up training.
4. **Improve Resource Mobilization**: In coordination with health authorities, the health cluster, UNFPA, and bilateral donors, address gaps in SRH supplies, transport, and infrastructure.
5. **Strengthen Community Engagement**: Deepen involvement with CMCs and address socio-cultural barriers through targeted messaging.
6. **Leverage Partnerships**: Ensure continuity of SRH preparedness activities by collaborating with health authorities at provincial and district levels as well as humanitarian partners like health cluster leaders, development partners, and local organizations.

Conclusion

SRH emergency preparedness activities in Cabo Delgado strengthened local resilience and advanced MISP readiness. Continued investment in SRH emergency preparedness, community engagement, training, and multi-level coordination is vital to sustain gains and remain prepared for future crises.

INTRODUCTION

MOMENTUM Integrated Health Resilience

Momentum Integrated Health Resilience (MIHR) works to strengthen health resilience in fragile settings, like northern Mozambique, focusing on ensuring the continuity of essential health services, particularly in reproductive health (RH), family planning (FP), maternal, newborn and child health, and broader health areas. In fragile and conflict-affected settings, MIHR addresses critical gaps by supporting local health systems and communities in adapting to shocks and stresses, maintaining access to essential health services, and building health resilience at multiple levels – individual, community, and local health system.

Neglecting lifesaving RH care during crises leads to serious consequences such as unintended pregnancies, unsafe abortions, preventable maternal and newborn deaths, increased gender-based violence (GBV) and spread of STIs and HIV. MIHR works to strengthen local capacity to implement the six objectives of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in crisis,[1] which is the globally recognized standard for RH services in humanitarian settings.

In Mozambique, Pathfinder International (Pathfinder) staff represent MIHR with technical backstopping from the MIHR FP/RH Team. The activity described in this report also leveraged staff and office resources in Cabo Delgado under the USAID-funded "Preventing Child Marriage in Cabo Delgado project," known as Uholo.[2]

MOZAMBIQUE NATIONAL CONTEXT FOR SRH IN FRAGILE AND CONFLICT-AFFECTED SETTINGS

In recent years, Mozambique has begun addressing the need for sexual and reproductive health (SRH) care in fragile and conflict-affected areas of the country. In 2022, UNFPA Mozambique conducted a MISP Readiness Assessment to assess Mozambique's laws, policies, resources, infrastructure, coordination mechanisms, and preparedness to respond to emergencies. Given their vulnerability to natural disasters and the ongoing humanitarian crisis, the assessment included a sub-focus on Cabo Delgado and Sofala provinces. The MISP Readiness Assessment Report,[3] highlighted that despite major efforts by the government and donors to improve access to contraception and SRH services, FP services were not prioritized during emergencies. Regarding gender-based violence (GBV) services, the report found the health system, as well as providers, were generally ill-prepared to respond to GBV survivors' needs, especially in emergencies. In the same year, the Government of Mozambique released its FP2030 commitment to increase the modern contraceptive prevalence rate for all women of reproductive age from 34.3% in 2020 to 43.4% by 2030. Additionally, Mozambique's objective to ensure unrestricted access without discrimination to quality RH/FP services for all women and girls, explicitly included FP provision in emergency contexts.

[1] Inter-Agency Working Group on Reproductive Health in Crises. (2018). Minimum initial service package (MISP) for sexual and reproductive health. In Inter-agency field manual on reproductive health in humanitarian settings (Chapter 3). https://iawg.wpengine.com/wp-content/uploads/2019/07/IAFM-3-MISP.pdf

[2] Pathfinder International. (2024, February). Mozambique: Preventing child, early, and forced marriage and countering violent extremism in Cabo Delgado (Uholo-Raparigas e Jovens). Pathfinder International. https://www.pathfinder.org/publications/preventing-child-early-and-forced-marriage-and-countering-violent-extremism-in-cabo-delgado/

[3] United Nations Population Fund (UNFPA) Mozambique. (2022, June–July). MISP Readiness Assessment Report. UNFPA Mozambique..

This objective is reflected in Mozambique's 2024 Humanitarian Needs and Response Plan , which stated, "Due to the country's precarious position in humanitarian crises, emergency health assistance will focus on managing common pathologies, treating injured people, providing minimum initial service packages (MISPs) in SRH, and vaccinating children aged 6-59 months.[4]''

Despite commitments at the national level, Mozambique has struggled to make progress towards its goals. Starting in September 2023, MIHR has worked with local partners to address this in Cabo Delgado.

SRH CONTEXT IN CABO DELGADO PROVINCE

This SRH emergency preparedness activity takes place in a context of ongoing violent extremism in Cabo Delgado province, particularly its northern districts, since October 2017. In addition to destruction of infrastructure and services, thousands of casualties, conflict, insecurity, and violence in the province have resulted in displacement of an estimated one million people since the conflict began. In 2023, there was a steady return of internally displaced persons (IDPs) to their home districts following improvements in the security situation. However, the province continues to endure a humanitarian emergency, as well as ongoing conflict and subsequent economic and social disruption undermining health and development outcomes. Since January 2024, there has been an upsurge in violence, only slightly reduced in March and with a peak in April 2024. In Ancuabe district, where the MIHR intervention focused, the security situation deteriorated in the second quarter of 2024, impacting the pace of implementation as staff travel was interrupted. Violence included insurgent attacks on villages; burning of homes, churches, and a school; and military and insurgent clashes.

Even prior to the conflict, women and girls in Cabo Delgado were highly vulnerable as a result of limited access to health care, poverty, and patriarchal social norms. The institutional delivery rate is one of the lowest in the country estimated at 68.8% in 2015, and declined further to 57.7% in the 2022-23 DHS, likely in part due to the humanitarian crisis.[5] The percentage of pregnant women aged 15-49 years that attended at least four antenatal visits in Cabo Delgado was the third highest in the country in 2015 (68.1%), but fell to 53.4% in 2022-23. Under 5 child mortality as well as infant mortality (<1 year of age) are both the highest of all the country's provinces (89 per 1000 live births and 55 per 1000 live births, respectively). Cabo Delgado also has one of the highest rates of child marriage in Mozambique: 62% of women aged 20-24 are married before age 18, compared to the national average of 53%.[6] Adolescent pregnancy rates are also highest in the country at 55.3%. Only 13.7% of married women ages 15-49 in Cabo Delgado use a modern contraceptive method.[7]

- The consequences of GBV, sexual exploitation, and early and unintended pregnancies are only exacerbated by health facilities being closed or operating at minimal capacity due to a lack of essential medical supplies, equipment, and personnel. UNFPA reported in 2021 that the

[4] United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2023, December). Mozambique Humanitarian Needs and Response Plan 2024. OCHA. https://www.unocha.org/publications/report/mozambique/mozambique-humanitarian-needs-and-response-plan-2024-december-2023-enpt

[5] Instituto Nacional de Estatística (INE), The DHS Program, & ICF. (2024). Moçambique Inquérito Demográfico e de Saúde 2022–23 [Final report]. Instituto Nacional de Estatística (INE) and ICF. https://dhsprogram.com/pubs/pdf/FR389/FR389.pdf

[6] United Nations Population Fund. (n.d.). Population Data Portal. UNFPA. https://pdp.unfpa.org/?page=Explore-Indicators#/viewer?country=508&indicator=496&column=9122

[7] Instituto Nacional de Estatística (INE), The DHS Program, & ICF. (2024). Moçambique Inquérito Demográfico e de Saúde 2022–23 [Final report]. Instituto Nacional de Estatística (INE) and ICF. https://dhsprogram.com/pubs/pdf/FR389/FR389.pdf

province needs the following actions to ensure continuity of SRH services:[8]Training health professionals in life-saving SRH practices, while strengthening human capacity in the medium and long term through training and sharing good practices.

- Equip health services with equipment and material for SRH services, including post-rape kits
- Ensuring adequate contraceptive stock, including long-acting reversible contraceptives.
- Deployment of mobile health clinics to provide integrated SRH and GBV response services to women and girls in displacement sites, resettlement centers, and remote locations.
- Installation of emergency tents to provide essential reproductive and maternal health services
- Mobilization of community health workers and social activists for community interventions, including referral to SRH and GBV services and distribution of FP methods.

SRH PREPAREDNESS PROJECT DESCRIPTION

In response to needs identified through the MISP Readiness Assessment findings from Cabo Delgado and in support of Mozambique's FP2030 commitment, MIHR launched an SRH preparedness activity in partnership with local authorities and civil society actors in September of 2023.

RESULT 1: STRENGTHEN FP/RH/MNH/GBV RESILIENCE CAPACITIES OF LOCAL ACTORS TO MAINTAIN CONTINUITY OF CARE

Intermediate Results

- 1.1: Providers trained and demonstrate improved capacity to provide FP/RH/MNH/GBV services during and after shocks (Aligns with MIHR Result 1.4 Health resilience capacities for access and use of MNCH/FP/RH services and interventions improved)
- 1.2: Health system prepared and equipped to respond to future shocks and stressors (Aligns with MIHR Result 1.1 Improved service readiness to provide quality MNCH/FP/RH interventions in public and private sectors, including emergency care)
- 1.3: Evidence on FP/RH/MNH/GBV preparedness and response and its influence on MISP delivery and response documented (Aligns with MIHR Result 3.1 Increased appropriate and timely availability and use of data for decision-making in MNCH/FP/RH policy and programs at global, regional, and sub-national levels).

RESULT 2: ENACT NATIONAL-LEVEL PLANS TO INTEGRATE MISP TRAINING AND SERVICES INTO HEALTH PROGRAMMING AT THE DISTRICT LEVEL.

