Strengthening Private Sector Provision of Voluntary Family Planning and Select Primary Health Care Services in Mozambique: Recommendations for improved market performance
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ACRONYM LIST

AIPROMEM  Association of Importers and Manufacturers of Medical Products
ANAFP    National Association of Private Pharmacies
ANARME   National Medicines Regulatory Authority
ANC      Antenatal Care
APROSAP  National Association of Private Healthcare Providers
CTA      Confederation of Economic Associations
DHS      Demographic and Health Surveys
DMPA-SC  Subcutaneous Depot Medroxyprogesterone Acetate
FP/RH    Family Planning/Reproductive Health
GDP      Gross Domestic Product
GoM      Government of Mozambique
HCF      Health Care Facility
HIV/AIDS Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSSP     Health Sector Strategic Plan
ISSM     Instituto de Supervisão de Seguros de Moçambique (Mozambique’s Insurance Supervision Institute)
IUD      Intrauterine Device
LARC     Long-Acting Reversible Contraceptive
MISAU    Ministério de Saúde (Ministry of Health)
MOQ      Minimum Order Quantity
MZN      Mozambican Metical
PHC      Primary Health Care
PSI      Population Services International
SIFPO2   Support for International Family Planning and Health Organizations 2
USAID    United States Agency for International Development
US$      US Dollar
WHO      World Health Organization
EXECUTIVE SUMMARY

The USAID Mission to Mozambique seeks practical, strategic input to strengthen collaboration between the country’s public and private health sectors, particularly for voluntary family planning (FP) services. Much of what is known of the private sector is from official registration data at provincial levels. As unregistered and informal providers are not systematically tallied, the official data gives only one angle of what the private sector looks like in Mozambique. Establishing a holistic understanding of the sector, and capturing the voices of providers and consumers themselves, would offer more nuanced insights on health-seeking behavior, existing service provision, and where the private sector may complement the efforts of the public sector. With support from USAID’s Support for International Family Planning and Health Organizations 2 (SIFPO2) project, PSI/Mozambique sought to provide a more complete landscape of the private health sector. PSI/Mozambique contracted a global market research specialist, Ipsos, to map out both registered and unregistered private providers in the key urban centers of Maputo, Matola, and Nampula. Ipsos also carried out extensive provider and consumer interviews on service offerings and perceptions of care in these locations.

Overall, the assessment found that the private health sector is relatively small and nascent in these locations. It is concentrated within urban centers with high population density and ability to pay. Many facilities have been operating for less than five years, suggesting recent growth of the sector. The private sector provides a broad set of goods and services from treatment products and common consumer goods to diagnostics, triage, and counseling. Yet, the private sector currently serves less than 10% of the population in Maputo, Matola, and Nampula. Despite its small size, the sector has been effective in responding to consumer needs by offering a range of services based on consumer demand as a complement to public sector provision.

Consumers interviewed through this research have a positive view of care received in the private sector due to perceived higher standards of customer care and quality of care, availability of products, convenience, and good hygiene. Consumers also report that they save money to afford private services when possible. Despite these positive perceptions by consumers, there are constraints that prevent the private sector from serving more consumers. First and foremost, only people who can afford the private sector access services due to various financing constraints. Second, safety and quality in the private sector is variable, due to largely unregulated products and services. Third, growth of the private sector is limited by inadequate guidance and policies, lack of quality standards, and insufficient investment in demand generation.

Research findings, key market challenges and opportunities, and recommendations for interventions are outlined in this report to assist USAID and the Government of Mozambique (GoM) in making strategic decisions that will increase access to priority voluntary FP and primary health care (PHC) services in the private sector. This work builds on previous USAID-funded projects implemented by PSI/Mozambique, as well as a study conducted by ThinkWell in 2019 under the USAID-funded Mozambique Monitoring and Evaluation Mechanism Services project: Overview of Private Actors in the Mozambican Health
System and Rapid Assessment of the Supply Chain.¹ PSI/Mozambique's assessment recommends an initial roadmap to harness private sector potential in a selected number of strategic health areas. These recommendations can be used by USAID/Mozambique, Ministério de Saúde/Ministry of Health (MISAU), and other local stakeholders to design and execute impactful and sustainable interventions that may contribute to Mozambique’s progress toward self-reliance, as outlined by USAID’s Private Sector Engagement Policy.²

A well-governed mixed health system, in which the private sector supports progress toward affordable, accessible, and improved quality of care, is vital to achieving universal health care. With the increasing interest in the private health sector’s role in Mozambican society and economy, MISAU has expressed interest in working with the private sector to meet National Health Service objectives, particularly in its Strategic Guidance Document: Health Sector Financing 2020-2035.³

The theory of change in Figure 1 proposes how the recommendations for consideration may result in improved public health outcomes by changing user behavior, creating an enabling environment, and shaping private sector health care markets. This report proposes a wide-ranging list of activities that support private sector governance, health financing, private sector health networks, and health system and infrastructure building. Strategic prioritization of these recommendations and of the resources assigned to them will be important for achieving the greatest impact with limited investment. It is important to recognize that the potential impact of recommendations throughout this report are interconnected. An adaptative and responsive environment—including rules, regulations, and enabled private sector entities—is essential for a sustainable supply chain and referral system.

All recommendations have been designed with sustainability as a primary objective. The “Summary of Findings and Recommendations” in Table 2 outlines the future vision for the private sector in Mozambique as it moves from its current, nascent state to a more robust, agile, and resilient one. The recommendations in this report highlight opportunities to achieve this long-term vision within a 10-year time frame.

³ Documento orientador estratégico: Financiamento do Sector Saúde 2020-35
**Figure 1. Mozambique Health Service Delivery: Proposed Theory of Change**

**Goal**: Improved health outcomes for women, children, infants, and families
- Modern contraceptive prevalence rate, unmet demand while in need, maternal mortality and morbidity rates, under-5 child mortality rate, perinatal/neonatal mortality rate

**Outcomes**
- Increased use of PHC services and modern contraceptives within the context of informed choice
- Decreased financial health care-related financial hardship
- Improved affordability, accessibility, quality assurance, availability, and awareness of a wide range of voluntary FP services through building PHC capacities in the private sector

**Outputs**
- Improved enabling environment for private sector
- Improved supply functions (provider & supply chain)

**Activities**

**Governance**
- **Recommendation 1**: Create a specific, intentional vision to nurture strategic public/private engagement and representation for the private health sector.
- **Recommendation 2**: Reform or develop policies to ensure effective service delivery and a functioning insurance industry.

**Health Financing**
- **Recommendation**: Support the GoM in advancing the health financing strategy to improve equal access to services by leveraging the private sector.

**Service Delivery**
- **Recommendation**: Build capacity of private providers through network-building or other support; using data, pursue expansion of service offerings in order to increase availability of services.

**System & Infrastructure**
- **Recommendation 1**: Strengthen coordination and planning of private sector supply chain through more transparent information.
- **Recommendation 2**: Outline and capacitate a referral system that leverages private sector service provision.
- **Recommendation 3**: Increase the size of the private sector workforce and provide increased opportunities for training and continuing medical education.
1. BACKGROUND

1.1 Introduction

1.1.1 Organization of this Report

Section 1 of the report details Mozambique’s socioeconomic context, analysis of supply and demand for voluntary FP, private health care delivery performance, drivers of private sector demand, and gaps and constraints in the current market environment. Section 2 describes assessment findings and recommends possible actions that USAID and the GoM may consider in the short-, mid-, and long-term to increase the contribution of the private sector in voluntary FP and PHC provision. Section 3 concludes the report.

1.1.2 Assessment Objective

This activity has been funded by USAID’s SIFPO2 project, a 6-year initiative implemented by PSI to strengthen voluntary FP programs and other health services worldwide, with a focus on strengthening private sector channels, including social franchise networks. SIFPO2 is committed to the principles of voluntarism and informed choice in voluntary FP and reproductive health (FP/RH), while reaching underserved populations, particularly youth.

In order to formulate evidence-based recommendations, PSI, through Ipsos, conducted on-the-ground data collection in 2019 on the private health care market in three urban areas: Maputo, Matola, and Nampula. Many of the research tools and approaches were adapted from USAID’s Assessment to Action framework and guidance. This research was presented in an accompanying Ipsos deliverable referred to as the “Technical Report.” The research explored and analyzed supply- and demand-side factors that affect private sector service delivery. This data constitutes the basis for this report’s recommended areas of consideration for market system changes that may sustainably improve health outcomes in Mozambique.

The primary objectives of the research and this report are to:

- Map local private sector actors, in real time, confirming whether/how they provide voluntary FP services;
- Identify supply- and demand-side opportunities and constraints;
- Recommend and prioritize potential synergies/complementarities between the private sector and the national health system; and
- Provide recommended areas for consideration to USAID/Mozambique, MISAU, and other stakeholders on how to strengthen future engagement on voluntary FP and PHC objectives.

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1.1.3 Assessment Methodology

Research Methodology
The assessment used a mixed-methodology approach, combining qualitative and quantitative research to develop a holistic understanding of the private sector. Quantitative methods were used to map the private sector in the three locations, while qualitative interviews were used to gain insights from key stakeholders, including consumers, health care providers, pharmacies, and upstream value chain actors.

Data was collected in three phases. First, published literature was reviewed to inform the mapping of the private health sector in Maputo, Matola, and Nampula. Second, geographic information was collected to plot out facilities. Third, qualitative and quantitative information was collected from a sample of providers, consumers, and supply chain players.

The summarized approach to mapping the health facilities included:
- Mapping local private health sector actors, such as hospitals, clinics, stand-alone pharmacies, and other health facilities;
- Mapping secondary health actors, such as insurance companies, importers, distributors, wholesalers, and transporters; and
- Categorizing the above actors according to the services provided (e.g., voluntary FP, antenatal care (ANC) and delivery, child health services, or other health services).

The summarized approach to supply-side data collection included:
- Conducting face-to-face interviews based on structured and semi-structured questionnaires to a representative sample of health care providers (i.e., hospitals, clinics, pharmacies) in Maputo, Matola, and Nampula;5 and
- Conducting individual in-depth interviews with relevant stakeholders. These included importers, wholesalers, distributors, insurers, health plan companies, pharmacies, clinic/hospital managers, and medical officers attending patients in the areas of voluntary FP, ANC/delivery, and child health services. Interviews also included a representative of MISAU, which is responsible for licensing of private health care facilities. These interviews allowed a deeper understanding of the variables impacting the provision of health care services.

The summarized approach to demand-side data collection included:

5 The sample was drawn from the universe of health care facilities that was mapped and stratified to reflect all types of facilities and their respective service offerings by surveyed geographic areas. Sample stratification ensured that all types of health care facilities (HCFs) were reflected. Stratification criteria included geographic area, setting, business size, and health care services (voluntary FP, ANC/delivery, and child health), reducing the likelihood that particular HCFs (e.g., those located in certain areas) were left out of the sample.
• Conducting 24 focus group discussions with women aged 20-35 and residing in Maputo, Matola, and Nampula, of which eight focused on ANC/delivery, eight on child health, and eight on voluntary FP;
• Per Mozambique’s Ethics Review Board request, conducting three additional focus group discussions with women aged 36-49 in Maputo, one for each health area. These focus group discussions were treated as control groups (identical to all others except for age); and
• Conducting 36 individual in-depth interviews with women aged 20-35 who were recent users of private HCFs: 12 for ANC/delivery, 12 for child health, and 12 for voluntary FP, in Maputo, Matola, and Nampula.

Analysis Methodology
PSI's market system development tool, the Keystone Design Framework, and associated human-centered design tools were used to analyze market trends, to draw insights from consumers on health-seeking experiences and behaviors, and to propose a future vision of sustainability for the private health sector in Mozambique.

