

CHILD POVERTY AND DISPARITIES

IN MOZAMBIQUE 2010



United Nations
Mozambique

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Foreword

The 2010 *Study on Child Poverty and Disparities in Mozambique* provides an opportunity to take stock of the progress made towards the realisation of the rights of the country's ten million children since the 2006 *Childhood Poverty Study: A Situation and Trends Analysis*, and to assess the immense challenges that remain for the coming years.

The Government of Mozambique has shown its commitment to the realisation of the rights of all Mozambican children by ratifying the Convention on the Rights of the Child in 1994. The rights and needs of children are distinctive from those of adults, in that poverty and deprivation faced as a child have life-long impacts on health, productivity and the ability to raise a family and live a happy life. This means that investment is needed today to ensure a productive, healthy and fulfilled next generation of Mozambicans.

Poverty in Mozambique has stagnated over the past six years. More than half of the population continue to live on less than 50 cents a day, a number that includes more children than adults. A staggering number of children are stunted – suffering from chronic malnutrition – the effects of which cannot be reversed. The number of children with access to safe water is declining and even fewer have access to safe sanitation. These gaps in children's basic needs make it all the easier to fall victim to the four leading causes of child mortality: malaria, neonatal causes, acute respiratory infections, and AIDS. Girls, orphans, children with disabilities and living in rural areas and the poorest households, are even more vulnerable as they face great inequity of access to already scarce services.

This does not mean that no progress has been observed over recent years. Absolute poverty, measured by deprivation of basic needs and services, has fallen significantly in Mozambique, with more children having access to essential services such as health and education, as a direct result of the Government's dedication to increasing access to essential services. The importance of education cannot be overstated, as an educated mother is a key determinant in the health and welfare of her children. Eliminating geographic disparity is equally vital, as the children of central and northern provinces, such as Zambezia, are being left behind with lower budget allocations and an equivalent lack of access to the very services they need to catch up to their peers in the south.

There are only four years left until the target year of the Millennium Development Goals (MDG), 2015. While it is becoming increasingly evident that Mozambique is unlikely to achieve all of these goals, the upcoming four years are an opportunity to scale up interventions to reduce the burden caused by poverty, hunger, child mortality, gender inequality and diseases that too many children continue to face. Each MDG target that is obtained will be due to the concerted, collaborative efforts of the Government of Mozambique, the UN family, the donor community, civil society and the people of Mozambique.

Recent years have proven that investments can be made to better the lives of children in Mozambique. It is now time to redouble these efforts so that each and every Mozambican child can look forward to a long, healthy, happy and fulfilling life.

UN Resident Coordinator



Jennifer Topping

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Acronyms

ADE	Apoio Directo às Escolas (Direct Support to Schools)
ADE-COV	Apoio Directo à Escola – Crianças Orfãs e Vulneráveis (Direct Support to Schools – Orphans and Vulnerable Children)
ADPP	Ajuda de Desenvolvimento de Povo para Povo (Development Aid from People to People)
AMCOW	African Ministers’ Council on Water
AIM	Agência de Informação de Moçambique (Mozambique News Agency)
APE	Agente Polivalente Elementar (Community Health Workers)
ARI	Acute Respiratory Infection
AZT	Zidovudine
C4D	Communication for Development
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIMCI	Community-Integrated Management of Childhood Illness
C-IMNCI	Community-Integrated Management of Neonatal and Childhood Illness
CLTS	Community Led Total Sanitation
CMC	Community Multimedia Centre
CWIQ	Core Welfare Indicator Questionnaire
DHS	Demographic and Health Survey
DNA	Direcção Nacional de Águas (National Water Directorate)
DPT	Diphtheria-Pertussis-Tetanus
DRN	Direcção Nacional dos Registos e Notariado (National Directorate for Registry and Notary)
ECD	Early Childhood Development
EFA-FTI	Education for All – Fast Track Initiative
EP1	Ensino Primário do Primeiro Grau (lower level primary education)
EP2	Ensino Primário do Segundo Grau (upper level primary education)
EPC	Ensino Primário Completo (primary education)
EPE	Escolas Primárias Expandidas (expanded primary schools)
ESG1	Escola Secundária Geral do Primeiro Grau (lower level secondary education)
ESG2	Escola Secundária Geral do Segundo Grau (upper level secondary education)
EPF	Escola de Professores do Futuro (Training College for Teachers of the Future)
FASE	Fundo de Apoio ao Sector da Educação (Education Sector Common Fund)
FORCOM	Forum Nacional das Rádios Comunitárias (National Forum of Community Radios)
FRELIMO	Frente de Libertação de Moçambique (Liberation Front of Mozambique)
GABINFO	Gabinete de Informação (Information Office)