Intermediate Results

2.1: Evidence on FP/RH/MNH/GBV preparedness and response and its influence on MISP delivery and response documented and disseminated (Aligns with MIHR Result 3.1 Increased appropriate and timely availability and use of data for decision-making in MNCH/FP/RH policy and programs at global, regional, and sub-national levels).

KEY ACTIVITIES IMPLEMENTED

MISP training and development of EPR and Community Engagement Plans

[8] United Nations Population Fund (UNFPA). (2021, June 15). UNFPA Cabo Delgado Flash Appeal June 2021. UNFPA Mozambique. https://mozambique.unfpa.org/sites/default/files/pub-pdf/unfpa_cabo_delgado_flash_apeal_-_updated_june_2021.pdf

MIHR conducted a competitive procurement process to recruit a Mozambique-based professional services provider (PSP) team with MISP training experience to conduct a 3-day **MISP training** using slides from Inter-Agency Working Group on Reproductive Health in Crises (IAWG) and International Planned Parenthood Federation (IPPF).[9] Trainees included 24 providers from three health facilities and health authorities from Ancuabe District. The last day of the MISP provider training was dedicated to Emergency Preparedness and Response (EPR) action planning for districts and facilities. The PSPs also conducted two, three-day EPR for SRH and gender workshops in which they referred to but did not use materials (i.e., agenda, slides, exercises, handouts) developed by the Women's Refugee Commission,[10] given the low literacy levels of some workshop participants. Workshops conducted in Metoro and Ancuabe involved 53 participants including community members and medical staff. Workshops concluded with the development of Community Engagement plans to respond to identified gaps and needs in Ancuabe, Metoro, and Intutupue communities. The PSPs used notes from these sessions to draft EPR plans and CE action plans for the district and the three targeted communities. MIHR worked with the PSPs for six months to finalize action plans and the workshop report; dissemination and follow-up on the action plans commenced soon thereafter.

Socializing EPR and Community Engagement Plans

After the MISP training and EPR workshops, the following steps were taken to involve provincial and district structures and non-governmental partners. In collaboration with local health authorities, MIHR staff disseminated workshop results and action plans to health, disaster management, and civil society members at district level in March 2024. This meeting was attended by the district's Chief Medical Officer and heads of programs for GBV, Youth Friendly Services (YFS), maternal and child health (MCH), HIV, Community Health, and Pharmacy.

In April, MIHR met with the Cabo Delgado office of the National Institute for Disaster Risk Reduction and Management, which is responsible for emergency response in the country. The idea of creating local emergency committees at the Ancuabe district level was explored but deemed not feasible or sustainable. Instead, it was decided to implement the CE plans through the co-management committee (CMC) structures that already exist at facility level and include trained community agents.

In May, MIHR participated in two SRH cluster meetings and presented results from the EPR workshops, highlighting SRH emergency preparedness capacities, gaps, and plans in the three communities. MIHR staff also held meetings in May with the Provincial Directorate of Health and Provincial Health Services to present and seek approval of the plans.

Monthly monitoring visits, technical assistance, and resource mobilization

Starting in March 2024, MIHR staff began monthly follow-up visits with providers and community members on implementing EPR and community engagement plans. MIHR, facility staff, and the president of the local CMC reviewed the health unit's record books and MISP medicine supplies. Progress on EPR plan activities and challenges were noted with solutions to barriers discussed. In

[9] International Planned Parenthood Federation (IPPF) & Inter-Agency Working Group on Reproductive Health in Crises (IAWG). (2023, January 29). A training for service providers on sexual and reproductive health in emergencies: An introduction to the Minimum Initial Service Package (MISP). IAWG. https://iawg.net/resources/ippf-training-modules-misp-service-providers

[10] Women's Refugee Commission. (2021, June 10). Facilitator's kit: Community preparedness for reproductive health and gender. Women's Refugee Commission. https://www.womensrefugeecommission.org/research-resources/drr-community-preparedness-curriculum/

response to the needs identified through EPR plan review, MIHR provided limited support for procuring medical surgical supplies for facilities and mobile brigades, in collaboration with UNFPA and other SRH cluster partners. MIHR met with UNFPA to discuss EPR for SRH activities in Ancuabe district and requested support for procuring RH kits. Staff also provided on-the-job training on record keeping, GBV survivor care, offering FP methods to all women and girls, and improving quality of awareness-raising talks at facility level. MIHR also tested the use of the MISP checklist as a preparedness monitoring tool.

community engagement plans were also reviewed with Metoro, Ancuabe-sede and Intutupue CMCs to track implementation progress and discuss challenges. CMCs discussed how emergencies can impact rates of unwanted pregnancies, limit contraceptive care-seeking, and increase GBV cases, as well as how members can help the community prepare for emergencies. MIHR provided on-the-job training and guides on how to use banners provided by the project (e.g., banners on how to respond to sexual violence or on the importance of FP to the health of women, children, and families). During follow-up visits with the CMCs, members shared challenges in addressing GBV in their communities and how prevailing myths and misconceptions around contraception created barriers to accessing services.

PURPOSE OF LESSONS LEARNED DOCUMENTATION

The goal of this activity is to document the experience of implementing SRH preparedness activities at district level in Mozambique and draw from these learnings to inform the design of future SRH resilience programming. Specific objectives include:

1. Reflect on the perspectives of project participants, MIHR staff, and other key stakeholders about the SRH preparedness activities
2. Identify key factors that may have facilitated or inhibited MISP readiness and response
3. Explore to what extent the SRH preparedness activities contributed to perceived readiness to implement MISP for SRH in this part of Mozambique

KEY QUESTIONS/THEMES

Specific questions explored are listed in Annex 2. Some questions are drawn from the IAWG MISP Process Evaluation Tools Key Informant Interview guide.[11]

METHODS

Design

This documentation effort included:

- **Project Document Review:** The evaluation team reviewed reports from the MISP training and SRH preparedness workshops (where EPR and community engagement action plans were developed), as well as monitoring forms captured during visits to facilities and communities for action plan follow-up.

[11] Inter-Agency Working Group on Reproductive Health in Crises (IAWG) & Women's Refugee Commission. (2022, June 1). Minimum Initial Service Package (MISP) process evaluation tools (revised 2022). IAWG. https://iawg.net/resources/minimum-initial-service-package-misp-process-evaluation-tools-revised-2022/

- **Qualitative Interviews:** Semi-structured interviews were conducted with key stakeholders, including a UN emergency focal point; provincial health staff; facility managers; focal points for MCH, GBV, Pharmacy, YFS; and community involvement at district and facility levels.
- **Focus group discussions (FGDs)** were conducted with community members of CMCs, youth, *Agentes Polivalentes Elementares* (APE, community health workers in Mozambique), and MIHR staff working for Pathfinder in Mozambique.

Sites, population and sampling

Interviews and FGDs were conducted in intervention areas of Ancuabe District of Cabo Delgado Province. Facilities included Ancuabe, Metoro, and Intutupue Health Facilities. Respondents were purposively sampled given their direct involvement in one or more MIHR SRH preparedness activities, including MISP training, EPR and community engagement planning workshops, or monitoring visits (See Annex 3 for a full list of respondent titles). Respondents included youth and adults 18 years and older.

DATA COLLECTION AND MANAGEMENT

DATA COLLECTION, TRANSCRIPTION, AND TRANSLATION

Guiding questions used for interviews and FGDs are listed in Annex 2. During data collection, questions were added or removed, or other adjustments made to probe a specific aspect of an implementation process, result, or lesson learned.

Interviews and FGDs were conducted in Portuguese. Both took approximately one hour and were recorded on tablets with participant consent. Audio recordings did not include any identifiers and were transcribed in Portuguese using an automatic artificial intelligence (AI) service called Turboscribe. We disclosed the use of AI for transcription to participants during the consent process. Transcribed drafts and notes were uploaded and stored in a secure, encrypted, cloud-based folder.

The documentation team reviewed and cleaned the transcriptions along with the recordings to ensure data were correctly transcribed. De-identified, transcribed data were translated into English using DeepL. All data uploaded to DeepL were reviewed by the documentation team to ensure they were de-identified, and outputs were reviewed to ensure accuracy and suitability. Documentation team members ensured that all use of AI complied with JSI's official AI guidance document: "Artificial Intelligence (AI) at JSI: Guiding Principles and Considerations."

DATA MANAGEMENT AND ANALYSIS

Data management was led by Pathfinder's Mozambique MEL Director. Information and data were stored and protected in a secure location where only documentation team members with permission could access files. Information was organized according to the above key questions. We also identified recurrent sub-themes and insights that emerged from the data and used these to code transcripts.

FINDINGS BY KEY TOPICS OF INQUIRY

Implementation Process and Experience

- What and how were SRH preparedness activities implemented?

- What challenges were encountered, and how were they overcome?

MISP TRAINING AND EPR WORKSHOP FOR HEALTH PROVIDERS

The MISP for SRH training and EPR workshop was conducted in three days in September in Ancuabe District. According to training guidelines,[12] this workshop "joined" national efforts to initiate "a process of strengthening the health sector's capacities to improve response in emergency situations through the introduction of the MISP for SRH." MIHR staff perspectives on training objectives were similar: "to give health providers [and community actors] the capacity to respond to sexual and reproductive health issues in emergency contexts" and "to strengthen the health system in Ancuabe, particularly to make it more resilient in emergency situations, to be better prepared to respond in emergency situations in the area of SRH with a focus on FP, contraception, especially violence." Staff also saw this training as a response to UNFPA's MISP assessment from 2022, which found that despite Mozambique's susceptibility to climate emergencies and ongoing conflicts in northern provinces, the country had not yet prioritized SRH in emergency situations.