The preliminary findings from the supply-side data collection were analyzed with MISAU and USAID through a 2-day workshop organized by PSI/Mozambique. Preliminary research findings were presented during the workshop, including outputs from the mapping exercise, consumer journey maps, and a production-to-use matrix (a tool outlining a summary of market functions by various players). Stakeholders including MISAU representatives, USAID, Ipsos researchers, and PSI/Mozambique collectively identified key constraints based on the research, and prioritized recommended interventions through participatory discussion and voting. The results of this workshop informed the recommendations and are integrated across the analysis in Section 2.

1.1.4 Definitions

The following definitions are applied consistently throughout the report:

• **Private sector:** Includes for-profit and not-for-profit (i.e., non-governmental organizations, faith-based organizations, not-for-profit hospitals), privately operated providers and other actors along the supply chain;
• **Providers:** Includes all health care providers, including pharmacies, but excluding other supply chain actors such as distributors, importers, and manufacturers;
• **Public sector:** Includes only GoM-funded and -managed facilities and staff; and
• **Supply chain:** Includes importers, wholesalers, distributors, insurers, and health plan companies.

1.2 Mozambique Context

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1.2.1 Demographics and Economics

Mozambique has a fast-growing population of 28 million, which has increased by 35% since 2007, according to the 2017 national population census. The highest population growth has been clustered around Mozambique’s three largest cities, Maputo City (1.1 million inhabitants), Nampula (472,000 inhabitants), and Matola (324,000 inhabitants). Despite significant improvement in social indicators since the civil war ended in 1992, the improvement of health status in Mozambique has been uneven. While the under-five child mortality rate more than halved between 1993-2013, Demographic and Health Surveys (DHS) data shows that the total fertility rate for women aged 15-49 has remained constant over the past 20 years (5.2-5.4, DHS 1997-2018). The increase in the HIV prevalence rate among women from 13.1% to 15.4% (AIDS Indicator Survey, 2009-2015), also influences the high maternal mortality rate (408 per 100,000 live births, DHS 2011). Mozambique has the 9th highest rate of child marriage in the world,\(^7\) which correlates to early childbearing and a high total fertility rate. The legal age of marriage is 18 years, and the median age at first marriage is 18.2.

Communicable diseases are the main contributors to the country’s disease burden, while lack of access and inconsistent quality of PHC has made it difficult for the GoM to meet the population’s health needs. According to the Mozambique Poverty Reduction Strategy Paper,\(^8\) about 30% of the general public does not have access to any health care, and 50% does not have access to the level of care they need.

Mozambique also faces a national shortage of human resources for health, and among the current workforce many require further training. The country’s doctor-population ratio is 1:13,605, while the World Health Organization (WHO) recommended doctor-population ratio 1:1,000. This problem is not unique to Mozambique—for example, doctor-population ratios in neighboring countries range from 1:13,106 in Zimbabwe to 1:7,429 in Rwanda. Absenteeism, estimated at 23.4%,\(^9\) exacerbates health worker shortages. Furthermore, there is inequity in the distribution of health workers between rural and urban areas, and between PHC facilities and higher levels of care. According to National Plan for the Development of Human Resources for Health (2016-2025), there are 176 health technicians per 100,000 inhabitants in urban areas and only 65 in rural areas; there are 12 doctors per 100,000 inhabitants in urban areas and only two in rural areas. The research also observed that doctors and nurses working exclusively for private health care providers have no access to training, affecting quality of care; and that a lack of training and turnover of health care providers negatively affects consumer service delivery.

The government experiences fiscal pressures and has limited budget allocation for health. While Mozambique has a gross domestic product (GDP) of US$499 per capita, the GDP growth rate decreased


from 7.4% in 2014 to 3.4% in 2018. The root causes of this decline include low global commodity prices, climate disasters, and undisclosed debts, which will likely continue to suppress GDP growth in the short term. Health has been predominantly financed by external aid, with around 73% of expenditure (US$24 out of US$33 per capita), coming from development assistance for health.

With these economic challenges, increasing the contributions of the private health sector and enhancing the impact of available funding through effective and efficient health care delivery are critical. Mozambique is projected to have one of Africa’s fastest growing economies driven by the extractive industry, including Africa’s largest mining investment and a resulting increase in associated commerce. The key developments and growth in economy will drive increased demand for health products and services. The private health sector can play an essential role in complementing public sector health service provision, given the anticipated growth in consumer demand and potential increase in consumer ability to pay for health services.

Given the health context, the GoM’s Health Sector Strategic Plan (HSSP) emphasizes strengthening PHC and focuses specifically on FP/RH, child health, and nutrition. The strategy aims to reduce unintended pregnancy and maternal and child mortality rates, and to address the consistent unmet need in voluntary FP in Mozambique (21.4%-28.9%, 1997-2015). As suggested by the World Bank, an increased modern contraceptive prevalence rate and reduced unintended pregnancy rates by 2050 could yield better pregnancy outcomes and a significant reduction in the poverty rate.

In spite of strong government commitment to strengthening the overall health sector, it is clear that additional resources will be required to improve health outcomes. The private health sector has the potential to expand access beyond that of the public sector as economic growth generates more personal income and insurance becomes a more affordable option.

1.2.2 Voluntary FP in Mozambique
Mozambique has made significant progress increasing access to modern contraception. From 2011 to 2015, the modern contraceptive prevalence rate increased from 11.3% to 25.3%.\textsuperscript{16} However, over half of women aged 15-49 in middle- and low-income groups have unmet need for voluntary FP services in both rural and urban areas.\textsuperscript{17} Furthermore, the modern method mix remains skewed toward short-acting methods. According to the Reproductive Health Supplies Coalition’s Commodity Gap Analysis in 2018,\textsuperscript{18} the most commonly used methods in the public and private sectors are injectables (40%), pills (24%), condoms (20%), implants (8%), intrauterine devices (IUDs) (2%), voluntary sterilization (1%), and other (4%).

Public health facilities generally offer a wide range of voluntary FP products, including short- and long-acting methods. In the private health sector, surveyed health care providers also offer a wide variety of short- and long-acting voluntary FP methods, including oral contraceptive pills (72%), implants (76%), IUDs (72%), condoms (60%), progestin-only pills (52%), and progestin-only injectables (48%). Only 38% of the pharmacies surveyed offer voluntary FP services, and among those, methods offered are mostly short-acting, including condoms (100%), emergency contraceptive pills (93%), oral contraceptive pills (87%), progestin-only pills (60%), progestin-only injectables (13%), and IUDs (2%). The study also found that the relatively new injectable technology, subcutaneous depot medroxyprogesterone acetate (DMPA-SC), is not available in Maputo or Nampula. Only 25% of surveyed health care providers in Matola prescribe, counsel, or refer for DMPA-SC. Despite the lack of presence of this method, 34 of the 108 HCFs that do not offer DMPA-SC are interested in offering it. Voluntary FP products are generally offered free-of-charge in the public sector; however, some women still choose to access voluntary FP products in the private sector for convenience, privacy, and accessibility.

As this assessment will illustrate with additional details, there are both demand- and supply-side barriers that prevent women from accessing modern contraceptives. The demand-side barriers include lack of knowledge and/or support from sexual partners and family members, and side-effects (including misinformation about potential side-effects). On the supply-side, product stock-outs limit access. These are often rooted in logistics issues such as lack of and/or expense of transportation and insufficient forecasting of stock needs. Procurement policies may also limit market competition, as importers have exclusive rights to products, which undermines the power of others seeking to import and distribute.

\subsection*{1.2.3 Private Health Care Service Delivery in Mozambique}

\textsuperscript{17} Mozambique AIDS Indicator Survey (AIS). (2015).
\textsuperscript{18} Retrieved from: https://www.rhsupplies.org/cga/
Despite a “free” public health system, consumer interviews indicated that a proportion of Mozambicans seek care in the private sector for a variety of reasons, such as relatively good customer service, quality, convenience, and cleanliness. Accordingly, the private sector has grown to meet this demand, accounting for a significant portion of the health infrastructure in key cities, per the mapping exercise.

The private sector in Mozambique includes a total of 1,118 registered health outlets, according to a 2018 service availability and readiness assessment;\(^\text{19}\) however, pharmacies comprise more than half of these (57%).\(^\text{20}\) Furthermore, almost half of the country’s private health units (44%) are located in urban Maputo, Nampula, and Matola, totaling 602 private facilities, of which 67% are pharmacies. Private facilities are primarily located in the city centers or places with higher population density. The coverage of public and private services can be seen in the geographic information system maps below. There are 291 private facilities in Maputo (see Figure 2). In Matola, the private facilities are the most dispersed near the border with Maputo and in the south region of the city, expanding into areas where public facilities are not present (see Figure 3). In Nampula, private facilities are concentrated in the city center; some overlap with public facilities and some do not (see Figure 4).

To put this private sector data in context, Mozambique has 1,651 registered public health units, of which 96% (1,575) are at the PHC level.\(^\text{21}\) Despite the extensive public health network, it was reported that in 2014, only 68.3% of the population had access to health services within 30 minutes’ walking distance from their home, with greater inequalities in some provinces.\(^\text{22}\) There is an average of 17,000 people per PHC unit, which does not meet WHO’s recommended ratio of 5,000 inhabitants per facility.\(^\text{23}\)


\(^{20}\) This includes pharmacies, training institutions, clinical laboratories, and clinical providers (primary, secondary, tertiary).


\(^{23}\) The HCF ratio is an indicator of approximation of access to outpatient services, calculated as the number of identified outlets divided by the population of interest in the health area concerned. The value of reference is WHO and MISAU’s standard of two facilities per 10,000 inhabitants. (Drawn from SARA INVENTÁRIO NACIONAL Report. (2018). Retrieved from: https://www.afro.who.int/sites/default/files/2020-02/SARA_2018_Invet%C3%A1rio_Nacional.pdf)
Figure 2. Location of Public HCFs and Private HCFs in Maputo

Legend:
- Public HCF at the epicenter of red perimeter with a 5km radius
- Private HCF

Figure 3. Location of Public HCFs and Private HCFs in Matola

Legend:
- Public HCF at the epicenter of red perimeter with a 5km radius
- Private HCF
Among the facilities in this study, health care providers receive 868,000 annual visits\textsuperscript{24} in the three cities, which have a combined total population of about 3 million, while pharmacies receive 4.4 million visits annually. Although all of the studied private facilities in Nampula reach fewer consumers overall in comparison to the other two cities, the smaller size of private sector infrastructure means that each facility, on average, receives a higher volume of consumer visits per week than the average facility in Matola and Maputo. Nampula has the largest number of weekly visits (665 visits), followed by Maputo (398 visits), which likely includes inhabitants of Matola (336 visits) who travel daily to their jobs in Maputo.

Research indicates that private health care providers cover a range of services, while pharmacies primarily offer medicines and pregnancy testing. According to the providers in the study (see Table 1), the most common services that health care providers offer (including prescribed, counseled, or referred services) are: lab testing (76%), diagnosis and/or treatment for non-communicable diseases such as diabetes and cardiovascular disease (73%), pregnancy testing (70%), voluntary FP services (65%), curative care services for children under five (64%), ANC (56%), ultrasounds (55%), and HIV/AIDS diagnostics, treatment, and follow-up (49%). For pharmacies, commonly offered services include sales of medicine (100%), pregnancy testing (64%), and voluntary FP (38%), with the majority offering short-term voluntary FP methods. While current regulation allows pharmacies to provide information and sell voluntary FP methods for onward administration by facility-based providers, respondents reported that some pharmacies are illegally administering injectables and implants to consumers.