GDI	Gender Development Index
GDP	Gross Domestic Product
GEM	Gender Empowerment Measure
GPI	Gender Parity Index
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IAF	Inquérito aos Agregados Familiares (Living Conditions Household Surveys)
ICS	Instituto de Comunicação Social (Institute of Social Communication)
ICT	Information and Communication Technology
IFP	Instituto de Formação dos Professores (Teacher Training Institute)
IFTRAB	Inquérito Integrado à Força de Trabalho (Labour Force Survey)
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Neonatal and Childhood Illness
INCM	Instituto Nacional das Comunicações de Moçambique (National Institute for Communications in Mozambique)
INGC	Instituto Nacional de Gestão de Calamidades (National Institute for Disaster Management)
INSIDA	Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA em Moçambique (National Survey on HIV/AIDS)
IOF	Inquérito ao Orçamento Familiar (Household Budget Survey)
IOM	International Organisation on Migration
IPAJ	Instituto do Patrocínio e Assistência Jurídica (Legal Aid Institute)
IRS	Indoor Residual Spraying
LOLE	Lei dos Órgãos Locais do Estado (Law on Local State Organs)
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MICOA	Ministério para a Coordenação da Acção Ambiental (Ministry for the Coordination of Environmental Affairs)
MINED	Ministério da Educação (Ministry of Education)
MMAS	Ministério da Mulher e da Acção Social (Ministry of Women and Social Action)
MMR	Maternal Mortality Ratio
MTEF	Medium-Term Expenditure Framework

NVP	Nevirapine
OVC	Orphans and Vulnerable Children
PACOV	Plan de Acção para as Crianças Órfãs e Vulneráveis (Action Plan for Orphaned and Vulnerable Children)
PAP	Parceiros de Apoio Programático (Programme Aid Partners)
PARP	Plano de Acção para a Redução da Pobreza (Plan of Action for the Reduction of Poverty, 2010 – 2014)
PARPA I	Plano de Acção para a Redução da Pobreza Absoluta (Action Plan for the Reduction of Absolute Poverty, 2002-2006)
PARPA II	Plano de Acção para a Redução da Pobreza Absoluta (Action Plan for the Reduction of Absolute Poverty, 2010-2014)
PASD	Programa de Apoio Social Directo (In-kind Social Transfer Program)
PCR	Polymerase Chain Reaction
PES	Plano Económico e Social (Economic and Social Plan)
PESA-ASR	Plano Estratégico de Abastecimento de Água e Saneamento Rural (Strategic Plan for Rural Water Supply and Sanitation)
PMTCT	Prevention of Mother-to-Child Transmission
PRONASAR	Programa Nacional de Abastecimento de Água e Saneamento Rural (National Rural Water Supply and Sanitation Programme)
PSA	Programa de Subsídio de Alimentos (Food Subsidy Programme)
RED	Reaching Every District
RENAMO	Resistência Nacional Moçambicana (National Resistance of Mozambique)
RM	Rádio Moçambique (Radio Mozambique)
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Education Quality
SETSAN	Secretariado Técnico de Segurança Alimentar e Nutricional (Technical Secretariat for Food Security and Nutrition)
SISTAFE	Sistema de Administração Financeira do Estado (State Financial Administration System)
TVM	Televisão de Moçambique (Television of Mozambique)
UEM	Universidade Eduardo Mondlane (Eduardo Mondlane University)
UP	Universidade Pedagógica (Pedagogical University)
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
ZIP	Zona de Influência Pedagógica (School Cluster)

