ADVANCING PARTNERS & COMMUNITIES

# COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: MOZAMBIQUE

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**Advancing Partners & Communities**
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**JSI RESEARCH & TRAINING INSTITUTE, INC.**
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@advancingpartners.org
Web: advancingpartners.org

# ACRONYMS

| | |
|---|---|
| APC | Advancing Partners & Communities |
| APE | agente polivalente elementare (elementary polyvalent agent) |
| CHS | community health system |
| DDSMAS | Direcção de Saúde, Mulher e Acção Social (District Health, Women, and Social Action Directorate) |
| DPS | Direcção Provencial de Saúde (provincial health directorate) |
| FP | family planning |
| iCCM | integrated community case management |
| IUD | intrauterine device |
| MISAU | Ministério da Saúde (Ministry of Health) |
| NGO | nongovernmental organization |
| PESS | Plano Estratégico do Sector da Saúde (Health Sector Strategic Plan) |
| SIS | Sistema de Informação de Saúde (health information system) |
| TB | tuberculosis |
| UNICEF | United Nations International Children's Emergency Fund |
| USAID | United States Agency for International Development |
| WASH | water, sanitation, and hygiene |
| WHO | World Health Organization |

# INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

# MOZAMBIQUE COMMUNITY HEALTH OVERVIEW

Mozambique's main community health program revolves around the *agente polivante elementare* (APE), the country's key community health provider. APEs were first introduced in 1978 alongside a growing global interest in primary health care. Though they originally conducted health promotion and disease prevention activities, their scope has evolved over the years to include activities such as first aid and referral for signs of common illnesses. APEs have experienced periods of inactivity due to the country's turbulent political and changing health context. During the 1980s, they nearly disappeared during a lengthy civil war. In the 1990s, community health activists emerged in response to the HIV epidemic, causing confusion about the respective roles of community health providers and duplication of efforts.

In 2010, Mozambique's Ministry of Health (MISAU) revitalized the APE program to ensure greater efficiency and sustainability of community health services. The renewal formalized the cadre and better defined APE roles and responsibilities within the larger health system. A document entitled *APE Revitalization Program* outlines their scope of work, coverage, selection, training, supervision, and incentives as well as plans for the program's management, budget, financing, and monitoring. The APE program is financed by the United Nations International Children's Emergency Fund (UNICEF) and the World Health Organization (WHO) and implemented by the MISAU and supporting nongovernmental organizations (NGOs). It operates primarily in rural areas and is scaling nationwide.

In 2016 and 2017, the country has been in the process of updating the APE program, but has not yet released related policies or guidance. Thus, this profile draws information from the 2010 program description as well as more recently developed policies and strategies.

**Table 1. Community Health Quick Stats**

| | | | |
|---|---|---|---|
| Main community health policies/strategies | *Programa de Revitalização dos Agentes Polivalentes Elementares (APE Revitalization Program)* | *Estratégia Nacional de Promoção de Saúde 2015–2019 (National Health Promotion Strategy)* | *Plano Estratégico do Sector da Saúde (PESS) 2014–2019 (Health Sector Strategic Plan)* |
| Last updated | 2010 | 2014 | 2014 |
| Number of community health provider cadres | 1 main cadre : Agentes polivalentes elementares (APEs) | | |
| Recommended number of community health providers | *Information not available in policy* | | |
| Estimated number of community health providers | 3,442 APEs | | |
| Recommended ratio of community health providers to beneficiaries | 1 APE : 250–2,000 people | | |
| Community-level data collection | Yes | | |
| Levels of management of community-level service delivery | National, provincial, district, health unit, community | | |
| Key community health program(s) | APE Program; various programs in specific health areas including nutrition, malaria, and reproductive health | | |

The *Health Sector Strategic Plan (PESS) 2014–2019* is Mozambique's overarching health framework. Its mission is to maximize the health and well-being of Mozambicans by improving access to and quality of health services through a more decentralized system. The plan includes community engagement among its seven guiding principles, underscoring the importance of the population's role in identifying and solving health problems. It stipulates that greater community involvement in health activities, such as supporting treatment adherence and distributing FP methods, is critical for bringing programs to scale. The plan also identifies some of the health sector's challenges, which include health worker shortages, poor-quality equipment, unavailability and inconsistent distribution of medicines, and failure to adhere to standards and protocols.