\textsuperscript{24} “Number of visits” data were collected by Ipsos and defined as consumer “visits” that receive services or purchase products. One person may make multiple visits during the period.
<table>
<thead>
<tr>
<th>Service</th>
<th>Health Care Providers</th>
<th>Pharmacies</th>
<th>Diagnostic Centers/Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sample base:</strong></td>
<td>108</td>
<td>408</td>
<td>13</td>
</tr>
<tr>
<td><strong>Voluntary FP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy testing</td>
<td>70%</td>
<td>64%</td>
<td>77%</td>
</tr>
<tr>
<td>Voluntary FP methods and services</td>
<td>65%</td>
<td>38%</td>
<td>15%</td>
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<tr>
<td><strong>ANC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td>55%</td>
<td>-</td>
<td>46%</td>
</tr>
<tr>
<td>ANC</td>
<td>56%</td>
<td>-</td>
<td>15%</td>
</tr>
<tr>
<td>Normal delivery</td>
<td>27%</td>
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<td>-</td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td>26%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Child Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curative care services for children under age 5 at the facility or as outreach</td>
<td>64%</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Child vaccination services at the facility or as outreach</td>
<td>39%</td>
<td>-</td>
<td>15%</td>
</tr>
<tr>
<td>Growth monitoring services at the facility or as outreach</td>
<td>40%</td>
<td>-</td>
<td>31%</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of medicines</td>
<td>44%</td>
<td>100%</td>
<td>8%</td>
</tr>
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<td>Non-communicable diseases: diagnostic or management (i.e., diabetes, cardiovascular diseases, and chronic respiratory conditions in adults)</td>
<td>73%</td>
<td>14%</td>
<td>46%</td>
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<tr>
<td>HIV/AIDS: diagnostics, treatment, prescription, and/or follow-up</td>
<td>49%</td>
<td>-</td>
<td>62%</td>
</tr>
<tr>
<td>Tuberculosis: diagnostics, treatment, prescription, and/or follow-up</td>
<td>46%</td>
<td>-</td>
<td>54%</td>
</tr>
<tr>
<td>Laboratory diagnostic services, including rapid diagnostic testing</td>
<td>76%</td>
<td>1%</td>
<td>92%</td>
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<tr>
<td>Blood grouping services</td>
<td>53%</td>
<td>-</td>
<td>69%</td>
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<td>Diagnostic services (e.g., magnetic resonance imaging and x-ray)</td>
<td>4%</td>
<td>-</td>
<td>23%</td>
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<tr>
<td>General and specialized consultations</td>
<td>22%</td>
<td>1%</td>
<td>46%</td>
</tr>
<tr>
<td>Minor surgeries</td>
<td>10%</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Weight measurement</td>
<td>2%</td>
<td>6%</td>
<td>8%</td>
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<tr>
<td>Dental services</td>
<td>10%</td>
<td>-</td>
<td>8%</td>
</tr>
<tr>
<td>Physical therapy and massages</td>
<td>5%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Acupuncture, Chinese medicine</td>
<td>2%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sale of natural products and/or herbs</td>
<td>-</td>
<td>1%</td>
<td>-</td>
</tr>
<tr>
<td>Sale of cosmetics</td>
<td>3%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
<td>2%</td>
<td>-</td>
</tr>
</tbody>
</table>
The findings from this study show that, despite the variety of voluntary FP options offered by health care providers in the private sector, services are concentrated in high-density areas. To reach more remote populations, private providers could be encouraged to expand services into these communities. With appropriate training and approval, pharmacies could be permitted to expand their service offering to include more options, such as voluntary long-acting reversible contraceptive (LARC) methods.

1.2.4 Drivers of Demand

According to interviews of consumers of private health care, the private sector offers more friendly and continuous services, less wait time, a more spacious environment, detailed consultations, and a wider range of voluntary FP methods which are not usually provided in the public sector. The study indicates that availability of voluntary LARC methods, as well as privacy afforded in a doctor’s office, play an important role in women’s decision and uptake of voluntary FP, ANC, and child health care in the private sector.

Many consumers choose to use both public and private health services, opting for private services when facing more serious health issues, when they have disposable income, or when services are not widely available in the public sector. For example, according to respondents in the focus group discussions, women prioritize using private providers for child health over their own, and particularly for sick-child visits over well-child visits. This finding is substantiated by a 2016 analysis of wealth and use of health services in the private sector in Kenya, which illustrated that consumers move interchangeably between the public and private sector, depending on the health intervention and who in the family needs health care.25

The primary mechanisms driving consumers to the private sector are word of mouth (82% of surveyed consumers), followed by referrals from other entities (25%; referred from hospitals, doctors, pharmacies), and walk-ins (23%). According to the surveyed consumers, the major differentiating factors that drive consumers to the private health sector are:

- **Consumer satisfaction and quality of care**: Good customer care was reported to be the major differentiating factor that drives consumers to private HCFs. Consumers feel that in the private sector, providers listen attentively and respect them, which makes consumers feel safe and comfortable.

- **Medicines and equipment**: Consumers state that medicines and modern equipment, such as ultrasound machines and devices for blood and urine tests, are regularly available at private HCFs with internal pharmacies. The ability to validate diagnoses with exam results at private

HCFs increases consumers’ trust in the provider and adds to their perception of higher quality care.

- **Hygiene**: Hygiene is another important factor. Consumers perceive private HCFs to be clean and to adhere to better hygiene standards, and they consider private health professionals to follow hygienic procedures more regularly.

- **Convenience**: Consumers also highlighted convenience when selecting a private HCF. Appointments for consultations, exams, and other procedures can be scheduled in the facility or by phone on the same day, and private facilities also accept walk-ins. Furthermore, the waiting time is normally short, and waiting rooms are comfortable.

- **Financial barriers**: Some private sector consumers reported that they have insurance or health plans through their employer, making the cost of private health care affordable for them. However, at least half of the study participants said they pay out-of-pocket. For these consumers, cost becomes a barrier, and the choice of using the private sector versus the public sector becomes a strategic decision each time they seek care. While the private sector charges upfront fees, consumers report that there are “hidden fees” when accessing public services, such as paying to skip lines to see the doctor more quickly.

### 1.2.5 Private Sector Gaps

Despite the demand for private health services, there are gaps on the supply-side that prevent consumers’ optimal usage of private HCFs. These include low literacy concerning insurance among consumers and providers, delays in payment from insurance companies, poor access to credit to expand operations, and a weak supply chain. These factors seem to affect all surveyed private providers equally.

Only 9% of the pharmacies and 45% of the clinical health facilities surveyed accept insurance. A number of reasons were cited for this, including lack of interest, never being approached by insurance companies, and economic reasons (payment delays or preference for immediate payment). Some of these barriers originate with insurance providers, and others with the facility. On the provider side, the insurance market is distorted by competition from poorly regulated health plans that have a history of insolvency, leaving unpaid bills. There is a need for an adequate billing infrastructure to process insurance claims, along with access to the necessary capital to hold significant accounts receivable while insurance providers process claims.

In general, the facilities surveyed are small enterprises with a sole proprietor. They rely on equity to make investments in business expansions. The lack of access to credit, plus its high interest rates, reported at around 30%, prevent these types of businesses from borrowing to expand operations or to enter into leasing agreements, such as for medical equipment. The high interest rates charged to health care facilities appear to originate both with lending institutions, which may not be familiar with evaluating and assessing risk for health care businesses, and with providers themselves who may not have adequate accounting resources to leverage business revenue.
Breakdowns in the medical commodity supply chain also lead to business challenges, specifically stock-outs of key health products. Some of these challenges are intensified by national policy and regulations that dictate the terms of trade for medical commodities, including fixed margins and minimum order sizes. These constraints are addressed further in the next section.

Pharmacies face unique challenges. There are issues with licensing and registration compliance which put a double burden on legally operating pharmacies, as they first incur legal registration costs and then face competition from unregistered pharmacies. Research shows that 33% of pharmacies are not licensed in Nampula. While regulation is lax regarding who can own a pharmacy, each facility is required to employ a technical director who must be a licensed pharmacist to oversee operations. However, due to a shortage of pharmacists, the research shows that only 41% of surveyed pharmacies have a trained pharmacist onsite. Pharmacies also tend to serve low- and middle-income consumers, and only 5% of surveyed pharmacies accept insurance. This challenge prevents pharmacies from generating large consistent revenue streams or sufficient margins to expand.

In summary, pharmacies primarily serve consumers who live in close proximity to the facility. They typically rely on income from sales of medicine, and almost half generate less than 1,500,000 Mozambican metical (MZN) (around $21,000) in revenue annually. Many of those surveyed are interested in expanding services to increase income. The most mentioned service is routine child health (e.g., growth monitoring), but pharmacies are deterred by complicated processes to obtain authorization and training. Others report being interested in information dissemination, such as running educational campaigns on the use of voluntary FP methods.

Figure 5. Client Profile Served by Surveyed Pharmacies

![Figure taken from Ipsos “Technical Report”](image-url)
Clinical health care providers face challenges similar to those faced by pharmacies. Many clinical health care provider businesses are small, single-member enterprises that are frequently owner-operated. They face difficulties recruiting sufficient staff to expand, particularly for specialty services like gynecology. They have a clientele with somewhat better resources, largely middle-income consumers who tend to come from a wider catchment area. As 44% of the surveyed health care providers accept insurance, they have access to additional financing from insurance payments, compared with pharmacies that are less likely to accept insurance. Health care providers report low relative overall revenues; for example, 39% of those surveyed have an annual revenue at the same level as the surveyed pharmacies, approximately 1,500,000 MZN (around $21,000).

Figure 6. Client Profile Served by Surveyed Health Care Providers

1.2.6 Enabling Environment

Despite the absence of a formal private health sector engagement strategy from MISAU, private health businesses are growing and playing a more active role in voluntary FP, ANC, and child health service delivery within the national health system. As evidenced by Mozambique’s *Strategic Guidance Document: Health Sector Financing 2020-35*, there is growing interest in working with the private sector to better serve public health needs. However, several significant constraints exist in the current market environment.

**Regulations**

Some regulations pose challenges to operations across the value chain, which could limit private provider coverage and consumer access to services in the private sector. Importers and wholesalers face difficulties in licensing new medicines, as the process is deemed expensive and lengthy. Consequently,
many of the commodities offered in Mozambique are those that have already been replaced by newer generations of product in other countries. Furthermore, fixed margins make it cost-ineffective for importers and wholesalers to deliver commodities beyond transporter routes, resulting in last mile costs being transferred to providers.

Transporters are required to pre-pay taxes on current year profits based on the previous year’s tax returns. This situation was identified by transporters as a business constraint, and it applies to all private corporations. Participants reported that inspections do not occur routinely as the enforcement bodies are often under-resourced. For example, pharmacies are inspected by the National Pharmaceutical Directorate, but there is neither sufficient funding to evaluate the quality of services provided by the private sector nor a pricing reference for service and products sold.

Pharmacists reported limited profitability due to fixed margins on commodities they sell. According to Mozambique’s pharmaceutical law, margins for importers are fixed at 23.5% and margins for retailers are fixed at 66.3%. The pharmacies operating in lower-income areas and those which need to pay for the last mile of transportation expressed difficulty in generating profit within the established margins. Many acknowledge selling commodities above the legal price to stay in business, as the regulations around this are not regularly enforced.

Many clinics, medical centers, and hospitals cited challenges in adhering to the current reporting requirements into the national health system, as reports are required to be handwritten in a ledger book, even though the information is available electronically. With private providers already regularly facing staff attrition and shortages, this extra reporting burden is cited as difficult to manage.

Consumers struggle to access high quality, affordable services in the private sector because of gaps at each of these value chain levels, and because private sector options other than pharmacies are largely limited to urban centers. Even within urban centers, consumers may struggle to find the essential drugs, diagnostics, or devices they require due to manufacturing and importation challenges. This also affects consumers’ access to the newest generation of drugs for specific health conditions.