Executive Summary

Childhood poverty has immediate and long-term effects on children. Chronic malnutrition, for example, in the first two years of life can permanently impact a child's growth, resulting in stunting and reduced mental development. The impact of inter-generational childhood poverty and its cyclical nature is also evidenced by poverty's proven role as a barrier to accessing social services. Poor households have more difficulty accessing good-quality health care, are less likely to have their children in school and are less likely to have access to safe drinking water and adequate sanitation facilities. Poor children have an elevated risk of growing up to become poor adults and in turn, have poor children.

In 2008/2009, out of Mozambique's almost 21.5 million people, nearly 12 million, or 55 per cent of the population, live below the poverty line of 18.4 Meticaís (around \$US 0.50) per day. Compared to 2002/03, poverty rates have stagnated. Other consumption-based measures include the amount of calories consumed a day. More than half of Mozambican children consume fewer calories daily than is considered adequate by the World Health Organisation. Consumption-based poverty rates have stagnated between 2002 and 2008, principally due to a lack of progress in the agricultural sector.

Mozambique has made great strides in recent years in reducing deprivation-based childhood poverty and in increasing access to essential services. The level of a family's income does not create a full picture of the health and well-being of a child. The deprivations-based approach focuses on the basic needs and key public services of which a child is deprived, allowing for a more multidimensional understanding of poverty. Using this measure, 48 per cent of Mozambican children are living in absolute poverty - as measured using a deprivations-based methodology - a fall

from 59 per cent in 2008. The reduction was driven by significant improvements in the health and education sectors. Children are particularly vulnerable to water, sanitation and information deprivations.

Child survival and development

Poverty and child survival are intrinsically linked. Low levels of child survival and health status are both a cause and a symptom of poverty. The principal indicator used to measure the level of child well-being and its rate of change in a country is the under-five mortality rate. The under-five mortality rate reduced from 153 deaths per 1,000 live births in 2003 to 141 in 2008. The under-five mortality rate is the result of a wide variety of factors including: the nutritional status and the health knowledge of mothers, caring practices, the availability, use and quality of maternal and child health services, income and food availability in the family, the availability of clean water and safe sanitation, and the overall safety of the child's environment. Although a disparity remains, improvements in the under-five mortality rate were driven by rural areas.

Malaria, neonatal causes and acute respiratory infections and AIDS are the four major immediate causes of mortality among young children in Mozambique. Undernutrition is the main underlying cause of child mortality. Stunting (or chronic undernutrition) remains very high - 44 per cent of children less than 5 years old are stunted, a decrease of only 4 percentage points since 2003. Stunting affects individual children but is also closely linked to the overall development of a country, as stunting affects cognitive development and is related to future educational outcomes.

Prevalence of malaria (the cause of a third of deaths in children under five-years-old) has changed little in recent years. In 2007, the overall prevalence was 51 per

cent of the population. Despite significant improvements, access to anti-malarial medicine remains low; just over a third of children with a fever receive treatment, reflecting both low awareness and demand among care-givers for treatment and low access to health facilities.

Acute respiratory infections (ARI) are another leading cause of morbidity and mortality among young children in Mozambique, with pneumonia being the most serious infection. There is a wide disparity in the proportion of children receiving treatment for ARI. Children living in urban areas, children from better off families and children with educated mothers are much more likely to receive treatment for ARI symptoms.

Unsafe water, poor sanitation and inadequate hygiene also contribute to child mortality and morbidity. Water, sanitation and hygiene are closely linked to childhood malnutrition. Access to safe water also has a significant effect on poverty rates by increasing the time households (particularly women and girls) can spend on more productive activities. Access to safe water and sanitation remains low, at 43 and 19 per cent of households respectively. There is a high level of geographical disparities in relation to access to safe water and sanitation.