Participants

According to the MIHR training report,[13] 24 health sector individuals from three facilities as well as district and provincial health directorates participated in MISP training and the EPR workshop.

Table I: MISP Training and EPR Workshop, number of participants by type, September 26-28, 2023

Type of Participant	Number
Health providers from Metoro Health Center (Type II Health Center)	7
Health providers from Ancuabe Health Center (Type II Health Center)	6
Health providers from Intutupue Health Center (Type I Health Center)	2
Ancuabe district health representatives (Clinical Medical, Chief of District Medicine and Supplies, and District Focal Points for MCH, GBV, and YFS)	5
Participants from the provincial level (Provincial Medical Chief, Provincial GBV and MCH Focal Points, and a Representative of MCH area at Provincial Directorate of Health (DPS)	4
TOTAL	**24**

Of the 11 interview respondents, seven health professionals at district and facility levels participated in the training. The majority of the respondents (n=9) believed that other individuals should have been invited to the training as well, including additional providers (e.g., preventive medicine technicians), community members, and professionals from other sectors (e.g., education). According to one respondent, "So [for] the MISP, everyone has to be trained, at all levels and all the actors involved in the humanitarian response." A health worker in Ancuabe remarked, "I think there were more groups that could have been part of that training. The community needs to be able to tell us the real situation of what they're going through beyond what we observe. So they can tell us first-hand what's going on." MIHR staff reflected on how many provincial staff were involved in the training (n=4), saying "The provincial level was very well represented considering that this was a district level training and

[12]Ministério da Saúde (MOH), MIHR, Pathfinder International, & United States Agency for International Development (USAID). (2023). Guião para treino dos provedores de saúde em pacote mínimo de serviços iniciais para saúde sexual e reprodutiva e violência baseada no género [Guideline for training health providers on the Minimum Initial Service Package for sexual and reproductive health and gender-based violence]. MOH, MIHR, Pathfinder International, and USAID.

[13] MIHR. (2023, October). Report of MISP training for health providers and emergency preparedness and response for community on SRH and gender, Ancuabe, 26 September–3 October 2023. MIHR.

planning process. And also, considering that we were (planning) to share (the results) with the DPS afterwards to have them also involved."

Training Package and Delivery

The MISP training guideline was built on the existing Ministry of Health (MOH) training package developed with UNFPA support, which had been translated and adapted from the 2018 IPPF/IAWG manual "Sexual and reproductive health in emergencies, An introduction to the Minimum Initial Service Package (MISP), A Training for Service Providers." According to MIHR staff, the MOH/UNFPA training package had been delivered previously in some provinces of Mozambique, including Cabo Delgado, but had not been introduced in Ancuabe district until MIHR's involvement. While the original training package was designed for a 3-day workshop, MIHR condensed the MISP training for Ancuabe to 2.5 days due to time and budget constraints. Additionally, the module on safe abortion care in the original training package was revised to focus only on post-abortion care for the sake of compliance with United States Government Family Planning and Abortion Requirements. The last half day was dedicated to developing the EPR action plans for health facilities.

Aside from these changes in the training package, all six MISP objectives were covered. MIHR staff observed that providers appeared to gain a greater understanding of their roles in ensuring SRH services during emergencies: "In terms of what the providers were expecting, I could feel that during implementation, because this package brings crucial elements, that the providers themselves can take ownership and know what to do." Seven interview respondents highlighted the topics that they learned about at the training; most (n=5) noted SRH topics including FP, HIV, MCH, and GBV, while a few also noted issues related to youth and emergency response. On FP in emergencies, one health provider shared, "I've learned that what's really important is that we can talk about, adopt, offer long-term methods in an emergency context. And much more the quarterly dispensing [of methods]. Quarterly and six-monthly dispensing are very important in an emergency context."

Reflecting on gaps in the MISP training package, a MIHR staff member observed that there was not a clear articulation of what should be done at each stage of an emergency—pre-crisis, during crisis, post-crisis. He noted that "it really should have very clear guidelines, for example, this issue of breaking down what interventions should be made at each stage…before the crisis, what is to be done, what preparation is to be made, but very clearly defined." While the sixth MISP objective focuses on transitioning from the MISP to comprehensive SRH services as soon as possible after emergency onset, the provider training may benefit from more structured guidelines including concrete actions to be taken to prepare for MISP implementation before an emergency happens.

The EPR planning portion of the workshop used a planning template adapted from the Facilitator's Kit (Module 3.3) called "Action Planning for Sexual and Reproductive Health and Gender". This template is based on the MISP for SRH checklist to guide participants in examining each objective when considering priority district activities. It was not clear to what extent the Facilitator's Kit was also referenced to guide the action planning process, aside from the use of the action planning template.

According to a UNFPA representative,

> *The MISP is a package of services, it's already pre-established. And I believe that, at the very least, we have to guarantee that package of services. Of course, each country has its own context and may have to make some adaptations…but we can also think about and include*

some actions that, in a way, aren't lifesaving, but are necessary actions.

In other words, the EPR plan should guarantee the MISP for SRH by proposing specific activities that the health and community sectors must do to prepare for an emergency.

The majority of interview respondents reported no challenges in the development of the EPR plan. One respondent admitted that this was his first time working on such a plan, so though it was initially challenging, he began to understand the objective and move forward with plan development. Even so, one MIHR staff shared, "So I think these plans need to be fleshed out a lot more, to be more concrete. And this is a long time coming, and this is the challenge of time that I was talking about at the beginning. This needs a lot more time as an implementation project."

MISP and EPR Workshop Facilitators

The MIHR team conducted a competitive bid process to procure PSPs in Mozambique who could deliver the MISP training in Ancuabe. Of the applications received, one PSP with three team members stood out based on their qualifications and experience: a medical doctor with long experience in SRH in Cabo Delgado, an anthropologist with experience working with UNFPA and on SRH in emergencies, and the third with community work and educational material development experience. This group had previously developed materials and conducted the MOH/UNFPA MISP training of trainers, as well as provincial level training, including in Cabo Delgado, and thus were recognized as MISP experts.

During the training, MIHR staff commented that the PSPs facilitated the sessions well, ensuring participant engagement, and were knowledgeable about the MISP for SRH. However, the MIHR team noted that the PSPs did not start the training with specific information about the context in Ancuabe district to enable providers to develop EPRPs tailored to the needs and priorities of facilities in the district. Furthermore, one MIHR staff member noted that while the EPRPs were developed during the workshop, the PSPs did not help providers prioritize proposed actions, which resulted in generic plans with a long "wish list" of activities.

There were several challenges working with the PSPs. MIHR staff noted the PSPs had little time to prepare for the training, due to delays in finalizing the consultancy agreement while the team awaited donor approval, the need to spend funds by the end of the fiscal year, and scheduling conflicts. As a result, working with the PSPs felt rushed, there may have been miscommunications or about EPR plan development, and the MIHR team had insufficient time to review training materials. The impact of these challenges on training was not significant, as the PSPs had already conducted this training previously and only a few changes were made to the content. However, these challenges may have affected more profoundly the way the EPR plan was developed during the workshop. MIHR provided the team with the Facilitator's Kit in English and a DeepL translation in Portuguese to explain how to develop EPR plans starting with establishing a MISP readiness baseline using the MISP checklist. The baseline and EPR templates were provided in English and Portuguese, as was feedback on the agenda that emphasized using the full third day for EPR planning. The PSPs may not have understood the guidance on how to facilitate action planning effectively to generate an EPR plan that is specific and tailored to the needs identified by participants. Alternatively, due to the short implementation deadline, they may not have had time to incorporate the guidance.

After the training, the PSPs' submitted a poor-quality report. One MIHR staff member remarked, "The first report was really quite poor for me, it lacked more quality, and it took us a long time to get a more

complete report with clearer recommendations."

From start to finish with the PSP group, one MIHR staff felt that the PSPs could have been more engaged, noting that most communication between the MIHR team and the group was with one specific individual. Staff surmised that while that individual was a leading expert on the team and also comfortable communicating in English, perhaps the lack of engagement with the others was due to language issues. The challenge of working in English could have also contributed to report quality as well as any misunderstandings about their deliverables (see Community EPR workshop section).

COMMUNITY EPR WORKSHOPS

Two, three-day community stakeholder EPR workshops were conducted in Ancuabe District: one in Metoro and the other in Ancuabe. The training report states that the workshops "mainly aimed to strengthen community capacity to plan and implement its own disaster risk reduction" plan. This aligns with the workshop objective outlined in the Facilitator's Kit, which is "to build capacity at the community level to prepare for and respond to risks and inequities faced by women, girls, and marginalized and under-served sub-populations in emergencies."

Participants

According to the training report, 53 individuals from the Metoro, Intutupue, and Ancuabe health areas participated in the two workshops. Table II below lists participants who attended by type.

Table II. Community EPR workshop, number of participants by type, September 28-30 and September 30-October 3, 2023.

Type of Participant	Number
Health providers	8
Members of the health co-management committees	11
Community health workers	9
Traditional Midwifes	8
Religious leaders	2
Community leaders and members of other community structures	9
Representative of Traditional Healers Association	1
Young community activists	3
Representatives of the district health services of Ancuabe	1
Provincial representative of National Institute for Disaster Management	1
TOTAL	**53**

When asked why respondents were invited to participate in the community EPR workshops, three primary reasons emerged:

- To learn: "learn about the emergency situation in particular" – FGD Ancuabe
- To prepare: "to see how emergency works, to prepare" – FGD Ancuabe
- To share: "we have the right to participate because we bring information to the community" - FGD Intutupue and "entrusted with spreading information in the community" – FGD Metoro

During FGDs with CMC members in Ancuabe, Metoro, and Intutupue, some participants mentioned individuals they felt should be included in EPR workshops, such as religious leaders and community leaders who were indeed already invited. Others mentioned advisors of initiation rites (both males and females) and, according to one young person in a FGD said "even our mothers should take part."