Lack of regulations and lack of enforcement of existing regulations also impose safety risks in the market, and exacerbate the inequity of service access. Importers and wholesalers cite a lack of compliance by their competitors and a lack of inspection by authorities, allowing pharmacies to sell non-approved commodities. For example, independent pharmacy owners reported that facilities with internal pharmacies are non-compliant with regulations, as they sell to outside point-of-sale consumers even though it is not legally permitted.

Prices vary tremendously from one HCF to another, and prices change frequently based on demand and consumer willingness to pay. For example, according to survey data, the price of a single ANC visit among surveyed facilities varies from 150 MZN (about US$2) to 1,967 MZN (about US$28). The research indicates that many pharmacies and clinics in Maputo City smuggle in products from South Africa because their prices are more affordable, despite it being prohibited by law. This is a large disincentive
for international pharmaceutical companies evaluating investments to enter the Mozambican market, as they must factor in the black-market impact.

Coordination
There is no formal coordinating body to convene actors within the value chain to discuss topics around private service provision, or to advocate for improved inclusion of the private sector in a mixed health system. The public sector governs both the public and private commodity supply chains, but there is little opportunity for suppliers and providers to articulate their needs or influence policy change. The Confederation of Economic Associations (CTA), which aggregates members from sectoral federations, trade chambers, and business associations throughout the country, officially represents the private sector in the dialogue with the GoM to promote a better business environment in Mozambique. However, conversations around private sector roles and service integration have been limited. According to the research, only 10% of surveyed private providers belong to a membership organization; many are unregistered and not compliant with the regulations.

Referral Systems
The research suggests that referrals between facilities, especially between public and private facilities, can be strengthened to improve the consumer care experience. Currently, there are few formal referral processes established to facilitate communication between the public and private sector, nor are there tracking systems to share consumer data and trace consumers throughout the care continuum. The lack of referral processes creates a perception of competition between the public and private sector, resulting in some consumers being rejected for follow-up treatment in the public sector when public providers become aware that the consumer received initial services in the private sector.

Workforce
There is a shortage of qualified human resources in both the public and private sectors. Most hospitals and clinics employ doctors on a part-time or hourly basis, which results in shared doctors and nurses across the public and private sector. Research shows that 58% of surveyed doctors and 44% of surveyed nurses are engaged in dual practice, and work in both public and private sectors, which is legal in Mozambique. Private hospitals, clinics, and diagnostic centers lack the capacity to train health

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26 “The Confederation of Economic Associations of Mozambique (CTA) [was] formed on April 5, 1996 as a result of the conversion of a Working Committee of Associations (CTA) created to respond to the challenges of introducing the Market Economy system. CTA is a non-governmental, nonpartisan economic organization whose mission is to contribute to the economic and social development of Mozambique, based on the growth of the Private Sector by promoting and protecting business opportunities and private initiatives, culture and business associations...The CTA currently congregates 140 members between Sectoral Federations, Chambers of Commerce and Economic Associations and is represented throughout the national territory and economic sectors of activity.” Quoted from: https://www.developmentaid.org/#!/organizations/view/79047/cta-confederation-of-economic-associations-mozambique-confederacao-das-associacoes-economicas-de-moc
professionals in key medical areas, and most pharmacies have a shortage of pharmacists, employing pharmacy technicians instead. Many private health staff are not equipped with necessary training.

**Access to Financing**

Respondents reported that new private players see the cost of starting a new business as a barrier, and access to capital is a barrier for existing players seeking to grow. Many value chain players, including importers, wholesalers, transporters, and pharmacies, cite high interest rates as a challenge in securing loans or credits to finance their businesses. There are also no systems that support private providers in accessing loans or building business capacity.

**Insurance Coverage**

According to respondents, there are 20 insurance companies offering a full range of insurance services in Mozambique, as well as one company that offers only health insurance plans. These findings align with data published by the Insurance Supervision Institute of Mozambique (ISSM). Before 2018, there was no data on the number of specific health insurance policies sold, as ISSM grouped these with personal accident insurance plans. ISSM’s 2018 annual report indicates a growing trend for the combined category; the total premiums for personal accident and health insurance policies in Mozambique increased from US$33.7 million to US$50.2 million between 2014 and 2018 – with a total of 147,494 such policies in 2018.27 ISSM also states that of the total non-life insurance plans sold in Mozambique that year, health insurance plans constituted 18.48% and personal accident plans constituted 2.99%. The data in this report shows growth in the health insurance market. However, with less than 150,000 policies sold in a country of approximately 30 million people, it is still relatively small.

The research indicates that both insurance companies and providers face constraints that prevent them from expanding insurance coverage. Insurance companies reported having difficulty ensuring that quality standards are met in HCFs. Insurance companies have a negative reputation among private providers, and generally lack demand from consumers. Providers lack capacity to manage insurance services, and are not protected from financial losses. It is difficult for insurance companies to expand their contract network of providers due to the heterogeneity of provider standards. Many providers do not comply with the minimum quality standards, including ranges of services, qualifications of workforce, and infrastructure requirements. Providers report that their prices frequently change, even in the course of one day. This is not acceptable for billing insurance or health plans, and it may confuse or deter patients who are paying out-of-pocket. Private providers lack the organizational capacity to manage their relationship with the insurers, including the submission of invoices, filing of claims, and managing of IT systems. The high turnover of staff further limits capacity.

Health providers surveyed in the study reported that some health plan companies have a history of defaulting. Many open and close their activities, leaving providers unpaid. Providers also experience chronic delays in payment, which damages the reputation of the entire insurance sector. Many providers have a “blacklist” of insurers and health plan companies, and reported denying services to

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beneficiaries covered by these companies. The health plan companies are governed by different 
regulatory requirements, which are substantially lighter than for insurers. The minimum capital to start 
a health plan business is 20,000 MZN (about US$280), and they are not regulated by the ISSM. 
Meanwhile, insurers must have minimum capital of 100 million MZN (about US$1.4 million) to start a 
business, and are regulated under an insurance law supervised by ISSM. ISSM tried to convert health 
plan companies to insurers, but so far it has only succeeded in doing so with the company Mediplus.

According to anecdotal evidence from market actors, a number of formal employers (e.g., 
PSI/Mozambique) choose to reimburse a certain percentage of their employees’ health care costs 
directly with a chosen pool of providers. Effectively, this puts the employer in the role of the insurance 
company, and many choose to do this because there are no competitively priced and suitable insurance 
products in the market for their employees. This presents an opportunity for growth in the insurance 
market if appropriate products are offered to private employers who already provide health coverage to 
employees.
2. FINDINGS, RECOMMENDATIONS, AND OPPORTUNITIES

The key findings from the research are summarized in Table 2 below. The column “Key Findings” summarizes the current state of the market, the column “10-Year Vision for Sustainability” outlines a vision for the future state of the market, and the column “Recommendations” defines broad strategic priorities and suggested actions related to this ten-year sustainable vision. Suggested key actors and possible sources of funding are also identified.

Short-term actions can be defined in two ways: 1) opportunities to address constraints in the near-term that are likely to be implemented through existing or readily available resources; and 2) initial steps necessary to establish mid- or long-term interventions that will have larger expected impact but will require more time and financial resources. Not all suggested recommendations include short-, mid- and long-term actions. Many of the suggestions dovetail, and can be viewed as different paths to the same goal of a more resilient mixed health system.

Mozambique is a relatively young country with evolving systems, having emerged from protracted conflict less than 30 years ago. Its private health sector is nascent and highly fragmented, but is expanding quickly due to general economic growth stemming from large foreign direct investments in the extractive industries. In consideration of this context, the recommendations are broken down into suggested actions that could be incrementally achievable, but that still aim to shape the market so that it can deliver improved health outcomes in more effective ways in the future.
<table>
<thead>
<tr>
<th>Private Sector Governance &amp; Health Financing</th>
<th>Key Findings</th>
<th>Suggested Recommendations</th>
<th>Short-term/Mid-term/Long-term Actions</th>
<th>10-Year Vision for Sustainability</th>
<th>Key Actors</th>
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</table>
| Private Sector Governance: The private sector appears in many MISAU health strategy and investment documents; however, a guiding vision or strategy on the private sector’s role in a mixed national health system does not yet exist. | Create a specific, intentional vision to nurture strategic public/private engagement and representation for the private health sector. | **Short-term:** Identify or strengthen a private sector platform or aggregators to facilitate engagement between public and private sectors.  
**Mid-term:** Draft an initial or “Phase 1” strategy, perhaps as a white paper, to outline objectives and expectations for the role of the private sector in contributing to Mozambique’s mixed health system.  
**Long-term:** Define a longer-term strategic vision for the private sector’s role and formally include or annex this to the next iteration of the GoM’s HSSP. | GoM formalizes engagement with private health sector with a defined strategic vision for a mixed health system, supported by WHO roadmap. MISAU demonstrates recommended core governance behaviors according to WHO roadmap. Private sector representative platform(s), such as a health subgroup under the Confederation of Economic Associations Mozambique / Confederação das Associações Económicas de Moçambique (CTA), established to represent private health sector’s voice in policy making and to act as a conduit of information between the public and private sectors. | Key actors: MISAU with support from WHO and key private sector stakeholders (e.g., CTA)  
Possible funding streams: donors (e.g., USAID, World Bank), WHO |
| Private Sector Governance: Current health protocols, policies, and standards are outdated and, in some cases, applied unevenly, inhibiting private health sector contributions throughout the value chain. | Reform or develop policies to ensure effective service delivery and a functioning insurance industry. | **Long-term:** Review private sector governing policies, include public and private actors in collaborative reform discussions, and enact reforms. | Key stakeholders work with MISAU and WHO to reform policy landscape, ensuring policy implementation is enforced evenly and fairly. | Key actors: MISAU, private sector representatives, and WHO  
Possible funding streams: donors (e.g., USAID, World Bank), WHO |
<p>| Health Financing: Despite some consumers stating that private sector services and products are reasonably priced, voluntary FP and PHC services in the private sector are not affordable enough to be used on a regular basis. | Support the GoM in advancing the health financing strategy to improve equal access to services by leveraging the private sector. | <strong>Short-term:</strong> Identify “shared value” opportunities during public-private dialogue to enable the private sector to provide profitable, yet more affordable, services to consumers. <strong>Mid-term:</strong> Support MISAU to develop a strategic purchasing pilot and to validate the value of public purchasing of private delivery for future discussions. | Financing options are expanded that allow consumers to seek care based on preference, ability to pay (insurance or other payment options), and willingness to pay. Systems and practices are in place to support consistent pricing to consumers and third-party payers. | Key actors: MISAU, private sector representative platform or aggregators, and public and private sector facilities Possible funding streams: donors, MISAU (for public facilities), corporate partners |
| Private Sector Health Care Networks &amp; Service Delivery: Private clinics and pharmacies lack capacity in quality assurance, consumer counseling on voluntary FP services, demand generation, business skills, and accurate health data collection. | Build capacity of private providers through network-building or other support; using data, pursue expansion of service offerings in order to increase availability of services. | <strong>Short-term:</strong> Recruit private clinics and/or pharmacies into networks and build quality assurance and demand generation systems for voluntary FP and PHC services. <strong>Mid-term:</strong> Formalize and link network data collection to national health management information systems, and map potential expansion of service offerings to ensure more consistent availability across providers. <strong>Long-term:</strong> As the evidence base for digital health solutions grows, leverage digital technologies strategically to increase availability and accessibility of voluntary FP and PHC services and information. | Well-enforced standards and quality assurance systems toward accreditation in place with holistically improved quality of care across public and private sectors. Private sector, supported through capacity building, strategically invests in demand generation activities, leveraging social media and technology. Consumers have a regular and accurate channel of health information, potentially through new digital mechanisms, and are empowered to understand the quality of care they should be receiving. Market-based solutions/supports exist to encourage private providers to open new businesses. | Key actors: Consumers, development partners, individual information seekers (digital), MISAU, non-profit organizations, private health network franchisors or representative aggregators, and public and private sector facilities Possible funding streams: Consumers, corporations, donors, MISAU (for public services), private franchisors, private health facilities, and social enterprises |</p>
<table>
<thead>
<tr>
<th>Systems &amp; Infrastructure</th>
<th>Supply Chain System: Inadequate planning and coordination contribute to continual stock-outs of health products in the private sector.</th>
<th>Strengthen coordination and planning of private sector supply chain through more transparent information.</th>
<th>Long-term: Build supply chain coordination and planning capacities with private value chain players.</th>
<th>Supply chain data collection strategy is revised for improved efficiency. Strong data collection systems are in place for private services within and outside of facilities.</th>
<th>Key actors: Health providers, MISAU, and value chain players</th>
<th>Possible funding streams: MISAU, private corporations, and private health providers</th>
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<tr>
<td>Referral System: While consumers alternate between both sectors fluidly, a comprehensive continuum of care is not assured due to weak linkages and referrals between the public and private sectors.</td>
<td>Outline and capacitate a referral system that leverages private sector service provision.</td>
<td>Short-term: Examine and formalize existing referral linkages; create a prototype for an improved referral process between private health providers or networks and public facilities to demonstrate value.</td>
<td>Long-term: Scale successful prototype into a comprehensive formal referral system between the public and private sectors to improve consumer care.</td>
<td>Public sector views private sector as a collaborator rather than as a competitor. MISAU develops formal coordination systems including a public-private referral system.</td>
<td>Key actors: MISAU and private sector representatives (e.g., CTA or others)</td>
<td>Possible funding streams: donors (e.g., USAID, World Bank), WHO</td>
</tr>
<tr>
<td>Workforce: The number and capacity of human resources across both sectors are insufficient to provide high quality services and accurate information.</td>
<td>Increase the size of the private sector workforce and provide increased opportunities for training and continuing medical education.</td>
<td>Short-term: Offer more training opportunities, particularly through cost-effective formats like e-learning, and integrate consumer care elements into performance measurement.</td>
<td>Long-term: Increase the size of the private sector workforce.</td>
<td>Private sector facilities have trained and qualified staff and are seen as complementary to public sector. Training for health care workers is accessible on an ongoing basis.</td>
<td>Key actors: MISAU, private health sector franchisors or aggregators, and private institutions</td>
<td>Possible funding streams: MISAU-financed educational institutes and private sector educational institutes</td>
</tr>
</tbody>
</table>
2.1 Private Sector Governance