Education

A well-educated population is one of the fundamental requirements for broad-based poverty reduction. Historically, Mozambique has had an extremely limited education system. Significant improvements have been achieved but massive challenges remain in the sector. Approximately 3.3 million of Mozambique's 4.1 million children in the age group 6–12 are now attending primary school. Net enrolment rates in primary have increased dramatically. Improvements were also achieved in terms of gender parity, but a continued focus on this area is warranted, as more girls remain out of the education system as compared to boys.

Long-standing disparities have been reduced in the sector. While urban and wealthier children are still more likely to participate in the education system than their rural and poorer counterparts, improvement have been more significant for the latter groups.

Being 'over-age' in school is a widespread phenomenon in Mozambique. While children have tended to start their schooling earlier in recent years, those aged 13-17 years are still more likely to be found attending primary than secondary schools. The 'over-age' phenomenon in primary education has significant implications for children's learning outcomes, as the same curriculum is taught to learners of different ages and levels of cognitive development.

The phenomenon of 'access shock' is pervasive. The massive increase in student numbers has put enormous pressure on the education system, resulting in deleterious effects in terms of the quality of education. Recent data indicate the reading and numeric skills of Mozambican children have deteriorated in recent years. Improvements are needed in terms of the number and quality of teachers; school infrastructure; and the protection of children from physical and sexual violence to further increase access and quality, and to translate access into development outcomes.

Child protection

Effective child protection ensures that the most vulnerable children are protected from harmful practices and not marginalised from poverty reduction. Child protection issues in Mozambique include sexual abuse and exploitation; trafficking; child labour; violence; disabilities; child marriage, among others. Effective national child protection systems begin with the existence of laws, policies, and regulations designed to uphold a child's rights. Important progress has been made in these areas in recent years but many challenges remain.

Violence against women and children has devastating short and long-term mental and physical health consequences. Physical and sexual violence is common, as many as 54 per cent of women have been beaten and 23 per cent subjected to some form of sexual abuse. Sexual abuse of female pupils in schools is also prevalent. A low level of knowledge of victims with regards to their rights combined with a culture of silence and acceptance of violence are the key barrier to addressing the problem.

Child labour is another common and serious form of abuse and exploitation in Mozambique. Child workers are often further exploited by poor working conditions, including verbal and sexual abuse, and wages paid late or not at all. Reducing the burden of work on children depends both on enforcing effective anti-child labour legislation and on ensuring those children and their families, particularly the poorest and most vulnerable, benefit from poverty reduction.

Early marriage may have serious health implications for girls. Adolescent pregnancy and childbirth are associated with poor health and nutritional outcomes both for the mother and her children. Over half of Mozambican girls are married before the age of 18. Child marriage is more common in the northern region of Mozambique.

Birth registration impacts on poverty through providing children with increased access to social services. Mozambique has significantly increased access to birth registration services across the country, although it remains low. The proportion of children under the age of five years who have had their birth registered from eight per cent in 2003 to 31 per cent in 2008.

There are an estimated 1.8 million orphans in Mozambique, 510,000 of whom have been orphaned due to AIDS. This figure is expected to grow in the coming years. Orphaned children may face a wide range of child protection threats. Female orphans are more likely than non-orphans to have

experienced early sexual debut and are more likely than non-orphans to marry young.

Although the capacity of justice systems in preventing and responding to different forms of violence, abuse and exploitation has been strengthened, the overall response continues to be fragmented, reactive, weak and under-funded. Improvements are also needed in terms of improved data collection, monitoring and reporting mechanisms at all levels.

Cross-cutting issues

Women are more likely than men to experience poverty in Mozambique. In 2007, Mozambique ranked 145 of 155 countries on the gender development index based on life expectancy, education, literacy and per capita GDP. This reflects the social, economic and cultural challenges faced by women. Women are more likely than men to participate in the work force, but have lower access to education, less opportunity for formal employment, lower income and less opportunity to diversify their incomes. Female students face barriers to accessing education including sexual abuse in schools and early marriage.