Training package and delivery

Initially, community EPR workshops were intended to be based on the three-day workshop curriculum included in the Facilitator's Kit, developed by the Women's Refugee Commission. To this end, MIHR translated and adapted curriculum materials, including the agenda, slides, exercises, and handouts, for use in Mozambique. However, the training report indicates that prepared slides were not ultimately presented but instead were "transformed into questions which stimulated debates," from which "the facilitator extracted key issues and recommendations." Facilitators adopted this approach due to low literacy levels among community EPR workshop participants.

The first two and a half days of the workshop focused on providing participants with an overview of MISP objectives and principles of EPR. In the training report, the PSPs who facilitated the workshop noted that "the adapted methodology allowed the interaction between health providers and community representatives." They also prepared a "brochure" to outline a set of training guidelines, in lieu of the Facilitator's Kit materials, that can be used for future community EPR workshops.

MIHR staff observed that the PSPs may have relied more on MOH/UNFPA training package for content when facilitating the community EPR workshops given their familiarity with it, as opposed to using the materials from the Facilitator's Kit. One staff member felt that "they should have used more of the materials from that community manual [Facilitator's Kit], and it was never very clear how they adapted or didn't adapt them. I think they took advantage of the material they already had, which had been used in the Ministry of Health's package with UNFPA. So, I think that maybe there wasn't as much preparatory work as we wanted." As with the MISP training, the PSPs did not have sufficient time to prepare for the workshops, and the MIHR team was not able to adequately review and influence finalization of materials or training methodology before workshops started.

Workshop topics highlighted most frequently by FGD respondents included FP, GBV, and early marriage. One FGD participant stated, "because there I learned about contraceptive methods to prevent pregnancy. So, it was very important for me to learn that part, because what I learned stuck in my mind. And I still have it in my head. I can teach other girls to do family planning, to adhere to contraceptive methods in order to have a normal life." In addition to these SRH topics, a few FGD participants also mentioned learning about emergency situations, and one participant noted gender and GBV were workshop topics most impactful to her, explaining that "in our communities, there is gender inequality, and in my community, there is gender inequality... For example… our parents say that men can't carry plates, sweep or anything. He has more school priority than the girl."

On the third day of the workshop, the PSPs facilitated a session focused on developing community engagement plans using the template from the Facilitator's Kit (Module 3.3) called "Community Engagement Action Tool." The tool presents four questions that participants were asked to consider for each MISP objective to help them identify next steps for their communities:

- How will you convey the information back to your constituents?
- How will you continue to engage constituents as the larger action plan is being implemented?
- How can your constituents be part of the monitoring process for accountability purposes?
- What is your timeline for activities?

Instead of developing community engagement plans during the workshop, the PSPs developed them post-workshop, based on written notes about needs and priorities from the workshops. One MIHR

staff member said, “What happened was they took the difficulties theme by theme and took those findings and the proposed solutions to overcome them and drew up a plan. But it's a plan that wasn't discussed in the workshop, so that's where the challenge lies, which is why we had things [in the community engagement plan] that had nothing to do with [workshop discussions].” Another MIHR staff member concurred that “community plans were standard, not plans that responded so directly to local concerns or realities.”

The community engagement plans for Ancuabe, Metoro and Intutupue were shared with their respective CMCs in May 2024 during the first round of monitoring visits by MIHR staff, approximately seven months post community EPR workshops. Plans were reviewed to determine which activities had been implemented since the initial workshop and what communities needed to implement the planned activities.

During FGDs conducted with CMCs, only a few participants expressed experiencing challenges during plan development, citing the first-time nature of this planning experience, the need for clearer language, and the challenging themes addressed in the plans, such as GBV. One adolescent FGD respondent explained, “It's difficult for me to make a plan and how to overcome this problem of GBV.”

Community EPR Workshop Facilitators

PSPs who conducted the MISP training and EPR workshop for providers also facilitated the community EPR workshops. In addition to what was described above on the process of working with these PSPs, MIHR staff noted the first draft of the training report did not include descriptions of community EPR workshops nor the completed community engagement plans. The report revision process to ensure inclusion of community EPR workshops took six months, which seems to reflect the PSPs’ lack of familiarity with this EPR planning approach and output, particularly for the community level.

MONITORING VISITS

As noted above, the MIHR team began conducting follow-up visits to supported facilities and communities in April 2024. However, according to staff members, the approach for monitoring the implementation of the EPR and community engagement plans was not clearly defined from the start. A decision was made to apply the MISP checklist to see if any change had occurred across the six MISP objectives. However, the checklist was not linked to the EPR and community engagement plans, so it did not allow for measuring whether and to what extent specific changes had occurred. For subsequent monitoring visits in June and August 2024, MIHR developed a separate monitoring tool based on the EPR and community engagement plans that also included questions to capture information on activities that already took place and those still outstanding.

Despite the initial lack of clarity, the team felt it was helpful to reconnect with stakeholders during follow-up visits, providing an opportunity to “reactivate” activities, discuss what was accomplished, and what additional support needs exist.

> *The visits, many of them were good because they were a chance to reactivate, to see what's going on. Useful too, because they also gave us a chance to get to grips with the program itself.* – MIHR staff member

REFLECTIONS ON IMPLEMENTATION EXPERIENCE

During an FGD, MIHR Mozambique staff reflected on what they perceived to be strengths of the SRH preparedness work implemented in the past year. First, it was clear that Pathfinder's existing presence in Cabo Delgado, and specifically Ancuabe District, through the Uholo project facilitated rapid start-up of activities by leveraging existing relationships with government health officials and community structures. Second, MIHR's approach for workshops and follow-up visits was inclusive, centered on engaging and bringing together community members including representatives of civil society, key focal points for FP, GBV, youth, and pharmacy at health centers, and district and provincial health authorities. And finally, embarking on SRH preparedness work in collaboration with MIHR raised awareness among staff in Mozambique of how emergencies can impact SRH outcomes and the need for MISP and emergency preparedness activities in the country.

Conversely, MIHR staff also indicated several challenges that weakened overall implementation. The concern of feeling pressed for time was repeated during the staff discussion, and time constraints present from the start only continued to have a snowball effect on subsequent activities. Before MISP training and EPR workshops occurred, activity planning was hindered by a prolonged process in procuring PSPs which hinged on USAID Mission approval since this was a new activity in Mozambique, instability in the district due to conflict, as well as a strict deadline for the use of budgeted funds. This meant MIHR staff were running against the clock to complete preparation processes and ensure the training happened before the end of the fiscal year.

> *It was actually the confusion we were having with the funding and the availability to start. The PSPs were also under pressure because they couldn't do it in the week [proposed]…they were all spread out in different places, they had to come together and have programs, because the date came up at very short notice. The final date, because we started dragging out the date after we'd already got the consultant, we started dragging out the start date, but then the budget pressure came in and the PSPs themselves weren't available at the time.* – MIHR staff member

> *I think that we weren't aware of the fact that we needed more time, to invest more time with the communities in the district, considering that it's a district with its own fragility, where we even had to postpone some meetings because of security, so I think that the time was really short, so it was a bit of a weakness.* – MIHR staff member

According to MIHR staff, implementation gaps resulting from this initial time crunch included:

- Not involving the Health Cluster in Cabo Delgado in planning the MISP training and EPR workshops
- Not sufficiently building ownership and direct involvement of provincial and district health leaders prior to MISP training and EPR workshops
- Not reviewing PSP training materials thoroughly before MISP training was conducted
- Weaker capacity to facilitate (on the part of the PSPs) and monitor (on the part of MIHR staff) workshops with overlapping dates as both PSPs and MIHR staff were split between them

How the workshops were conducted may have resulted in a lack of understanding among PSPs about expectations for the EPR plan and community engagement plan. As a result, EPR workshops and the community engagement plans themselves were not included in the first draft of the PSPs' training report, requiring a time-consuming review process to obtain the final community engagement plans.

While plans were being finalized, MIHR took time to explore options for which entity would host community engagement plan monitoring meetings. Staff talked with provincial representative of the National Institute for Disaster Management (INGD) about forming new EPR committees, but ultimately decided it was not MIHR's role to create new committees. Instead, it was decided that MIHR should work with already-established CMCs in the three communities that were open to monitoring the community engagement plans.

> *And I also think that something that affected the implementation was that a lot of time passed between the initial training and then the follow-up. And then I think it was the delay on the part of the PSPs in delivering the report, all the feedback, all the plans. That really affected it, because that inertia between the training and the continuity in the steps, the response, was lost for a while.* – MIHR staff member

Results

- What role did SRH preparedness activities play in advancing MISP readiness or implementation?

IMPLEMENTATION OF THE EPR PLAN IN ANCUABE DISTRICT

During interviews with health professionals, nine respondents shared specific activities that occurred after MISP training and EPR workshop. The most frequently cited activity was educational talks to raise awareness about SRH topics such as unwanted pregnancies, HIV, and preventing disease. A few also noted engaging in planning and coordination efforts, as well as MIHR providing limited materials needed to support services, such as gynecological lamps and medical-surgical supplies. Conducting mobile brigades and prioritizing vulnerable populations was highlighted by one provider: "We've also been distributing contraceptive methods in the communities. Because there are some communities, as I've been saying, with a lack of mode of transportation. We've prioritized those." Another provider signaled the importance of sharing the information they received at the MISP training, "we went to all the peripheral facilities to do on-the-job training for those colleagues who weren't part of that training. The whole thing is about expanding or wanting to pass on the information we've received."