2.1.1 Key finding: The private sector appears in many MISAU health strategy and investment documents; however, a guiding vision or strategy on the private sector’s role in a mixed national health system does not yet exist.

While the private sector is referenced as a key actor in several national health strategy documents, there is no specific strategy for engaging the private sector in delivering on the GoM’s commitments to improved health outcomes. There are a number of reasons why more deliberate and strategic engagement of the private sector would benefit both sectors. While the private sector in Mozambique is smaller relative to other countries, it is clear from the research that it offers a valuable and more trusted consumer option for voluntary FP, ANC, and child health. Formally leveraging this existing capacity and infrastructure where women are already seeking services can ease pressures on an overburdened public sector. Also, an articulated strategy for the private sector can provide clarity around required regulations, particularly quality of care standards, which, when enforced, can lead to increased quality of service delivery in the private sector. Currently, with no vision or strategy in place, the private sector continues to grow in tandem with consumer demand alone and with no clear motive to coordinate, supplement, or deliver contributions toward greater national health goals.

Conversely, even when an articulated strategy is developed, the private sector remains so highly fragmented that there is no representative entity for the private sector with which to engage. Currently there is no such coordinating body or structure that can represent the interests of private health sector actors or providers. CTA serves the private sector across all industries—including some health sector members—in promoting a better business environment in Mozambique. CTA is a powerful lobby for wider private sector and commercial interests, but it does not regularly engage in specific health sector issues. Without a body like CTA to represent private health sector actors and interests, there is no conduit between the public and private sectors to lead any engagement or negotiation, nor to disseminate information, such as protocol updates, revised guidelines, or data for decision making.

In 2019, the WHO’s Advisory Group on the Governance of the Private Sector for Universal Health Care developed a roadmap entitled Engaging the private health service delivery sector through governance in mixed health system that is currently under consultation. It proposes four potential objectives for a government in deciding how to leverage the private health sector to ensure better health outcomes at the national level. The four objectives (see Figure 7) can form a starting point for policy makers to consider the structure and scale of private provision in a mixed health system.

Currently, any of the four objectives in Figure 7 could apply to the Mozambican context. However, without a representative private sector entity or platform (or multiple key entities or platforms), the engagement needed to execute such a vision cannot move forward. There are several private sector associations in Mozambique with links to health businesses, such as CTA, the National Association of Private Health Care Providers (APROSAP), and the National Association of Private Pharmacies (ANAFP). However, none of these are currently focused on facilitating policy discussions or disseminating information throughout the private health sector. It will be important to nurture an existing or new private sector platform or aggregators\(^{29}\) to lead collaborative dialogue between the public and private sectors.

**Suggested recommendation:** Create a specific, intentional vision to nurture strategic public/private engagement and representation for the private health sector.

\(^{29}\text{Aggregators, also known as intermediaries, are defined as organizations that form networks between small-scale providers to interact with governments, patients, and vendors. These organizations can perform key health systems functions which are typically more challenging for individual private providers to do on their own. For more information, see: }\text{https://r4d.org/resources/intermediaries-missing-link-improving-mixed-market-health-systems/}\)
Short-term action: *Identify or strengthen a private sector platform or aggregators to facilitate engagement between public and private sectors.* In the absence of such an entity at present, key actors such as MISAU, private sector associations, and partner organizations could review findings from this and other studies to carry out a stakeholder analysis toward identifying possible options. Candidates for this role could include the associations mentioned above, or other organizations with the capacity to form a network of private providers, thereby reducing fragmentation. Once identified, this entity—or a select number of entities representing different actors in the value chain—should be endowed with the authority to coordinate and engage with public counterparts on the private health sector’s behalf through regular consultative dialogue with joint agenda-setting.

Mid-term action: *Draft an initial or “Phase 1” strategy, perhaps as a white paper, to outline objectives and expectations for the role of the private sector in contributing to Mozambique’s mixed health system.* Development of this draft should reflect the voices of both the public and private sectors to ensure appropriate motivations exist on both sides for continued collaboration. Initially, areas of public-private partnership could focus on lower-cost, more pragmatic issues, such as: co-definition of quality indicators, possibly with a view toward eventual accreditation; data sharing for improved health service delivery in a select number of health areas; participation of private sector providers in publicly-led training or continuing medical education; increased private sector access to public or subsidized commodities in strategic health areas at no or lower cost; or even public-private leasing terms for diagnostic equipment. After appropriate review and consultation with stakeholders, particularly MISAU, this document could be adopted and implemented during an initial review period.

Long-term action: *Define a longer-term strategic vision for the private sector’s role and formally include or annex this to the next iteration of the GoM’s HSSP.* Building from the draft strategy, a strategic vision could include measures of progress and expected targets for the private sector or certain private sector actors. By this time, the WHO’s roadmap may be finalized, and could serve as a resource to inform the direction of this vision.

2.1.2 Key finding: Current health protocols, policies, and standards are outdated and, in some cases, applied unevenly, inhibiting private health sector contributions throughout the value chain.

The current private sector health care policy environment in Mozambique is complicated and fragmented throughout the value chain. The research indicates that existing policies impede the growth of private sector value chain players, while others are unevenly applied throughout the market or foster corruption. There is also a lack of regulation covering certain topics, which leaves providers and consumers unprotected from unfair practices or discrimination.

Among the private providers that reported dissatisfaction regarding current policies and legislation, the major constraints reported include bureaucracy, a prolonged licensing and legalizing process, and burdensome manual reporting. Respondents reported that these obstacles either affect the availability
and affordability of drugs and services, or result in private sector players overlooking regulations in order to reduce costs or meet consumer demand.

The research highlighted several policies that inhibit access, quality of care and lawful growth in the private sector. Those with significant ramifications are outlined below, while an expanded list is included in Annex 1.

Table 1. Identified Prohibitive Policies

<table>
<thead>
<tr>
<th>Policy</th>
<th>Reference</th>
<th>Details and Description</th>
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<tbody>
<tr>
<td><strong>Tax policies for private providers</strong></td>
<td>Ministerial Diploma No. 40/2003, of 2 April 2003</td>
<td>This legal diploma outlines the partnership between MISAU, or institutions integrated in the National Health Service, and private non-profit legal persons—but not private for-profit entities—in the provision of health care to the population.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This law authorizes the intervention of private entities in the provision of health care in Mozambique. It establishes the basic principles for these activities and the general conditions for authorization, recognition, and registration of professionals, as well as their fundamental duties and obligations.</td>
</tr>
<tr>
<td><strong>Fixed margin for supply chain players</strong></td>
<td>Ministerial Order No. 21/2017, of 13 March 2017</td>
<td>This approves the regulation on the fixing of prices for medicinal products and revokes Ministerial Order No. 56/2010 of 23 March 2010 and Ministerial Order No. 109/90 of 26 December 1990.</td>
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<td>The regulation on the fixing of prices for medicinal products was approved by the Minister of Health, through a Ministerial Diploma, due to the need to update the marketing margins of the importer, wholesaler, and retailer. This regulation was approved to 1) make the aspects relating to exchange rate fluctuations that influence the price of medicines more flexible, and 2) to ensure the creation of incentives for the national pharmaceutical market as well as the presence of a mechanism for exchange of information on the price of the medicine between MISAU, operators in the pharmaceutical sector, and the general public.</td>
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30 Details sourced from local law firm Coutro, Graca & Associates.
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<td>Importers and wholesalers face difficulties in licensing new medicines, as the process is expensive and lengthy.</td>
<td>This law authorizes the intervention of private entities in the provision of health care in Mozambique. It establishes the basic principles for the exercise of this activity and the general conditions for authorization, recognition, and registration of professionals, as well as their fundamental duties and obligations. Private hospitals, infirmaries, health stations at the workplace, medical offices or clinics, and centers for the transportation of patients, among others, are subject to prior licensing with the Health Department.</td>
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<td>The minimum capital for health plan companies to initiate business is 20,000 MZN (about US$280). Insurers have a minimum capital of 100 million MZN (about US$1.4 million) to start a business. ISSM is trying to convert health plan companies to insurers but has only succeeded with Mediplus to date.</td>
<td>The Regulation on Financial Guarantees for the Exercise of Insurance Activity was approved by the Council of Ministers, by decree, due to the need to regulate financial guarantees required of entities qualified to conduct insurance business. This includes the regime of representation and the guarantee of technical provisions, taking into account the current stage of development and modernization of the insurance sector.</td>
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<tr>
<th>Minimum capital requirement for health plan companies</th>
<th>Decree No. 9/2018, of 5 July 2018</th>
<th>This approves the table concerning minimum amounts of share capital (guarantees) and an establishment fund required for entities qualified to exercise insurance and reinsurance mediation.</th>
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<td>The minimum capital for health plan companies to initiate business is 20,000 MZN (about US$280). Insurers have a minimum capital of 100 million MZN (about US$1.4 million) to start a business. ISSM is trying to convert health plan companies to insurers but has only succeeded with Mediplus to date.</td>
<td>This decree was approved by the Council of Ministers.</td>
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<th>Minimum capital requirement for health plan companies</th>
<th>Notice of the Insurance Supervisory Institute of Mozambique, of August 2018</th>
<th>This approves the schedule concerning minimum values of share capital for entities qualified to exercise insurance activities.</th>
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<tr>
<td>The minimum capital for health plan companies to initiate business is 20,000 MZN (about US$280). Insurers have a minimum capital of 100 million MZN (about US$1.4 million) to start a business. ISSM is trying to convert health plan companies to insurers but has only succeeded with Mediplus to date.</td>
<td>Subsequent to the approval of decree 39/2018, as referenced above, ISSM issued the notice to inform all interested parties, and the public in general, about updating the minimum capital values for insurance operators, who have three years from the enactment of decree 39/2018 to adjust to the approved minimum capital values, under penalty of revocation of authorization to engage in insurance activities.</td>
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Suggested recommendation: Reform or develop policies to ensure effective service delivery and a functioning insurance industry.