**Mozambique's Ministry of Health is updating its APE program to guide and support APEs conduct their rapidly expanding scope of work.**

Another key document is the *Health Promotion Strategy*, which emphasizes community participation in health and behavior change interventions aimed at improved health outcomes. It lays out a framework for multi-sectoral integration of health promotion using APEs, community health committees, civil society, and other community-based actors to implement, advocate, monitor, and evaluate health promotion interventions.

**Table 2. Key Health Indicators, Mozambique**

| | |
|---|---|
| Total population[1] | 27.2 m |
| Rural population[1] | 68% |
| Total expenditure on health per capita (current US$)[2] | $42 |
| Total fertility rate[3] | 5.9 |
| Unmet need for contraception[3] | 23.9% |
| Contraceptive prevalence rate (modern methods for married women 15-49 years)[3] | 11.3% |
| Maternal mortality ratio[4] | 489 |
| Neonatal, infant, and under 5 mortality rates[3] | 30 / 64 / 97 |
| Percentage of births delivered by a skilled provider[3] | 54.3% |
| Percentage of children under 5 years moderately or severely stunted[3] | 42.6% |
| HIV prevalence rate[5] | 10.5% |

[1]PRB 2016; [2]World Bank 2016; [3]MISAU, Instituto Nacional de Estatística and ICF International 2013; [4]World Health Organization 2015; [5]UNAIDS 2015.

Together, policies provide guidance across many health areas, including HIV and AIDS, malaria, and sexual and reproductive health, and on fundamental aspects of the APE program, such as training and supervision. However, policies are less specific about certain APE processes, such as how they should request and access commodities. Guidance is also unclear about how APEs should interface and share responsibilities with other cadres of community health providers, like community health activists. Policies also mention community health committees, which engage communities to support APEs in their work.

Available guidance briefly mentions gender, indicating that women should take priority over men during selection as APEs because they are better positioned to provide community care. APEs are trained to educate communities about gender-based violence and abuse prevention.

# LEADERSHIP AND GOVERNANCE

Community health services in Mozambique are managed and coordinated through the APE program at multiple levels of the health system.

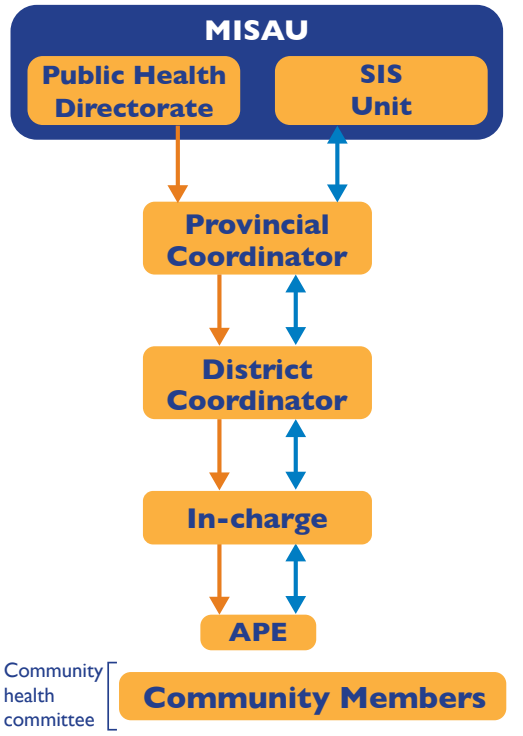
- At the **national** level, the MISAU sets national health priorities and agendas; develops health sector policies and strategies; plans and coordinates health programs and activities; mobilizes and allocates funds; and monitors training and program implementation. The APE program is housed within the public health directorate of the MISAU.
- The **provincial** coordinator at the provincial health directorate (DPS) manages the APE program. The coordinator plans and implements APE training; allocates and manages resources; supervises APE program actors at the district level; conducts monitoring and evaluation, including compiling and disseminating district data; and coordinates relevant entities, including the pharmaceutical sector.
- At the **district level**, a district coordinator at the district health, women, and social action directorate (DDSMAS) has a similar role to that of the provincial coordinator.
- In **health units**, which may be health posts, centers, or higher-level facilities,[1] the in-charge or another trained health professional supports the APEs within the catchment area of that health unit, including conducting supervision and coordinating health activities.
- At the **community level**, the community health committee supports APEs through mobilization and engagement in problem-solving. Elected by the community and in collaboration with district and health unit staff, community health committees comprise leaders and members of local groups. APEs are supposed to establish these committees if they do not already exist. Guidance for community health committees is broad, as their membership, roles, and responsibilities are defined locally. Although recognized by the MISAU, the committee has no formal authority over APEs.