These activities align with the information captured during MIHR staff's follow-up visits to facilities and communities. See the table below for the specific activities noted in monitoring forms.

Table III. Activities noted across three monitoring visits, by health facility, April-August 2024.

MISP	Proposed Action in EPR plan	Actions Taken		
		Ancuabe	Intutupue	Metoro
Objective 2: Sexual violence prevention & response	Training of more technicians in area of GBV to increase the number of staff able to see GBV survivors		Conducted on-the-job training with seven health technicians	Training provided on GBV in emergencies package
Objective 2: Sexual Violence	Rehabilitation or construction of latrines and installation of security system.	Bathroom built but not yet operational	Bathroom built but not yet operational	Acquired partner to rehabilitate bathrooms
Objective 2: Sexual Violence	District is working with a psychiatric technician. Need support hiring a psychologist.	Contracted clinical psychologist		Facility supported by partner organization (PEPFAR hires

		to assist with GBV cases		psychologists to support GBV survivors)
Objective 2: Sexual Violence	Insufficient staff to cover all communities. Need to train community activists.		Four community activists trained	
Objective 4: MCH	Increase uptake of services by creating a community radio show to disseminate educational messages and promote SRH services in local language s			Talks at facilities by MCH nurses encouraging facility-based birth, and in communities by traditional midwives
		All districts lack funds for radio shows. A community radio in Ancuabe has worked with Uholo staff to broadcast a program on SRH and gender issues. Radio stations belonging to the Institute for Social Communication (ISC) are required to offer airtime for educational content. Ask if health staff can produce free radio programs.		
Objective 4: MCH	Long distances to reach a facility with a maternity unit offering basic emergency obstetric care. Support health system expansion including expansion of mobile brigades and building more facilities with emergency obstetric services. Partners and District Health Authorities should collaborate with ISC.			Three mobile brigades established: Nanona, Nacololo, Silva Macua
Objective 4: MCH	Reduce delays in care-seeking for women in labor. Support construction of a waiting house for mothers. Promote men's involvement in women and children's health.		Talks in facilities promoting delivering at the facility	Talks held with traditional midwives encouraging them to refer laboring women to facilities immediately
Objective 4: MCH	Development partners should support availability of medical supplies to maternity wards for obstetric complications.	Delivery of medical and surgical equipment	Delivery of medical and surgical equipment	Delivery of medical and surgical equipment

During interviews with health professionals, 10 individuals shared challenges they believe hindered EPR plan implementation. The most frequently cited challenge was insufficient funds or supplies during an emergency.

> *We don't have a lot of stuff stored away…so it's taken us a while to respond*. – Health official
>
> *It's just that when we drew up the plans, there were things that we didn't need any resources for and that we could overcome locally, but there were also other things that we did need some resources for.* – Health official
>
> *There's no shortage of challenges...I'm going to talk about my area, where I'm still having a*

lot of difficulties. Many difficulties in terms of acquiring supplies. The province or the Ministry is still not giving a satisfactory response to the needs of the district. Even if you make the requests, to get a satisfactory response, it's not even 50%. So it's a challenge. – Health official

Other challenges that emerged from interviews included:

- Lack of coordination and government support: "the government sends out a message that it doesn't give importance to certain actions. So, this also affects proper implementation." – UNFPA representative
- The need for more people trained: "If we can get grassroots structures involved, as well as the population knowing where they stand, that can also help to have an impact on the implementation of this plan." – SDSMAS
- A changing population: "People move around all the time. It's very difficult to locate our points, our target groups." (Health provider)
- Lack of transport for mobile brigades, as well as social and cultural barriers: "The things that prevented some of the plans from being implemented…was the means of transportation, then another thing is the community itself, because of the taboos that we're still challenging." – Health provider

Relatedly, nine interview respondents also offered their perspectives on what the district or their facility needed to strengthen implementation of their EPR plans. Aligned with challenges faced, resources (including supplies and infrastructure needs) were mentioned by five respondents, while training, transport, community involvement, and outreach were each mentioned by two respondents. In terms of community involvement, one health provider said they "could increase the number of community actors to give more talks, especially in places where people are most concentrated. For example, in mosques, churches, the market." Another provider shared they "need more community involvement, at that time we had the involvement of Co-management Committees, but we can also involve the matrons [traditional midwives], as they are women, and the community trusts women more than men. So, we can get these women involved."

When asked whether the EPR plan meets the needs of women, youth, and other vulnerable populations, only one of eight respondents reported no, specifying that vulnerable women and girls need a post-emergency safety plan that ensures basic needs are met and that they are not exposed to GBV. Some of those who responded yes provided caveats that the EPR plan meets the needs of vulnerable populations if funds are available to support prioritized activities.

Health professionals interviewed believe the EPR plan will help facilities implement the MISP for SRH. Specifically, two individuals noted the EPR plan will help them raise awareness about the MISP and prepare, as summarized by this provider: "This plan has helped us because we've been able to sit down, analyze, and see what the priorities are and we've been able to discuss how long we can do this activity. So, it helped us prepare for the situation on the ground."

Others shared that if there's coordination and community engagement led by community leaders and APEs that is adequately resourced, the EPR plan will help with MISP implementation. Some respondents explained that the EPR plan will only move forward if there's local ownership, partners, resource availability, and continued training, monitoring and support for mobile brigades that take

SRH services to the communities. According to eight respondents and MIHR team members, those responsible for implementing the EPR plan are health authorities at provincial and district levels.

> *The (development) partners must be there to facilitate the activities or to support the government's activities. It is the government that should take the lead. The technical group should be led by the government, assisted by the partners.* – UNFPA representative

> *The first step is ownership. Handing over these plans to the health unit...These plans have to be handed over to the provincial health directorate and the district. And it's supposed to be a monitoring activity. They do this monitoring of activities.* – MIHR staff member

Some respondents mentioned that CMCs should lead on relevant community activities, while one individual said development partners should support the health sector in EPR plan implementation.

IMPLEMENTATION OF COMMUNITY ENGAGEMENT PLANS

FGD participants said CMCs in all three communities held educational talks since the EPR workshops.

> *We transmitted the message from there to the community. Life began to improve.* – FGD participant, Intutupue

> *Through meetings in the community, where there are a lot of people, so we provide information. These are lectures that we're giving to people in the village.* – FGD participant. Intutupue

> *As I said, we do talks, debates, both the emergency debate, so that people can come prepared, even though we haven't had any emergencies yet*. – FGD participant, Ancuabe

> *We've done some community learning. Family planning. As well as gender-based violence. If someone says they've been raped, they should report it.* – FGD participant, Metoro

Table IV. Activities noted across three monitoring visits in the three target communities, April-August 2024.

MISP	Proposed Action in CE plan	Actions Taken		
		Ancuabe	Intutupue	Metoro
Objective 2: Sexual Violence	Hold talks to raise awareness among families and in communities about GBV	Community awareness activities initiated on preventing sexual violence and referring survivors to services.	Began conducting community awareness activities. Allocated communication materials such as banners. Trained CMC members.	Began GBV awareness-raising activities. Received materials for awareness-raising and on-the-job training. Four talks held on reporting cases of violence. Increase in community awareness that survivors first go to facilities, then to police
Objective 4: MNH	Carry out awareness raising campaigns	APEs and traditional midwives held community talks to encourage pregnant women to attend prenatal visits and seek care at a facility at labor onset to deliver in maternity ward.	APEs were trained. Monthly mobile brigades conducted. Activities in communities carried out in coordination with community component for mobilization.	

Objective 5: Prevent unintended pregnancy	Organize community debates to promote FP services			Awareness raising referring people to facilities for FP methods.

CMC members shared challenges and ongoing needs that hindered community engagement plan implementation. One challenge centered around socio-cultural barriers and misinformation in communities, with one FGD participant noting, “We've encountered challenges in the community, because there are those who understand and those who don't and begin to deny the things we're saying [about fertility and the use of contraceptive methods], but in reality, a larger number are accepting the information. But in the community, you can find young people and adults who contradict us.” Another challenge was the support needed for awareness-raising efforts, including information, supplies, and IEC materials, as well as megaphones.

> *The community always needs support. It needs moral support, psychological support. So, therefore, the community needs this help and, above all, it also needs a lot of information. The community, in particular, needs a lot of information from community radio, from lectures, from theaters. So, to get the information and always be in the process.* – FGD participant

Some FGD participants felt community engagement plans will help MISP implementation in emergencies by guiding efforts to raise awareness among community members and promote use of health services.

> *We know that whatever we're trained to do there, we'll have no trouble introducing [it] to the community. The community will actually listen to us, with that information, the community will understand and will go to the health unit*. – FGD participant, Metoro

Others FGD participants noted that community engagement plans will help communities coordinate activities with health facilities. One respondent said, “The health unit, together with the community, will be united.”

However, as was noted with the EPR plans among providers, one community member reminded the interviewer and others in the FGD that the plans will only help if implemented. “Program made with the plan. So, if we go within the plan, it means that things will improve. But when you're out of it, things won't improve.” CMC members highlighted that support is needed in order for activities in the community engagement plans to move forward, which focused on continuing to raise awareness about SRH issues such as GBV and FP. One FGD respondent noted the specific need of a development partner organization to work alongside communities and feared activities would stop as Pathfinder, the only partner supporting SRH work in Ancuabe district, is no longer able to provide support. Another FGD respondent mentioned the need for more materials to support their community talks.

FGD respondents recognized that their role goes beyond implementing specific activities in the community engagement plan, noting that the CMCs, together with community leaders and APEs, are responsible for holding facilities accountable for providing essential SRH services during emergency situations.