Provincial disparities exist across the board, with children in northern and central provinces having lower access to health services, education, water, sanitation and protection. Provinces such as Zambezia have lower budget allocation, fewer services and lower human development outcomes in terms of child survival and mortality. Southern provinces have higher HIV/AIDS prevalence along with correspondingly higher health services and treatment.

HIV and AIDS affect household poverty through incapacitating breadwinners and raising the level of dependence across the population. Through its effects on the numbers of trained teachers, health workers and other providers, AIDS also impacts on the future generation of human capital. The 2009 National Survey on Prevalence, Behavioral Risks and Information about HIV

and AIDS (INSIDA) shows a national HIV prevalence among 15–49 year olds of 11.5 per cent. The results disaggregated by region confirmed the highest prevalence in the south followed by the centre. HIV prevalence is significantly higher in urban than rural areas across all regions, and among women, particularly young women. There is however some evidence that HIV incidence is decreasing. Data also show an overall positive trend in knowledge and awareness of HIV transmission and prevention.

Emergency situations such as droughts and floods have severe impacts on the well-being of a child. The vulnerability of children increases in emergency situations as they have less access to health facilities; at the same time they increase water-borne diseases such as cholera. Education and routine are disrupted and children have less protection from exploitation such as sexual abuse and survival sex. Emergencies, along with the vulnerabilities they increase, are likely to intensify as climate change

increases the occurrence of cyclones in Mozambique.

Environmental factors are also linked to leading causes of child mortality such as malaria and acute respiratory infections.

Environmental degradation means increased pollution, water stress, deforestation and soil degradation that put pressure on children's basic health and food security needs.

Communication and a robust media are essential for all citizens, including children, to have a say in the issues that affect their lives. They are also a way to transmit vital information to parents on health, education and protection issues such as how to protect their children from malaria or on the damaging effects of child abuse. Innovative communication for development strategies, including Child-to-Child Radio and Multimedia Mobile Units, have a tremendous potential to engage more people, particularly youth, in educational activities, public dialogue and debate.

CAPÍTULO

1



POVERTY IN MOZAMBIQUE

POVERTY IN MOZAMBIQUE

1. Introduction

The national five-year plan or Programa Quinquenal do Governo 2010–2014 establishes Mozambique’s national governmental priorities. This plan and its accompanying operational plan and monitoring and evaluation framework – the Plan of Action for the Reduction of Poverty, or PARP – in turn guides the contributions of the United Nations (UN), donors and civil society partners in support of those priorities. The UN System in Mozambique will prepare a new Development Assistance Framework for 2012–2015, and individual agencies and partners will develop their own Country Programmes of Cooperation in support of, and aligned with, national priorities and planning processes.

In 2006, the UN System in Mozambique published the *Childhood Poverty in Mozambique: A Situation and Trends Analysis*¹ that described how poverty affects the lives of children and their ability to realise their rights. The primary focus of this 2010 Study is to assess childhood poverty in Mozambique and to identify barriers to the realisation of child rights. This 2010 update provides a comprehensive description of the situation in which the ten million children of Mozambique live. It also describes the public policy, financing and service delivery environments for children, and will act as a source of quantitative and qualitative data to inform evidence-based policy decisions on national development priorities and associated interventions.

Since the publication of the 2006 *Childhood Poverty in Mozambique: A Situation and Trends Analysis*, additional data and analyses of the

situation of children have become available, primarily through the 2007 Census,² the 2008 Multiple Indicator Cluster Survey (MICS),³ the 2008/09 Household Budget Survey (IOF),⁴ the 2008 National Child Mortality Study,⁵ the Concluding Observations of the Committee for the Convention on the Rights of the Child⁶ and the 2009 joint evaluation of progress towards the goals and targets of the Government of Mozambique’s PARPA II (2006–2009).⁷

Childhood poverty has immediate and long-term effects on children. Chronic undernutrition, for example, which is developed in the period covering pregnancy up to the first two years of life can permanently impact a child’s growth, resulting in stunting and reduced mental development. The impact of inter-generational childhood poverty and its cyclical nature is also evidenced by poverty’s proven role as a barrier to accessing social services. Poor households have more difficulty accessing good-quality health care, are less likely to have their children in school and are less likely to have access to safe drinking water and adequate sanitation facilities. Poor children have an elevated risk of growing up to become poor adults and in turn, have poor children.