Figure 1 summarizes Mozambique's health system structure.

1 Policies categorize health units at the district level of the health system, but this profile lists health units as a separate level to distinguish the administrative management body (DDSMAS) with the service delivery management body (health unit in-charge).

**Figure 1. Health System Structure**

| Level | Managing Administrative Body | Service Delivery Point | Key Actors and Their Relationships* |
|---|---|---|---|
| National | MISAU Public Health Directorate | Specialized Hospital Central Hospital | |
| Provincial | Provincial coordinator (DPS) | Provincial Hospital | |
| District | District coordinator (DDSMAS) | District Hospital General Hospital Rural Hospital Urban Health Center Rural Health Center Health Post | |
| Health Unit | In-charge | (see district facilities) | |
| Community | Community health committee | APE | |




* NGOs and development partners provide support at all levels and work in close collaboration with the government in community health planning and implementation.

# HUMAN RESOURCES FOR HEALTH

APEs provide Mozambican communities with a multitude of services, including FP; maternal, newborn, and child health; nutrition; HIV and AIDS; tuberculosis (TB); WASH; integrated community case management (iCCM); and basic first aid. They also receive training on community mapping; commodity management; reporting; communication; health promotion; and community mobilization.

Other community health providers in Mozambique include community health activists, who provide HIV and AIDS services such as home-based care and support, and traditional midwives, who conduct maternal and newborn health interventions. Traditional midwives encourage institutional deliveries and only conduct deliveries in emergency situations. The programs and initiatives that support these two cadres have encountered challenges related to equity in coverage, sustainability, and integration within the health system. Policies do not comprehensively or consistently provide guidance for their roles, responsibilities, or support systems.

Table 3 provides an overview of APEs.

### Table 3. Community Health Provider Overview

| | APEs |
|---|---|
| **Number in country** | 3,442[1] |
| **Target number** | *Information not provided in policy* |
| **Coverage ratios and areas** | 1 APE : 500–2,000 people, which ranges by community to meet local needs. APEs are generally stationed in rural areas. |
| **Health system linkage** | The APE program is led by the MISAU. |
| **Supervision** | Health workers at the health unit supervise APEs. They may be APE officers, nurses, or other trained health professionals appointed by the district coordinator. The district coordinator supervises the APE supervisors, and the provincial coordinator supervises the district coordinator.<br>NGOs may also supervise APEs in selected provinces, though policies do not specify how they should coordinate with MISAU supervisory staff. |
| **Accessing clients** | On foot<br>Bicycle<br>Public transport<br>Clients travel to them |
| **Selection criteria** | Male or female but preference for female applications<br>Over 20 years of age<br>Achieved third or fourth class of the Old Education System and can present proof<br>Speak, read, and write with satisfactory fluency in Portuguese<br>Basic arithmetic skills<br>Respected and accepted by the community<br>Previous involvement in community activities<br>Willing and available to serve the community |
| **Selection process** | Community and district authorities should agree upon the number of APEs needed and call a meeting to select them. Candidates must undergo a simple oral and written test to assess literacy level, reading comprehension, and mastery of simple arithmetic operations. |
| **Training** | Training is 16 weeks in a modular format. Each module has theoretical and practical components. |
| **Curriculum** | *APE Training Manual* (2015). Includes information on APE role and responsibilities; basic community health principles; health education and promotion; disease prevention; WASH; first aid; iCCM of diarrhea, malaria, and acute respiratory infections; FP; HIV and AIDS, and other sexually transmitted infections; and maternal, child, and newborn health and nutrition. |
| **Incentives and remuneration** | UNICEF and the WHO provide per diems for APE training and monthly or quarterly subsidies for APEs. Along with NGOs, they also supply T-shirts and bicycles as forms of nonfinancial incentives. |

[1] As of June 2016.