PERCEIVED GAINS IN CAPACITY

All 11 interview respondents said they believe MISP training will help them respond differently in emergency situations. Seven explicitly mentioned that due to the training, they now know what to do.

> *Because from then on, you know how to act in emergency situations. This helps a lot for the person's life, as well as the others who are there. So I think it's had an impact. Even if it's small, but there is an impact*. – Health official

> *We should respond differently because we've now been trained and we're now prepared for what's going to happen, we're anticipating what could probably happen.* – Health provider

> *I think each of us now knows our role, what to do in that situation.* – Health provider

Similarly, CMCs also felt that they would respond differently after community EPR workshops because they gained knowledge of what to do.

> *So in the event of an emergency, I would act, first thinking about what I've learned.* – FGD participant, Ancuabe

> *Because we've been trained, we have the knowledge to be able to regularize the situation.* – FGD, Intutupue

MIHR staff's observed changes in participant knowledge align with these stated views. Since MISP training and EPR workshops were new to Ancuabe district, they believe there is a greater awareness among those trained of what to do in emergency situations, on the availability of MISP RH kits, and greater general familiarity of SRH issues in emergencies. This perception stems from follow-up visits conducted with stakeholders in each supported facility and community. These changes are also corroborated by pre-post test results among MISP training participants. On average, 58.4% of participants provided correct answers to the pre-test questions. This increased to 85.6% of participants at post-test.

A few interviewed respondents specified that response in emergencies would be different due to the training because they now know how to better prioritize.

> *Because of verticalization, sometimes health professionals have some programs that, perhaps because of funding, are given higher priority, but which in a way may not have a great impact in an emergency situation or may, in the order of prioritization of activities, not be at the top when you want to save lives.* – UNFPA representative

> *Health has to respond according to priorities, including the target group most affected. So, we're going to work in this context, we're going to see what the priorities are, we're going to see which target group is most affected. In these situations, it's women, adolescents, and young people.* – Health provider

Not only gaining an understanding of priority activities, one health worker reported that she would respond differently in an emergency as the MISP training "left us a responsibility [to respond]".

At community level, FGD respondents focused on their capacity to share knowledge they've gained with others. One respondent remarked, "I could talk to the community when I got there, knowing that I had been trained. I could bring those people together and tell them what I was trained to do."

PROPOSED ACTIONS TO ENSURE ESSENTIAL SRH SERVICES

When discussing how providers would ensure SRH service continuity in an emergency, nine of 11 interview respondents (including a CMC member) focused on conducting mobile brigades or relying on APEs, emphasizing the need to reach people where they are with contraceptive methods and other information and services as part of an integrated health care package.

> *We, as health professionals, have an obligation to set up mobile brigades*. – Health provider

> *If we're in an emergency, we'll offer the services wherever we are. And for example, we can offer contraceptive methods in the community.* – Health provider

> *The only way to guarantee these situations is to set up mobile brigades. A mobile brigade is when we try to carry the health service to that point where those people are located, how can I say, displaced people… So we're the ones who have to go and meet them to offer all those services.* – Health official

> *We just have to mobilize the community of informal workers who are appearing in mobile brigades here, we have to go there to get these medicines because we are in a time of emergency*. – FGD participant, Metoro

One interview respondent highlighted the need to bring information about SRH in emergencies to schools to better reach adolescents and involve them in emergency response.

> *If we still had the opportunity, we would still have to maintain some activities, as what we don't have here is access to adolescent services, even in schools….so, from the boys and girls there in the schools, to have the information that in an emergency situation we're going to act like this, like this, like this, in terms of FP, in terms of other services…If we had access to schools...children would know, teenagers would grow up knowing that it's like, let's say, getting through an emergency situation. ...Because we already have the grassroots structures, the community meetings, but we also need, starting with the schools, to bring this together so that they can speak the same language everywhere.* – Health official

Two other interview respondents offered a different perspective on ensuring service continuity, focusing on supporting providers sufficiently so they can best care for others.

> *Health professionals are also affected. Depending on how they are affected, it can interfere with their provision of services*. – UNFPA representative

> *The good lesson is that the providers who are in the health units or conflict districts, they are displaced, but it doesn't take away the reason they can't assist users where they are going to be assured. When they leave the place of conflict, they are displaced, they come to a safe place and they integrate into a health unit. He is starting to be a provider again and has to continue to provide services*. – Health official

VALUE OF THE MISP AND EMERGENCY PREPAREDNESS PROCESS

During interviews and FGDs, stakeholders reflected on whether and how the MISP and EPR process differ from routine FP programming and planning. All interview respondents and FGD participants concurred that the two processes are different. The most common response was related to the need for more supplies. For example, according to health workers, stock forecasts and requisitions must maintain a greater supply, and provision of contraceptive methods should cover a longer time period.

In an emergency, we'll take a quantity according to the stock we have in our warehouse. If there's a small amount, we can take it all, because we don't know when we'll return to our normal activities. – Health provider

Let's talk about FP. We have to have enough supplies first to give them a period they want to consume. A pill packet, for example, instead of leaving one pack, the likelihood of us leaving three or six is greater [in an emergency] because we're not seeing clients regularly. So, we'll leave a quantity of contraceptives to make up for that period when we won't be in the community. – Health provider

So, if we're dealing with an emergency, we have to have emergency medication that will last a long time… We can order in emergency matters, stored to answer the MISP. – Health provider

It's different, let's say, when it's a family planning center, when it's an emergency, I know how to manage it. For example, if I'm doing Depo, I'll manage it by month. Every month I have to go to the health unit to do the planning. It's routine, then. When it's an emergency, I increase the medication, I use it and for the forecast I increase it. – FGD participant, Ancuabe

Similarly, other respondents remarked on the need to adopt different priorities or strategies during an emergency situation. Health authorities underscored the MISP focus on saving lives first and recognized that strategies have to be adjusted to account for changes in the population or the urgency of the situation. As one health official put it, "In our case, we receive many, many displaced people. So, then we need to turn the normal strategy into an emergency strategy, so automatically the strategies are different." Another official noted, "Because in an emergency, you have to run more." Even from an individual perspective, one community member explained that a different FP strategy may be adopted during an emergency instead of their routine method – "while the emergency one has to apply a long-term method because she's in the moment of emergency."

The uncertainty of crisis situations also affects how SRH services are planned and provided, as a health worker explains "because in an emergency we don't know when we're going to get back to normal. It's different from making a routine plan." CMC members in FGDs also highlighted the unpredictability nature of emergencies and its effect on planning.

Because on a day-to-day basis, you have an appointment. Whereas emergency appointments start at the beginning. – FGD participant, Metoro

Emergencies are emergencies, routine is what you predict. – FGD participant, Intutupue

Given stakeholders' perceptions on the differences between routine FP programming and the MISP, all interview and FGD participants also felt there was no specific time when emergency preparedness activities would be most useful. Rather, they emphasized they must always be prepared.

This first step starts with preparation, which means we don't need to be in crisis. Even now, we can start with small actions to implement the MISP, which are training technicians, setting up groups, setting up a monitoring system, setting up a logistics system in case the situation arises. – UNFPA representative

It means every day we have some situation to anticipate and we are prepared for every day. Now, we don't relax. That's what our cluster and technical group meetings are about. Every

day we check if there's stock, which partner is in X place, how we're doing. It's every day and when the whistle blows, everyone has to run. – Health official

As a provider, I have to be prepared at any moment. – Health provider

There isn't a moment to say now I'm going to prepare, every moment is a moment of preparation. – FGD participant, Metoro

REACTIVATION OF THE SRH CLUSTER IN CABO DELGADO

In Cabo Delgado, the SRH Cluster appeared dormant when MIHR began the SRH preparedness activity. MIHR staff were not aware of the Cluster's existence until informed by its chair, UNFPA. Once MIHR understood the Cluster existed but was inactive, the team worked with UNFPA and the Provincial Directorate of Health to reactive the group.

If this cluster of sexual and reproductive health within the humanitarian team in Cabo Delgado really is reactive and works, I would consider it a gain of this project that it managed to get it off the ground. And the pity was that we didn't start doing this at the beginning of the project, not even before we started, because then we would have learned more about INGD, about how UNFPA is working in Cabo Delgado … We found out about this cluster later. And I think we helped to reinvigorate it…because they've decided to hold monthly meetings. And I don't know if it will, but for me it would be a positive point of sustainability. – MIHR staff member

Lessons Learned and Recommendations

- How can implementation of this SRH preparedness work be strengthened?

During interviews, health sector stakeholders provided recommendations for improving MISP implementation in Ancuabe district, listed below with direct quotes to illustrate key points.

- Improve coordination (four respondents): *It's important that the parties are informed and involved throughout the process. The essential is communication*. – Health official
- Train more health workers (three respondents): *The issue I really wanted to add is not to reduce the number of providers and people to be trained. We know that... the providers from the conflict district themselves are displaced, but they also come to join the district that accommodates them. The number of staff increases. There are our APEs, there are our community activists. They are also displaced, but they have to come and assist their community. So let the number be more comprehensive. And maybe all levels need to be trained in the MISP package.* – Health official
- Engage the community (two respondents): *Here we have to involve the community a lot. The community has to be informed of this activity and we have to make great use of the leaders, the community lead*ers. – Health provider
- Ensure provision of supplies (two respondents): W*e have to have kits, we have to be prepared, we have to organize emergency kits. For those of us who requisition, we have to requisition with a stock, looking at emergency issues.* – Health provider
- Allow local ownership (two respondents): *The improvement I was going to ask for would be the management of the funds, which is centralized. At least be provincial, where you can coordinate with the people in the province and know that now we're going to carry out activity X of the plan.*

The plan can also be shared with the district and say that within this plan that you have, we now want to do this thing. Then yes, everyone is on the same path. – Health official

- Continue with routine monitoring and follow-up (two respondents): *Also continuing with the meetings. They can be monthly or depending on the situation.* – Health official
- Provide dedicated safe space (one respondent): *For social and reproductive health issues, family planning, GBV, cervical cancer, and the supply of long-acting methods, we need privacy. We need a safe place to put our medicines and supplies.* – UNFPA representative

The recommendations offered by CMC members during FGDs are similar to those provided above. The suggestion to ensure supplies and materials are available for facilities and communities to implement emergency preparedness activities was most frequently mentioned by FGD participants.