**Long-term action:** Review private sector governing policies, include public and private actors in collaborative reform discussions, and enact reforms. Building on the above recommendation, a review of inhibitive policies could be discussed and built into the longer-term vision for the role of the private health sector in contributing to the GoM’s national health commitments. As policy change can be a slow process, outlining a timeline for reforms could be helpful in setting expectations for all stakeholders. As reforms take place, review periods could be built in before finalization to allow iterative rounds of updates to troubleshoot issues during implementation. Ongoing monitoring and discussion could be a regular agenda item during joint consultations between the MoH and the private health sector representative entity or aggregators. The representative entity(ies) would be expected to feed member concerns into these discussions, and in turn to disseminate information and updates coming from these discussions to members.

### 2.2 Health Financing

#### 2.2.1 Key finding: Despite some consumers stating that private sector services and products are reasonably priced, voluntary FP and PHC services in the private sector are not affordable enough to be used on a regular basis.

While some respondents stated that prices in the private sector are often reasonable, the research also shows that many women will skip ANC visits, stop taking medicines, or forego their choice of voluntary LARC services if price is a barrier. Of those surveyed, about 50% of private HCFs are offering price discounts for multiple visits to make these services more accessible to consumers. Some consumers reported prioritizing maternal and child health when visiting the private sector. Some respondents delayed pregnancy to save money for a private sector delivery, rather than going to the public sector and experiencing what they perceived to be a poor standard of care.

“I go to the Sommerschield clinic because they provide a good service. There are no waiting lines and when you arrive with a sick child, they observe her really fast. It is expensive and it is not easy for us to get the money, but it is worth it. The consultation is 3,000 MZN [about US$42].”

(Consumer respondent)

While the research indicates that consumers in Mozambique are unfamiliar with insurance options for health care, consumers working in the formal sector may have private insurance plans for which the employer pays the premium. However, less than 5% of surveyed pharmacies and around 45% of surveyed health care providers accept insurance, and therefore rely heavily on consumer out-of-pocket payments. Respondents reported that hospitals, larger clinics, medical centers, and well-located pharmacies rely on wealthier consumers, and establish contracts with insurers or health plan companies for a steady inflow of patients and revenue. Often, consumers are unaware of the benefits included in their packages, resulting in misunderstanding and misusage.
Suggested recommendation: Support the GoM in advancing the health financing strategy to improve equal access to services by leveraging the private sector.

**Short-term action:** Identify “shared value” opportunities during public-private dialogue to enable the private sector to provide profitable, yet more affordable, services to consumers. The strategic guidance document notes that “[t]he private sector has an increasingly important role in Mozambican society and economy, ...restricted to that part of the population with the capacity to pay money.” This reflects a potentially limited perception that the private health sector is only interested in serving wealthier consumers, and that its value to the public health sector is negligible. Effectively leveraging private resources can reduce public sector patient crowding, enable savings in equipment, diagnostic, or staffing costs, and increase access for consumers who cannot attend visits during public sector working hours. With greater ability to serve more consumers—who are already demanding services from a growing private sector—the savings to the public sector can also increase.

Identifying these areas of shared value as an initial step during joint consultations may help further define the value of private health sector contributions as the health financing strategy is rolled out. For example, the GoM could introduce various measures or exemptions to encourage growth in the existing insurance market. While the short-term growth of an employer-funded health insurance system may initially provide unequal access to health services, it could build the capacity of providers to work with insurance, enhance consumer familiarity with insurance products, and develop the necessary support services, all of which would be foundational to a more equitable future national health insurance program. Similarly, making collaboration more attractive for the private health sector could increase the GoM’s ability to access private sector data, which could better inform budget development, particularly for service availability and supply chain planning. Clearer insights on private sector delivery may also identify geographic or health areas where strategic purchasing could accelerate progress toward improved health outcomes.

**Mid-term action:** Support MISAU to develop a strategic purchasing pilot and validate the value of public purchasing of private delivery for future discussions. Strategic purchasing mechanisms, while gaining popularity, are relatively sophisticated, come with a long-term timeline to allow for adaptive management, and have been challenging for many countries to implement. A small and targeted strategic purchasing pilot could be used to identify areas for the public and private sectors that require greater capacity building, such as performance indicator development, pricing structures, contract execution, accurate claims submission, and validation of submitted claims. These areas could be strengthened over the life of the health financing plan, so that a large-scale strategic purchasing initiative is not rolled out too quickly. While Mozambique does not currently have a purchaser, aggregators could serve as the initial purchasers of services, leveraging donor or corporate partner funding. Longer-term timelines should be expected in an activity like this, both to allow time for careful deliberation on populations, services, and providers to be covered, as well as for thorough analysis of successes and challenges. Lessons from this pilot could directly feed future discussions on a larger state-funded strategic purchasing scheme, if there is evidence that such a mechanism would effectively advance the GoM’s priorities in meeting its health commitments.
2.3 Private Sector Health Care Networks & Service Delivery

2.3.1 Key finding: Private clinics and pharmacies lack capacity in quality assurance, consumer counseling on voluntary FP services, demand generation, business skills, and accurate health data collection.

Many of the challenges that private providers reported facing in delivering high quality FP, ANC, and child health services stem from issues raised in the previous sections. Generally, private providers are not effectively networked or represented with a common voice in consultation with public sector counterparts. Health sector policies and regulations are deemed overly burdensome, outdated, or applied unevenly such that providers seek to offer unauthorized services and products, often without repercussion. Providers are reliant on consumer out-of-pocket payments, as insurance is not reliable or widely used.

The majority of the surveyed private providers reported that they generate business through word-of-mouth promotion, with very few dedicated demand generation activities to increase consumer flows. This hampers their ability to advertise new service offerings, to cross-sell services to existing consumers, or to attract new users, particularly those with employer-based insurance schemes. This further contributes to low profits and minimal business growth among private health facilities.

"Sometimes we turn to banks, we used leasing to purchase equipment, but the interest rates are just too high. Still, we took loans to purchase supplies and equipment for the lab, and for the anesthesia device." (Provider respondent)

The research also shows that, even though consumers reported they perceive quality of care to be better in the private sector, most surveyed providers do not receive the continuous medical education needed to remain up to date with medical advances and standard operating procedures. The current private workforce in study areas include doctors (20%) and nurses (13%), half of whom also work for the public sector, and so are not consistently available at private facilities. Specialized health providers, such as gynecologists, are sourced from an even smaller pool of qualified candidates. There is also a nationwide shortage of pharmacists, with only 41% of the interviewed pharmacies reporting an onsite trained pharmacist. Respondents indicated that facilities have limited internal quality assurance systems to ensure clinical quality of care. All of these factors give rise to a private health sector that is understaffed, underqualified, and delivering variable standards of quality and safety to consumers.

Given the fragmentation of the private sector, capacity building in a standardized manner will require resources, time, and coordination. Health care providers and pharmacies require strengthening across many areas, including clinical, structural, and business capacity. The support needed could be provided with a more empowered and resourced MISAU or, more immediately, through the support of third parties, such as social franchisors or other health care network aggregators.
Social franchising, recognized as a promising high impact practice by USAID,\(^{31}\) is one option for networking providers while also building clinical and business capacity, enforcing standards, attracting new consumers, and expanding service offerings such as voluntary LARCs. Given the upfront cost and long-term sustainability challenges involved in some social franchising models applied this past decade, a more flexible “healthcare network” approach could better fit the Mozambican context and still yield similar benefits. Just as social marketing from the 1990s onward helped create markets for products such as condoms or oral contraceptive pills, so social franchising could create a market for stronger private health services. For this to be successful and sustainable, it will require aligning with the lessons of the past decade about how to implement social franchising effectively, both in terms of costs and desired health impact. For example, providers could still be aggregated into networks, but with a well thought out plan for which populations would most benefit, which providers would best fit this model, which improvements would need to be made, and what value propositions would resonate most with providers in the short and longer term. A clear plan to transfer the “franchisor” role to local entities that can assume responsibility in the long term is also a potential solution for sustainability, as is the need to ensure greater alignment and partnership with the public sector to avoid the creation of parallel systems.

Through such a model, networked providers could also receive needed support in business management and quality improvement, perhaps toward accreditation standards, without, for example, the extensive branding or free/subsidized services and commodities often included in social franchising. Depending on the timelines and business objectives, these supporting organizations could be MISAU’s new PHC development department, a professional association, a private business, a non-governmental organization, or the private sector aggregator entities suggested under Section 2.1. Capacitating supporting organizations such as this could present a significant opportunity to strengthen not only the clinical capacity of the private sector, but also of the public sector, as so many providers are shared between them.

Suggested recommendation: Build capacity of private providers through network-building or other support; using data, pursue expansion of service offerings in order to increase availability of services.

**Short-term action:** *Recruit private clinics and/or pharmacies into networks and build quality assurance and demand generation systems for voluntary FP and PHC services.* After establishing selection criteria and recruiting providers to establish networks, the priority of the supporting organizations or “franchisor” entities could focus on quality improvement and quality assurance. Baseline assessments will allow a deeper understanding of the major quality gaps within the network, and could guide the

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development of supportive supervision plans. Working with a private sector representative platform and other key stakeholders like MISAU, networked providers could be included in ongoing continuing medical education opportunities or publicly led clinical training. Joint supervision visits could be conducted with MISAU to build capacity and promote transparency in data collection in preparation for eventual transition to a MISAU-governed private sector quality assurance system. Regular external evaluators or mystery consumers could also be engaged to provide additional insights on network quality. Consumer experience mechanisms could also be incorporated, providing a critical understanding of where and why consumers choose to seek health services. Demand generation activities could also be formalized, coordinated, and measured for return on investment. Consumer insights could help to develop tailored messages for both existing and expanded services, and consumers could be sensitized on insurance options to reduce out-of-pocket payments.

**Mid-term action:** Formalize and link network data collection to national health management information systems, and map potential expansion of service offerings to ensure more consistent availability across providers. As part of its role, a supporting organization would support formalization (and possibly digitization) of data collection within the network, and ensure that this is fed to MISAU systems for improved tracking of private sector service provision. Building from this data as well as from the results of this report and other research, opportunity maps demonstrating expanded service offerings could be developed for each provider to ensure more consistency across the network. For example, using the research from this report, private clinics in Nampula could expand ANC services, and pharmacies in all three cities could extend their voluntary FP and PHC services further to include self-care products, like DMPA-SC and HIV self-testing, as these products are introduced in Mozambique. It will also be important to assess the willingness of providers to take up the proposed services and to understand potential implications on their consumer flows and profit margins.

The research indicates that pharmacies are a promising channel in Mozambique’s urban centers to increase and broaden the availability of clinical services related to voluntary FP, and PHC. Many of those surveyed indicated interest in expanding their service offerings to increase income. This may include child weight measurement, information campaigns, or counseling/administering of voluntary FP and self-care products. An expansion of these services to pharmacies or pharmacy networks would necessitate policy change to current task sharing guidelines, an advocacy goal that could be advanced by a private sector representative entity as suggested in Section 2.1. At the same time, pharmacy networks could ensure that pharmacies are registered properly, which is a particular issue in Nampula, where 36% of pharmacies are currently unregistered, and could also provide focused skill-building and training programs for pharmacists and pharmaceutical technicians.