# HEALTH INFORMATION SYSTEMS

APEs complete monthly paper-based activity reports and send them to the health unit in-charge. The in-charge aggregates all APE reports and transmits them to the DDSMAS, where they are integrated into a summary with data from the health units across the district. Data moves to the DPS and then to the health information system (SIS) unit within the MISAU.

Policies stipulate that each level of the system should share data with the lower levels, though the mechanism by which this is to occur is unclear. However, the APE training modules indicate that APEs should follow up with health unit staff for feedback so they can understand where and how they need to improve performance.

The blue arrows in Figure 1 show the flow of data.

# HEALTH SUPPLY MANAGEMENT

APEs are equipped with a kit of monthly supplies for provision of curative services, which includes medicines for case management of childhood illness; chlorhexidine; nutritional supplements; and FP supplies. APEs track their supply needs with a monthly drug consumption form and use an array of other forms to document their activities.

APEs are trained to manage the medicines and supplies, e.g., checking expiration dates, storage, transport to clients, and managing adverse reactions. APEs restock their supply at the health unit as needed, though available guidance does not outline the precise process. There is also sparse information on how APEs are to access emergency supplies or manage medical waste, apart from placing lancets and syringes in sharps containers.

The full list of commodities that APEs provide is not available, but Table 4 displays selected medicines and products included in Mozambique's *National List of Essential Medicines*.

**Table 4. Selected Medicines and Products Included in Mozambique's *National List of Essential Medicines* (2016)**

| Category | | Medicine / Product |
|---|---|---|
| **FP** | ☐ | CycleBeads® |
| | ☑ | Condoms |
| | ☑ | Emergency contraceptive pills |
| | ☑ | Implants |
| | ☑ | Injectable contraceptives |
| | ☑ | IUDs |
| | ☑ | Oral contraceptive pills |
| **Maternal health** | ☑ | Calcium supplements |
| | ☑ | Iron/folate |
| | ☑ | Misoprostol |
| | ☑ | Oxytocin |
| | ☑ | Tetanus toxoid |
| **Newborn and child health** | ☑ | Chlorhexidine |
| | ☑ | Cotrimoxazole |
| | ☑ | Injectable gentamicin |
| | ☑ | Injectable penicillin |
| | ☑ | Oral amoxicillin |
| | ☑ | Tetanus immunoglobulin |
| | ☑ | Vitamin K |
| **HIV and TB** | ☑ | Antiretrovirals |
| | ☑ | Isoniazid (for preventive therapy) |
| **Diarrhea** | ☑ | Oral rehydration salts |
| | ☑ | Zinc |
| **Malaria** | ☑ | Artemisinin combination therapy |
| | ☐ | Insecticide-treated nets |
| | ☑ | Paracetamol |
| | ☐ | Rapid diagnostic tests |
| **Nutrition** | ☑ | Albendazole |
| | ☑ | Mebendazole |
| | ☐ | Ready-to-use supplementary food |
| | ☑ | Ready-to-use therapeutic food |
| | ☑ | Vitamin A |

# SERVICE DELIVERY

Available policies do not elaborate on a community-level service delivery package, though APEs have a standardized curriculum and supply kit. However, the APE scope may vary across the country depending on local needs and the priorities of the implementation partners that support the APE program.

Table 5 provides information on how APEs deliver health education and curative services as well as mobilize communities to engage in health-related activities.

APEs are trained to refer clients to the closest health unit, which is often a health post or health center. Policies do not specify information about counter referrals. Using FP as an example, APEs may refer clients to:

**Table 5. Modes of Service Delivery**

| Service | Mode |
|---|---|
| **Clinical services** | Door-to-door |
| | Periodic outreach at fixed points |
| | Provider's home |
| | Special campaigns |
| **Health education** | Door-to-door |
| | In conjunction with other periodic outreach services |
| | Community meetings |
| | Mothers' or other ongoing groups |
| **Community mobilization** | Door-to-door |
| | In conjunction with other periodic outreach services |
| | Community meetings |
| | Mothers' or other ongoing groups |

- **Health posts** for condoms, oral contraceptives, injectable contraceptives, emergency contraception, and information on the lactational amenorrhea method.
- **Health centers** for the methods available at health posts as well as implants and intrauterine devices (IUDs).
- **Rural, district, provincial, and general hospitals** for the methods available at health centers as well as permanent methods.