In emergency situations, we mainly want the health department to have enough medicines so that we can be prepared. – FGD participant, Ancuabe

CMC members in Ancuabe recommended "support for work materials, support in terms of small meetings to reflect on the activities [CMC members] have been carrying out." FGD participants recommended training more APEs in communities and supporting transport for mobile brigades.

During the staff discussion, the MIHR team put forth recommendations related to the project's implementation approach for SRH preparedness:

- **Hold an orientation or training session for the project management team on SRH preparedness.** MIHR Mozambique staff involved in this initiative did not have direct experience working in humanitarian assistance. They have focused more on health and development programming but growing vulnerability to climate crises and conflicts in certain parts of the country, particularly in the north, has meant most staff have had to respond to emergency situations in their programs. However, they feel they would have benefited from more awareness and preparation in the beginning rather than having to learn while doing.
- **Connect with UNFPA and the SRH Cluster first to ensure coordination and continuity of SRH preparedness activities**. With Pathfinder leaving Ancuabe district, there are no other development partners that can continue providing support to facilities and communities for SRH preparedness activities. Staff felt if the project had begun working with the SRH Cluster from the beginning and with more time to strengthen the group, there would have been a structure in place to support the province and district in ensuring activities move forward.
- **Call a joint meeting to present the EPR and community engagement plans with the district health director and provincial chief medical doctor.** These two individuals are responsible for monitoring implementation of the plans at provincial and district levels. Given this, MIHR staff said the project should have engaged them more, particularly in the beginning, to cultivate a sense of ownership for this work. As one staff member put it,

  Once the results of the consultancy came out, immediately, the plans should have been made in a joint meeting. We held meetings…in between, we did one and then went to do another. If they had held… the meeting to present the results, in which the district director and the chief doctor were in the province… they would all have gone there at that time to say, look, this is the launch of the plan, the plan is with you, follow it up.

- **Explore the possibility of other partners and projects in province to continue the SRH preparedness work in Ancuabe district and Cabo Delgado.** Many FGD and interview respondents lamented that with Pathfinder's departure from Ancuabe district given the end of the Uholo project, there are no other partners working in SRH that can continue to support SRH preparedness activities.
- **Keep facility and community EPR planning workshops separate, but ensure plans are shared and discussed with each other.** MIHR staff felt EPR workshops should still be held separately, but emphasized the need to bring the two stakeholder groups together to present plans. This is particularly important for communities, as CMCs can hold facilities accountable in following through with their plans and commitments.
- Ensure any materials used with communities are tailored to a low-literate audience.

LIMITATIONS

We note a few limitations to this documentation effort. First, because the data collection period coincided with presidential election campaign activities in the target districts, three selected key informants, including a representative of the National Institute for Disaster Management, were not available as well as several CMC members in Ancuabe. Despite this, the team interviewed all other key informants at district, provincial, and facility levels. Secondly, due to budget constraints, the data collector selected for this documentation effort was a MIHR Mozambique staff member (hired by Pathfinder). This reality likely introduced both an interviewer bias and a courtesy bias to the data collection process, which in turn may have influenced interview and FGD responses. However, in reviewing the transcripts, we noted that respondents did provide critical feedback and suggestions for improvement. Finally, some questions in the interview and FGD guides were not clearly understood by respondents and thus did not generate the information we were looking to capture. The team did not have sufficient time to pre-test interview guides, which would have helped identify comprehension issues and allowed for standardizing revised questions prior to data collection.

CONCLUSIONS

This SRH preparedness activity in Cabo Delgado had two main objectives: to strengthen capacity of local actors to be prepared to deliver a minimum package of essential SRH services in an emergency and to share the results of what is learned from this pilot activity to inform plans to integrate SRH preparedness activities into broader health programming in Mozambique and beyond. As the interviews show, various health worker cadres received MISP training and demonstrated higher knowledge of MISP preparedness as a result of training and through repeated review of EPR plans to implement what they could over a short time frame.

Although respondents indicated that MIHR identified a good range of health staff for participation, in future iterations of this activity, more time needs to be invested in identifying civil society leaders to engage as partners before the training and EPR planning workshop. While there are not many CSOs and local NGOs in Ancuabe district, there was at least one other GBV support group that could have been involved. Other recommendations include providing more upfront orientation for facilitators on SRH preparedness and working with humanitarian partners and structures from the beginning. In future MISP training and EPR workshops, we recommend trainees visit facilities to conduct a MISP

checklist review to establish a MISP readiness baseline to inform EPR plans. During implementation, there were no major service delivery disruptions caused by shocks with which to test the level of health system preparedness, but periodic EPR plan reviews identified supply and material needs, some of which were addressed by MIHR. UNFPA offered to provide RH kits when requested by district or provincial authorities.

After community EPR workshops, CMC members in all three communities reported engaging with their constituents about SRH preparedness actions. In addition to what was covered at a high level in the EPR workshops, the CMCs needed additional support for developing community message campaigns and purchasing banners and garments to identify them as legitimate messengers for promoting SRH preparedness. FGD respondents recognized that their role goes beyond implementing specific activities in the community engagement plan, noting that the CMCs, together with the local community structures, are responsible for holding facilities accountable for providing essential SRH services in emergencies.

In terms of influencing the broader SRH preparedness agenda in Mozambique, there are several streams of preparedness activities into which MIHR results can support. For instance, in May 2024, USAID Mozambique met with Implementing Partners and recommended incorporating emergency preparedness training into bilateral projects, ideally before cyclone season. In response to this call and SRH preparedness needs identified among IDPs in Nampula province, USAID approved a Pathfinder proposal to expand the SRH preparedness activity to two districts bordering Cabo Delgado. Lessons learned from this activity will be applied in the USAID-funded Improved Family Planning Initiative (IFPI). With technical support from MIHR, staff in Cabo Delgado planned to conduct a training of trainers for IFPI staff, taking care to provide sufficient information about how a development project can advance SRH emergency preparedness activities alongside humanitarian actors.

Future MISP training agendas could include additional time for establishing a MISP baseline, detailing and prioritizing gaps, and clarifying with local actors on how to lead follow-up processes. The community engagement workshop will still be conducted separately, and workshop materials will be simplified from the original Facilitator's Kit. Importantly, MIHR will explore merging EPR and community engagement plans for joint tracking by health system and CMC members for mutual transparency, support, and accountability.

As a relatively new intervention, MIHR had planned to share these results with a broad array of local, national, and global stakeholders. In Mozambique, MIHR will share these lessons learned with stakeholders in Ancuabe, Metoro, and Intutupue, at the Provincial level in Pemba, with similar types of stakeholders in Nampula, and in the capital city of Maputo with the MOH, UNFPA, USAID, as well as the FP and GBV technical working groups. Currently, a MISP process evaluation is being organized by the SRH Task Team of the Global Health Cluster to document progress on the Mozambique 2022 MISP Readiness Assessment action plan. These lessons learned will be shared with the evaluation team. Globally, MIHR will share these results with SRH experts who work in the humanitarian-development-peace nexus in a webinar series organized by MIHR, FP2030, and PROPEL Adapt..

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Senior MEL Advisor (Connie Lee) and MIHR MEL colleagues. Interviews and FGDs were conducted by a Senior Technical Advisor for Adolescent and Youth (Joana Cunaca) SRH in the Pathfinder Mozambique office, based in Maputo, who is experienced in conducting interviews and FGDs and has provided technical assistance in implementing this activity. Data analysis was led by the Pathfinder Senior MEL Advisor, with technical support from MIHR's Deputy Technical Director and Pathfinder Mozambique staff. The Pathfinder Mozambique country office provided additional technical input, as well as operational and logistical support for data collection and management. The team is grateful to the health officials, providers, and community members who shared their insights and experiences to inform results.

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ANNEX 1: QUESTION GUIDES

Interviews with provincial and district health authorities and health providers

MISP for SRH - Providers Training

- Did you participate in the MISP for SRH training for health providers?
    - Why do you think you were invited to participate in these activities?
    - Are there any other key groups or individuals that should be involved in the MISP training?
- What did you learn about MISP for SRH during the training?
- What has occurred since the MISP training? Please describe (what changes, what actions, among who, support received/provided, why certain actions were prioritized, etc).

Emergency Preparedness and Response (EPR) Action Planning

- Did you participate in the development of an emergency preparedness and response (EPR) plan?
    - What challenges were faced during the development of the EPR plan?
    - Are there other groups or individuals that should be involved in developing the EPR plan?
- Are the MISP and emergency preparedness processes different than routine FP/RH programming and planning? If so, how are they different?
- In what situations are emergency preparedness and MISP most useful? Where/when are they not useful?
- Do you feel the EPR plan addresses the specific needs of women, youth, and other vulnerable populations? Please explain.
- How do you think the development of the EPR plan will contribute to the ability of health facilities and communities in Ancuabe to implement the MISP during emergencies?
    - What challenges have hindered further actions from being implemented?
- Is there anything that the facility needs to improve its implementation of activities in response to an emergency? If so, what are those needs?
- How will actions identified in the EPR plan continue to move forward? Who will take the lead?