With task sharing policy changes, Mozambique’s community health worker curriculum could be adapted to train pharmacists in counseling and provision of voluntary FP and PHC services. Since the research suggests that pharmacies receive the highest percentage of adolescent consumers, this is an opportunity to focus on voluntary FP counseling to meet their needs and to contribute to a reduction in

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32 Such as client exit interviews, consumer feedback boxes, or digital or paper-based follow-up surveys to visits.
unintended youth pregnancies. Formal referral systems could be developed within the franchises for pharmacies to refer complicated cases in a timely manner, and in a way that allows for overall consumer health outcomes to be tracked. In cases where pharmacies are already providing PHC services illegally, franchises could formalize and assure the quality of these services to ensure that consumer safety is the top priority.

**Long-term action:** As the evidence base for digital health solutions grows, leverage digital technologies strategically to increase availability and accessibility of voluntary FP and PHC services and information. While the evidence base for digital health solutions is still growing, digital health is emerging as a compelling opportunity to transform health services and systems, and to serve consumers in a way that is more tailored to their individual circumstances. These solutions can enable consumers to meet certain primary health needs without relying on public or private service provision. For example, consumer-facing digital solutions leveraging phones and social media could be optimized to reflect health messaging for specific audience segments. For networked providers, apps could be tailored for clinical and structural quality assessments, for trainings through e-learning modules, or for electronic referrals between mobilizers, private clinics, and pharmacies. Consumer-facing digital solutions, leveraging phones and social media, could be optimized to reflect messaging for target audiences, or to share information on specific health areas. Artificial intelligence symptom checkers or chatbots could be deployed as screening tools for consumers, and could signpost them to recommended referral sites within the catchment area. As the utility of these solutions is proven, various actors across Mozambique’s mixed health system could deploy them where needed.

### 2.4 Systems & Infrastructure

#### 2.4.1 Key finding: Inadequate planning and coordination contribute to continual stock-outs of health products in the private sector.

While the public sector has a dedicated supply chain, the private sector supply chain operates independently and is particularly susceptible to stock-outs. The research shows that minimum order quantities, Portuguese language packaging requirements, policies that constrain profits, inadequate order coordination, and lack of demand planning contribute to stock-outs. Minimum order quantities (MOQs) were noted as particularly problematic by the surveyed providers. Importers and wholesalers require an MOQ to remain profitable; however, many small providers reported being unable to meet the MOQ, leading to frequent stock-outs. Furthermore, as discussed above, restrictive policies requiring fixed margins limit economic drivers that could ensure availability of products and services in remote locations.

"We lack the FP methods, as is the case of the IUD and the implant. There has been scarcity, the supplier does not deliver all we need, and the order must be placed months in advance. If we could get more, we would have a lot more customers because we are in a densely populated area, where there is a lot of need for family planning." (Provider respondent)
Stock-outs have an obvious impact on clinical decisions and product uptake. Respondents indicated that providers tend to prescribe only products that are available in their pharmacies. This leads to consumer use of products that may not fit their needs, potentially leading to higher discontinuation rates for FP while still in need. According to interviews with doctors, stock-outs of voluntary LARC products such as IUDs and implants are frequent, while short-term methods such as oral contraceptive pills and injectables are commonly prescribed due to their availability.

Suggested recommendation: Strengthen coordination and planning of private sector supply chain through more transparent information.

Long-term action: Build supply chain coordination and planning capacities with private value chain players. Modern medical supply chains are complex. Addressing weaknesses, bottlenecks, and disjointedness in public and private supply chains in many countries is not a new challenge, or easy to solve. However, for the above suggested recommendations and related actions to successfully result in improved health outcomes in Mozambique, the fundamental mechanics of the private sector supply chain must be strengthened concurrently over the long term. A first step could be to improve transparency of information, as this is essential for effective planning and monitoring of supply chain performance. Currently, the fragmentation of the private health sector does not allow such broad transparency across value chain providers. Should a representative private sector platform or aggregators be identified or developed, consolidating and analyzing supply chain information may be a role it/they could play. In many countries, health market data and sales data can be purchased from private companies such as 2Logical in Mozambique. The existing data could be utilized to understand the market size, market value, regional distribution coverage, and so on. With a shared understanding of the quantified value or volume of the private health supply market, key stakeholders could decide where coordination and investment are most needed.

2.4.2 Key finding: While consumers alternate between both sectors fluidly, a comprehensive continuum of care is not assured due to weak linkages and referrals between the public and private sectors.

The research highlights immediate areas where the private sector could be leveraged to improve public health outcomes. For example: 1) voluntary LARCs are frequently not available in the public sector, but 76% of the surveyed private health care providers offer implants and 72% offer IUDs; 2) although many consumers use the public sector for free child delivery and routine child care (e.g., weight measuring), consumers reported that they are willing to save money or delay pregnancies to give birth in a private sector facility; and 3) respondents indicated that they prefer private facilities for ANC counseling and curative child health due to convenience and perceptions of more respectful customer care. The current Mozambique HSSP recognizes that an effective referral system is critical in ensuring the continuum of care, and acknowledges that the current referral process does not include private providers. While sustaining effective referral systems in general in many countries is an ongoing challenge, some
countries have seen their public and private sector actors work together to improve certain referral pathways, such as in Nepal.\textsuperscript{33}

Currently, the research shows that many private facilities have systems in place for referrals to other private health facilities, though this varies by location. 59% of the surveyed private health care providers in Nampula do not refer consumers to other facilities, but a majority of the providers do in Maputo (77%) and Matola (70%). Informal referrals are fluid among private sector facilities due to professional networks and personal relationships. Respondents indicated that referrals to the public sector were less frequent, and that there is an underlying sense of competition inhibiting dialogue on how to strengthen referrals and leverage complementary strengths. Most of the referrals between the public sector and the private sector take place during urgent situations, with no system that tracks consumer referrals throughout the care continuum. Private clinics generally have medical equipment, consumables, and commodities required to deliver basic services, but surgeries or laboratory services (such as biopsies) usually take place at public sector referral hospitals.

As noted in earlier sections, any sense of competition can have significant negative effects on a consumer’s care-seeking experience. Despite these challenges, consumers reported using both public and private health facilities. To improve the consumer experience across the continuum of care, there is an opportunity to strengthen linkages between the public and private sectors, to align data for voluntary FP and PHC service sharing and monitoring, and to promote a functional network across all levels of the health system.

**Suggested recommendation:** Outline and capacitate a referral system that leverages private sector service provision.

**Short-term action:** *Examine and formalize existing referral linkages; create a prototype for an improved referral process between private health providers or networks and public facilities to demonstrate value.* Using findings from this report and data collected through provider networks or through other data sharing actions as suggested above, a database of private providers and relevant details (e.g., their locations, registered medical personnel, pricing structure, available equipment, specialist services) could be established. This database would ideally be made available via a web interface or phone application. Key members, such as MISAU, private health associations, and other private sector aggregators could convene to establish a common goal for the referral system that is aligned with the national health care strategy and plan. Providers, MISAU, and other key stakeholders could then examine this database to determine where linkages between public and private facilities would be appropriate. While a database like this could be outdated relatively soon due to the transient nature of many health care businesses in Mozambique, it would serve to create a baseline from which to design an initial public-private referral system.

Existing care linkages should also be formalized through a tracking system. Information such as consumers referred from private facilities to other public or private facilities due to emergencies, stock-outs, or other reasons should be recorded and tracked, allowing for future analysis and reporting. Validating and tracking these linkages in the system could also help reduce stigma against consumers seeking care in different facilities. New referral linkages could be added to this prototype as it is built (e.g., voluntary FP consultations, sexually transmitted infection screening, or cervical/breast cancer screening). This prototype could then be utilized to demonstrate the value of a referral system for continuous improvement and implementation.

Private providers may not welcome such an initiative, as it may highlight dual practice and require an additional reporting burden. Securing their buy-in would be essential. Financial and policy incentives, such as tax breaks or access to free or subsidized commodities, could be considered in exchange for private sector participation and compliance in such a system.

**Long-term action:** *Scale successful prototype into a comprehensive formal referral system between the public and private sectors to improve consumer care.* Key stakeholders involved in initial development of the referral system prototype should convene to review its effectiveness and determine other health areas, necessary resources, or systems requirements that could be required at greater scale. Ineffective referral systems are a perennial challenge in health systems; to scale up a workable prototype, many moving parts would need to advance at the same time. Different cadres and actors across the health system would need to be instructed on how to interact with the referral system and when complicated cases should be referred upwards. Establishing a monitoring and evaluation process would be essential to track progress, along with output indicators for monthly, quarterly, and annual monitoring and reporting. Resource mobilization would also be required at national, provincial, and district levels to ensure sufficient financial commitment to adequately support the referral process. Once the referral system is established, an overall policy and strategic framework for operations could be included under the next iteration of the HSSP. This policy could include guiding principles and details such as expectations and standards for service providers, protocols which lead to referral system efficiency and effectiveness, and information system requirements to manage referrals.

**2.4.3 Key finding: The number and capacity of human resources across both sectors are insufficient to provide high quality services and accurate information.**

The research indicates that the private health sector in Mozambique has two primary challenges in terms of human resources: a workforce deficit and variable quality. Within the study locations, doctors and nurses were in short supply (20% and 13% of surveyed providers, respectively). Specialty doctors were rare, with the study finding only 80 licensed gynecologists/obstetricians. Permanent staff in smaller private clinics are predominantly health technicians. Pharmacies also have a shortage of pharmacists, and less than half of the surveyed private facilities (41%) had a trained pharmacist onsite. The human resource deficit spans the entire national health system and affects the public sector as significantly. Addressing the broader health worker shortage goes well beyond the private sector...
challenges alone, and will require a greater effort that should be directed under the overall human resources strategy currently being led by MISAU with support from external stakeholders, including WHO.

As noted in sections above, the research identified serious constraints related to quality of care among the private sector workforce. Providers cited a lack of continuous training for providers as a major impediment to providing high quality health services and accurate information. Most private hospitals, clinics, and diagnostic centers reported that they lack the capacity to train their health professionals, and that they rely on non-governmental organizations to train staff. Partners like PSI/Mozambique have seen a rapid increase in the number of pre-service training institutions in Mozambique over the last decade. Due to lack of available infrastructure in the private sector, privately-run institutions continue to leverage public facilities for practicums and other in-person requirements. However, partners report that the private sector rarely hires recent graduates, and instead draws from health professionals who have built their experience through public sector service. While professional associations can be valuable in providing access to continuing medical education for their members, most of the private health professionals interviewed in the study do not belong to a professional association.

Suggested recommendation: Increase the size of the private sector workforce and provide increased opportunities for training and continuing medical education.

**Short-term action:** Offer more training opportunities, particularly through cost-effective formats like e-learning, and integrate consumer care elements into performance measurement. In the context of health networks, the aggregators or “franchisor” entities could identify opportunities for regular training, and could devise a supervisory system to measure performance. With greater public-private engagement, private sector providers could regularly participate in publicly led trainings, and could be supervised through joint assessments with public counterparts. E-learning opportunities offer new ways of providing updated information at reduced cost. While the evidence base is still emerging for effectiveness of blended learning (e.g., e-learning with limited in-person practicums), informational webinars to provider refresher training or to disseminate protocol or policy updates could be deployed with limited investment. To measure absorption of training content and concepts, consumer experience mechanisms, such as those discussed in Section 2.3 above, could regularly be folded into supervisory processes and performance assessments. These mechanisms could apply not only to the private sector but also to the public sector. Consumer satisfaction ratings could be used to identify areas of improvement in consumer care, such as perception of convenience, attitude, cleanliness, and hygiene.