Table 6 shows interventions that APEs may conduct in FP, maternal health, newborn care, child health and nutrition, TB, HIV and AIDS, malaria, and WASH.

## Table 6. Selected Interventions, Products, and Services

| Subtopic | Interventions, products, and services | Information, education, and/or counseling | Administration and/or provision | Referral | Follow-up |
|---|---|---|---|---|---|
| **FP** | Condoms | APE | APE | APE | APE |
| | CycleBeads® | Unspecified | Unspecified | Unspecified | Unspecified |
| | Emergency contraceptive pills | Unspecified | No | APE[1] | Unspecified |
| | Implants | Unspecified | No | APE[1] | Unspecified |
| | Injectable contraceptives | APE | APE | APE | APE |
| | IUDs | Unspecified | No | APE[1] | Unspecified |
| | Lactational amenorrhea method | Unspecified | | Unspecified | Unspecified |
| | Oral contraceptive pills | APE | APE | APE | APE |
| | Other fertility awareness methods | Unspecified | | Unspecified | Unspecified |
| | Permanent methods | Unspecified | No | APE[1] | Unspecified |
| | Standard Days Method | Unspecified | | Unspecified | Unspecified |
| **Maternal health** | Birth preparedness plan | APE | APE | APE | APE |
| | Iron/folate for pregnant women | APE | APE | APE | APE |
| | Nutrition/dietary practices during pregnancy | APE | | APE | APE |
| | Oxytocin or misoprostol for postpartum hemorrhage | Unspecified | Unspecified[2] | Unspecified | Unspecified |
| | Recognition of danger signs during pregnancy | APE | APE | APE | APE |
| | Recognition of danger signs in mothers during postnatal period | APE | APE | APE | APE |
| **Newborn care** | Care seeking based on signs of illness | APE | | | APE |
| | Chlorhexidine use | APE | APE | APE | APE |
| | Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.) | APE | | APE | APE |
| | Nutrition/dietary practices during lactation | APE | | APE | APE |
| | Postnatal care | APE | No | APE | APE |
| | Recognition of danger signs in newborns | APE | APE | APE | APE |

| Subtopic | Interventions, products, and services | Information, education, and/or counseling | Administration and/or provision | Referral | Follow-up |
|---|---|---|---|---|---|
| **Child health and nutrition** | Community integrated management of childhood illness | APE | APE | APE | APE |
| | De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years[3] | APE | APE | APE | APE |
| | Exclusive breastfeeding for first 6 months | APE | | APE | APE |
| | Immunization of children[4] | APE | No | APE | APE |
| | Vitamin A supplementation for children 6–59 months | APE | APE | APE | APE |
| **HIV and TB** | Community treatment adherence support, including directly observed therapy | APE | APE | APE | APE |
| | Contact tracing of people suspected of being exposed to TB | Unspecified | Unspecified | Unspecified | Unspecified |
| | HIV testing | APE | No | APE | APE |
| | HIV treatment support | APE | APE | APE | APE |
| **Malaria** | Artemisinin combination therapy | APE | APE | APE | APE |
| | Long-lasting insecticide-treated nets | APE | Unspecified | APE | APE |
| | Rapid diagnostic testing for malaria | APE | APE | APE | APE |
| **WASH** | Community-led total sanitation | APE | APE | | |
| | Hand washing with soap | APE | | | |
| | Household point-of-use water treatment | APE | | | |
| | Oral rehydration salts[5] | APE | APE | APE | APE |

[1] Policies stipulate that APEs should refer clients to health units for the FP methods they do not provide, though they do not specify each method.
[2] Policies mandate that only trained nurses and midwives may administer misoprostol for postpartum hemorrhage. However, the 2015 APE *Training Manual* includes misoprostol as part of the APE kit and gives instruction on how to administer for women who have home deliveries.
[3] APEs may also administer de-worming medication to children over the age of 5.
[4] Including newborns.
[5] The APE *Training Manual* outlines dosage guidance for administration of oral rehydration salts in children up to 10 years of age..

# KEY POLICIES AND STRATEGIES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**ADVANCING PARTNERS & COMMUNITIES**
**JSI RESEARCH & TRAINING INSTITUTE, INC.**

1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Web: advancingpartners.org