In Cases of Emergency

- Since the MISP training, have there been any emergencies or shocks in your community?
    - If so, what type of shock(s) occurred and when?
    - Did the shock disrupt SRH services (FP, GBV, maternal/newborn, or HIV/STI)?
    - What type of SRH services were provided immediately after the shock?
    - Did health providers or community members respond differently because of MISP training or EPR action planning?

If no specific event, ask about a hypothetical emergency scenario related to insecurity.

- Which SRH services are most likely to be disrupted by insecurity?
- Would health providers or community members respond differently because of MISP training or EPR action planning?
- If services are disrupted by a shock, how do health providers ensure essential SRH service provision?
- How can we apply what we've learned about being prepared to provide MISP for SRH in cases of emergency? How can we support the community in the event of an emergency?
- What are your suggestions for improving MISP readiness and implementation in your setting?

Focus Group Discussions with Community Members of Co-Management Committees

Emergency Preparedness Workshop

- Why do you think you were invited to participate in the workshop?
  - Was there anyone else that you feel should be invited to participate in the workshop?
- What did you learn about SRH preparedness during the workshop?
- Which topics or themes discussed at the workshop impacted you the most and why?
- What were the main concerns raised during the workshop?

Community Engagement Action Planning

- Did you participate in the development of a Community Engagement (CE) plan?
  - What challenges were faced during the development of the CE plan?
  - Do you feel the CE plan addresses the specific needs of women, youth, and other vulnerable populations? Please explain.
- How do you think the development of the CE plan will contribute to the ability of facilities and communities in Ancuabe to implement the MISP during emergencies?
- What actions have taken place since the plans were developed? Please describe (who undertook them, what support was received/provided, why these actions were prioritized, etc.).
- What challenges have hindered further actions from being implemented?
- Is there anything the community needs to improve its implementation of activities in response to an emergency? If so, what are those needs?
- How will actions in the CE plan continue to advance or move forward? Who will take the lead?

In Cases of Emergency

- Have there been any emergencies since the workshop?
  - If so, what type of shock(s) occurred and when?
  - Did the shock disrupt SRH services (FP, GBV, maternal/newborn, or HIV/STI)?
  - If so, what type of SRH services were provided immediately after the shock (FP, maternal and newborn care, GBV, or HIV/STI)?

If no specific event, ask about a hypothetical emergency scenario related to insecurity.

Which SRH services are most likely to be disrupted by insecurity?

  - Would health providers or community members respond differently because of MISP training or EPR action planning?
- If services are disrupted by a shock, how would the co-management committee ensure essential SRH services are provided?
  - Who holds local authorities/health providers accountable for providing essential SRH services when a shock/crisis occurs?
- What suggestions do you have for improving MISP readiness and implementation in your setting?

Group Discussions with MIHR Mozambique staff working on SRH Preparedness Activity in Ancuabe District

1. What was the objective of the program? From your perspective, was this objective met? Please explain your response.
2. Based on your experience supporting implementation:
   a. What were the program's strengths?
   b. What were the program's weaknesses?
3. Please describe the process and outcomes of working with the consultant. Reflect on the following:
   a. Qualification and preparation for the SOW
   b. Execution of the SOW
   c. Is there anything we could have done better to improve the process and outcomes of the consultant's work?
4. Let's discuss the MISP training in more detail. Reflect on the following.
   a. What went well?
   b. What did not go as well?
   c. Did you think the training was sufficient to prepare health workers for implementing the MISP? If not, what particular areas do you think need additional training or mentorship?
   d. How would you do things differently the next time?
5. Now let's talk more about the EPR and CE action planning workshop. Reflect on the following:
   a. What went well?
   b. What did not go as well?
   c. Do you think actions identified in the EPR plans will continue to move forward? Who will take the lead? Explain your response.
   d. Do you think actions identified in the CE plans will continue to move forward? Who will take the lead?
   e. How would you do things differently in the future?
6. Specifically thinking about the training and workshop materials, would you recommend keeping them as is (3-days each), or do you think the materials should be modified? If so, how? Would you combine them and only use the EPR workshop materials for all stakeholders (health workers, govt, civil society etc).
7. Moving on to the monitoring visits. Reflect on the following:
   a. Were the visits helpful, and if so, for whom?
   b. What could we have done better to make these visits more productive or useful?
   c. How would you do things differently in the future?
8. What changes have you observed since the program began? Be as specific as possible and provide examples.
   - Reflect on the awareness, attitudes, beliefs, or behaviors of people involved
   - Consider changes in systems, policies, available resources, etc.
9. Do you feel that the MISP and emergency preparedness processes are different than routine FP/RH programming and planning? If so, how are they different?
10. In what situations do you think emergency preparedness and MISP are most useful? Where/when are they not useful?
11. Is there anything else (observations, perspectives, recommendations, etc) you would like to share that I have not already asked about?

ANNEX 3: RESPONDENTS

Respondents and Sample Sizes

Respondents	Sex	Location	Number
Key Informant Interviews			
Provincial MCH Focal Point – DPS	Female	Pemba	11
Emergency Response Focal Point – UNFPA	Male	----	
District Chief Medical Doctor – SDSMAS	Male	Ancuabe	
District Pharmacy Focal Point – SDSMAS	Male	Ancuabe	
District GBV Focal Point – SDSMAS	Male	Ancuabe	
Director of Health Facility and Community Involvement Focal Point	Male	Intutupue Health Center	
SAAJ Focal Point	Female	Metoro Health Center	
MCH Focal Point	Female	Metoro Health Center	
Community Involvement Focal Point	Male	Ancuabe Health Center	
Community Involvement Focal Point	Male	Metoro Health Center	
SAAJ and MCH Focal Point	Female	Ancuabe Health Center	
Focus Group Discussions			
Co-Management Committee Members: - President - Young person	 Male Female	CS Ancuabe sede	2
Co-Management Committee Members: - President - APE - Traditional birth attendant - Community leaders	 Male Male Female Male	CS Intutupue	4
Co-Management Committee Members: - President - APE - Young person - Traditional birth attendant - Community leaders	 Male Male Female Female Male	CS Metoro	5
MIHR Mozambique staff: - Project Director, Uholo Raparigas - Technical Director, Uholo Raparigas - Senior Advisor, Adolescents and Youth - Senior Program Officer	 Female Female Female Male	Virtual	4
Total			**26**

ANNEX 4: SAMPLE SRH EMERGENCY PREPAREDNESS PLAN

Name of District/Community: Ancuabe **Number of Hospitals:** 0 **Number of Health Centers:** 9

SRH Preparedness Action Plan		Baseline		How will gap be addressed?	Time to address gap?	Responsible Lead (person or org)	How measured?
1. SRH Lead Agency and SRH Coordinator							
1.1	Lead agency		N	WHO is leading at provincial level. Suggest leadership of District Health Authority.	Quarter 1	District Health Authority and Partners	Number of meetings/ month
	SRH Coordinator		N	UNFPA leading at provincial level. Suggest leadership of District Health Authority.	Quarter 1	District Health Authority and Partners	Number of meetings per month
1.2	SRH stakeholder meetings established and meeting regularly		N	Suggest establishing regular meetings between District Health Authority leaders and SRH partners.	Quarter 1	District Health Authority	Number of meetings, Number of partners in meeting
	Sub-National/district (BIWEEKLY)	Y		Participation in provincial meetings not regular. Need to reinforce participation.	Quarter 1	Health Authority and Partners	Number of meetings
	Local (WEEKLY)						
1.3	Relevant stakeholders lead/participate in district SRH Working Group meetings		N	Create or reorganize the SRH group. Orientation for the stakeholder to start participation in meetings.	Quarter 2	District health Authority	Number of stakeholders who attend meetings
	Ministry of Health	Y		Participation at national and some time at provincial level	N/A	N/A	N/A
	UNFPA and other relevant UN agencies	Y		UNFPA participates at provincial and district OCHA coordination meetings. Post meeting reorganization, districts will include UNFPA participation.	Quarter 2	District Health Authority	Number of UNFPA participants in district meeting
	International NGOs	Y		Some supporting the district, but need to reinforce coordination actions and meetings.	Quarter 2	Partners	Number of meetings
	Local NGOs	Y		Some supporting the district, but not coordinating or participating in meetings. Need to reinforce coordination actions and meetings.	Quarter 2	Partners	Number of meetings

ANNEX 5: SAMPLE COMMUNITY ENGAGEMENT PLAN

Objective MISP	Description of problem	Risk	Objective	What to do? (Activities)	Where	Who	When	Resources	Monitoring
Coordination	Lack of community and civil society involvement in managing health sector-related emergencies	Poor adherence to emergency response services in the health sector	Provide space for involvement of all actors (community, civil society) for better management and response to emergencies in the health sector	Create multisectoral and multidisciplinary working groups with active involvement of community actors and civil society	Communities in coordination with health sector, civil society, youth groups, APEs, traditional midwives	Community and religious leaders, health committees, Associations, APEs, traditional midwives; Community-based cooperation partners	Immediate and continuous	Financiers for regular coordination meetings	Meeting reports
		Risk of making decisions that do not reflect contextual reality							
		Risk of increasing unofficial alternatives in managing of emergency response services	Improve distribution of tasks for each actor involved	Creation of specific tasks for each actor for better ownership	In civil society associations, in community, in the health sector	Communities in coordination with health sector, civil society, youth groups, APEs, traditional midwives	Immediate and continuous	Resources for meetings and refresher training for community structures	Accountability meetings

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Integrated Health Resilience

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