**Long-term action:** Increase the size of the private sector workforce. MISAU is addressing human resource shortages across the entire national health system through a multi-year human resources for health strategy in collaboration with WHO. The private sector could be engaged in this initiative, potentially through a representative platform or through aggregators, to ensure that private sector human resource needs are integrated into planning. The private sector could then be expected to serve as an active contributor under the strategy.
3. **CONCLUSION**

While official data provides a window on availability, coverage, and accessibility of products and services in the private health sector, examining the sector more holistically and including the interactions between these providers and their consumers provides a much deeper understanding of the motivations, barriers, and opportunities within this sector. Broadly, the objective of this research was to achieve this deeper understanding: to plot out a more comprehensive map of all private health sector providers in major urban areas of Mozambique, regardless of registration status; and to provide a more granular understanding of supply- and demand-related constraints and opportunities regarding the private health sector’s role within the overall health system.

In doing so, the research has generated a better understanding of the private health sector’s true geographic breadth and depth in these locations and health areas, while also collecting intriguing insights into the consumer’s care-seeking experience. These findings provide the basis for the comprehensive set of evidenced recommendations to support an expanded role for the private health sector in voluntary FP and PHC products and services. The recommendations are drawn from a systems development approach to coordinating a health market. This approach is ideally driven by both consumer and market insights, and aims to lead to more equitable use of quality products and services.

While economic growth in Mozambique in recent years has been somewhat slow, projections for the coming years suggest that Mozambique will soon have a fast-growing economy bolstered by the expected award of several large natural resource extraction contracts to major corporations. These industries are expected to bring an increase in job opportunities in the formal sector, as well as employers who will likely seek to provide health benefits to their employees.

This assessment found that the private sector in urban centers is nascent but growing. Despite its small size, the private sector appears to be more effective in responding to consumer needs, and it complements the public sector by offering a range of services based on consumer demand. Generally, consumers in the study reported positive perceptions of private sector care, citing more respectful customer care, wider availability of products, increased convenience, and good hygiene. Respondents reported that it is the preferred sector for urgent needs like treating a gravely ill child, or for pivotal moments in the life cycle such as delivering a healthy baby. The private sector clearly offers a positive and valued care experience to consumers in Mozambique, despite services remaining too expensive to use on a regular basis.

However, if the economic boom materializes and more consumers are able to afford private health services, key barriers in governance, health financing, service delivery, systems, and infrastructure will need to be addressed in order for the private sector to meet demand effectively with high quality care.

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Through consultations with key health stakeholders in Mozambique, this report suggests recommendations and implementing actions for consideration by MISAU, other key stakeholders, and development partners such as USAID.

Implementing the recommendations in this report will require prioritizing relatively limited existing resources to ensure maximum impact. More deliberate and robust governance and engagement between the public and private sectors could result in greater transparency, improved quality assurance and systems, stronger market-based drivers, and better consumer care experiences. Infrastructure, system inputs, financing, supply of products, and other barriers need to be addressed in tandem to ensure a sustainable and commercially viable future market for voluntary FP and PHC services.

Investment in the private sector today is critical in shaping how the Mozambican population will receive health services tomorrow. Building a resilient and competitive private health sector that provides high-quality services, and that is appropriately regulated, financed, and resourced, will allow the overall system to grow and to meet increasing future demand. With a stronger private health sector to complement and coordinate with its public counterparts, particularly in the areas of voluntary FP, ANC, and child health, Mozambique’s mixed health system is more likely to deliver on national commitments in more effective ways in the future.
## ANNEX 1: PROHIBITIVE POLICIES FOR THE PRIVATE SECTOR

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<thead>
<tr>
<th>Policies</th>
<th>Reference</th>
<th>Details and Description</th>
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<tr>
<td><strong>Tax policies for private providers</strong></td>
<td>Ministerial Diploma No. 40/2003, of 2 April 2003</td>
<td>This legal diploma outlines the partnership between MISAU, or institutions integrated in the National Health Service, and private non-profit legal persons—but not private for-profit entities—in the provision of health care to the population.</td>
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<td>This law authorizes the intervention of private entities in the provision of health care in Mozambique. It establishes the basic principles for these activities and the general conditions for authorization, recognition, and registration of professionals, as well as their fundamental duties and obligations.</td>
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<tr>
<td><strong>Fixed margin for supply chain players</strong></td>
<td>Ministerial Order No. 21/2017, of 13 March 2017</td>
<td>This approves the regulation on the fixing of prices for medicinal products and revokes Ministerial Order No. 56/2010 of 23 March 2010 and Ministerial Order No. 109/90 of 26 December 1990. The regulation on the fixing of prices for medicinal products was approved by the Minister of Health, through a Ministerial Diploma, due to the need to update the marketing margins of the importer, wholesaler, and retailer. This regulation was approved to 1) make the aspects relating to exchange rate fluctuations that influence the price of medicines more flexible, and 2) to ensure the creation of incentives for the national pharmaceutical market as well as the presence of a mechanism for exchange of information on the price of the medicine between MISAU, operators in the pharmaceutical sector, and the general public.</td>
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<td>Regulations on the Provision of Health Care by Private Entities.</td>
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<td>This law authorizes the intervention of private entities in the provision of health care in Mozambique. It establishes the basic principles for the exercise of this activity and the general conditions for authorization, recognition, and registration of professionals, as</td>
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well as their fundamental duties and obligations. Private hospitals, infirmaries, health stations at the workplace, medical offices or clinics, and centers for the transportation of patients, among others, are subject to prior licensing with the Health Department.

<table>
<thead>
<tr>
<th>Prohibited activities</th>
<th>Ministerial Order No. 53/2010, of 23 March 2010</th>
<th>Regulation on the National System on Monitoring of Pharmacies.</th>
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<tr>
<td><strong>Prohibited activities</strong></td>
<td></td>
<td>The law on medicinal products aims to establish the legal framework to ensure the availability of effective, safe, and good quality products at affordable prices for the whole population and to guarantee their rational use.</td>
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<tr>
<td>Research indicates that 13% of pharmacies offer progestin-only injectables and 2% offer IUDs. Pharmacies, by law, are not allowed to counsel or administer injectables or IUDs.</td>
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<td>In this context, it has proven necessary to ensure the functioning of the National System on Monitoring of Pharmacies, responsible for the detection, evaluation, control, registration, and prevention of adverse reactions to medicines, and to monitor all aspects of quality, safety, and effectiveness of these products after their introduction in the national territory.</td>
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<tr>
<td>Pharmacies housed within hospitals and clinics often accept walk-in consumers, although they are only allowed to fill prescriptions written within the hospital or clinic.</td>
<td>Ministerial Order No 61/80, of 9 July 1980</td>
<td>Prohibits pharmacies from supplying to the public some medicines that may be harmful to the health of the population without a medical prescription.</td>
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<td></td>
<td>Ministerial Diploma No. 61/80, of 9 July 1980</td>
<td>Prohibits pharmacies from providing the public with certain over-the-counter medicines that may be harmful to the health of the population.</td>
</tr>
<tr>
<td><strong>Drug smuggling</strong></td>
<td>Ministerial Order of 06 March 2017</td>
<td>Determines that all imported medicinal products must undergo analytical testing for quality assurance prior to shipment to ensure that all pharmaceutical products in circulation in the national territory are safe, effective, and of good quality.</td>
</tr>
<tr>
<td>Research shows that many pharmacies and clinics in Maputo City smuggled in products from South Africa due to more affordable pricing, despite it being prohibited by law.</td>
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</table>
| Prices vary tremendously from one HCF to another, and prices change frequently based on consumer demand and willingness to pay. Currently, pricing standards are not applied evenly in private health sector. | | The regulation on the fixing of prices for medicinal products was approved by the Minister of Health, through a Ministerial Diploma, due to the need to update the marketing margins of the importer, wholesaler, and retailer. This makes the aspects relating to exchange rate fluctuations influencing the price of medicines more flexible,
and ensures the creation of incentives for the national pharmaceutical market and the creation of a mechanism for exchange of information on the price of the medicine between MISAU, operators in the pharmaceutical sector, and the general public.

<table>
<thead>
<tr>
<th><strong>Data sharing</strong></th>
<th><strong>Ministerial Diploma No. 195/2004 of 3 November 2004</strong></th>
<th><strong>Regulation of General Inspection of Health</strong></th>
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<tbody>
<tr>
<td>Less than half of HCFs report health service statistics to MISAU (42%), as data sharing is onerous and requirements are poorly enforced, with few consequences for non-compliance.</td>
<td>The purpose of these rules of procedure is to establish guiding principles governing the activity and operation of the General Health Inspectorate. The General Health Inspectorate aims to supervise and control compliance with the health, administrative, economic, and financial legislation in force in all institutions of MISAU in private health care establishments throughout the national territory. The inspection is carried out in conjunction with the Regional Health Inspectorates.</td>
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<tr>
<th><strong>Inspection of private pharmacies</strong></th>
<th><strong>Ministerial Order No. 53/2010, of 23 March 2010</strong></th>
<th><strong>Regulation on the National System on Monitoring of Pharmacies.</strong></th>
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<tbody>
<tr>
<td>Inspections do not occur routinely, as the enforcement bodies are often under-resourced. For example, pharmacies are inspected by the National Pharmaceutical Directorate, but there is insufficient funding to evaluate the quality of services provided by the private sector.</td>
<td>The law on medicinal products aims to establish the legal framework to ensure the availability of effective, safe, and good quality products at affordable prices for the whole population and to guarantee their rational use. In this context, it has proven necessary to ensure the functioning of the National System on Monitoring of Pharmacies, responsible for the detection, evaluation, control, registration, and prevention of adverse reactions to medicines, and to monitor all aspects of quality, safety, and effectiveness of these products after their introduction in the national territory.</td>
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<tr>
<th><strong>Regulatory requirement for health plan companies</strong></th>
<th><strong>Decree No. 1/2010, of 31 December 2010</strong></th>
<th><strong>Insurance Regime.</strong></th>
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<tr>
<td>Some health plan companies have a history of defaulting (many open and close their activities, leaving providers unpaid) and delaying payments, which damages the reputation of the entire insurance sector. The health plan companies receive different regulatory requirements (substantially lighter) than insurers and they are not regulated by ISSM. Insurers are regulated under the insurance law and supervised by ISSM.</td>
<td>The Legal Regime of Insurance was approved by the Council of Ministers, by decree, due to the existing need for establishing a legal regime of insurance. This statute sets forth the requirements applicable for conducting insurance business in Mozambique, as well as for the execution of related contracts.</td>
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</table>
The Regulation on Financial Guarantees for the Exercise of Insurance Activity was approved by the Council of Ministers, by decree, due to the need to regulate financial guarantees required of entities qualified to conduct insurance business. This includes the regime of representation and the guarantee of technical provisions, taking into account the current stage of development and modernization of the insurance sector. |
| --- | --- | --- |
| The minimum capital for health plan companies to initiate business is 20,000 MZN (about US$280). Insurers have a minimum capital of 100 million MZN (about US$1.4 million) to start a business. ISSM is trying to convert health plan companies to insurers but has only succeeded with Mediplus to date. | Decree No. 39/2018, of 5 July 2018 | This approves the table concerning minimum amounts of share capital (guarantees) and an establishment fund required for entities qualified to exercise insurance and reinsurance mediation.  
This decree was approved by the Council of Ministers. |
| Notice of the Insurance Supervisory Institute of Mozambique, of August 2018 | This approves the schedule concerning minimum values of share capital for entities qualified to exercise insurance activities.  
Subsequent to the approval of decree 39/2018, as referenced above, ISSM issued the notice to inform all interested parties, and the public in general, about updating the minimum capital values for insurance operators, who have three years from the enactment of decree 39/2018 to adjust to the approved minimum capital values, under penalty of revocation of authorization to engage in insurance activities. |