This chapter analyses childhood poverty, first by examining historical trends in consumption-based poverty and second by analysing deprivations-based poverty. This is followed by a comparison of the two measures and in-depth analysis by deprivation. Finally, a number of conclusions with regard to child poverty are drawn.

2. Measuring Poverty

2.1. Consumption-based poverty

Following the signing of the 1992 Peace Agreement, Mozambique made impressive progress in reducing the poverty headcount from 69 per cent in 1996 to 54 per cent in 2002, exceeding the PARPA I target of a poverty headcount of 60 per cent by the year 2005.⁸ This trend did not continue between 2002 and 2008. According to the 2008/2009 IOF, 55 per cent of Mozambicans are living below the national poverty line of 18.4 Meticais (around \$US 0.50) per day. Consumption and incomes increased and poverty fell for a majority of Mozambicans between 1996 and 2002, followed by stagnation between 2002 and 2008.⁹

Official national poverty estimates for Mozambique measure a household's ability to satisfy its most basic needs by measuring its consumption. The consumption-based poverty headcount is based on the Household Budget Survey (Inquérito ao Orçamento Familiar, IOF), which is conducted by the National Institute of Statistics and the Ministry of Planning and Development every six years. The third and most recent survey was conducted in 2008/09.

“Consumption” includes both food and non-food items and is adjusted for seasonality of the former, but omits public services and home produced services. A Cost of Basic Needs methodology is then applied. This approach consists of the development of a basket of food items consumed by the poor that is judged sufficient for basic caloric needs (the calorie content of each basket

depends upon the demographic composition of the region, but averages approximately 2,150 calories per day). The cost of this basket represents the food poverty line. A non-food poverty line is obtained by examining the share of total expenditure allocated to non-food by households living near the food poverty line. The overall poverty line is then calculated as the sum of the food and non-food poverty lines. It must be stressed that the poverty line represents an extremely basic standard of living.ⁱ

The indicator measuring the percentage of people living below the poverty line is known as the ‘poverty headcount’. Although the poverty headcount at a national level remained reasonably constant between 2003 and 2008, large disparities, in both poverty levels and variation in levels, were estimated at a provincial level. The largest reduction in poverty rates was found in Cabo Delgado (-26 percentage points) and Inhambane (-23 percentage points). In contrast, Zambezia (+26 percentage points) and Sofala (+22 percentage points) stand out as the two provinces showing the largest increases in poverty incidence since 2002/03. The stagnation in the overall poverty rate since 2002/03 is principally due to substantial increases in measured poverty in Zambezia and Sofala, which offset the large declines in poverty observed in five provinces. Zambezia province was estimated to have the highest poverty headcount in 2008/09: 70.5 per cent.¹⁰

The headcount does not convey information about levels of well-being among those below the poverty line. In order to measure the depth of poverty, the ‘poverty gap index’

ⁱ For a full description of the methodology used to estimate Mozambique's poverty rate see: Ministry of Planning and Development. ‘Poverty and Wellbeing in Mozambique: Third National Poverty Assessment.’ Government of Mozambique, Maputo, September 2010.

is used. This index is an average percentage distance measure that examines how far the average poor household is from escaping poverty and rising above the poverty line. In order to measure inequality amongst the poor, the 'squared poverty gap index' is used. This index averages the square of the poverty gaps, thereby giving weight to gains made by the poorest of the poor. The Third National Poverty Assessment found no change in the poverty-gap or poverty-squared gap measures between 2002/03 and 2008/09, implying that the real income of the poor relative to the poverty line has been relatively constant between 2002 and 2008.¹¹

Levels of equality have remained reasonably constant between 2002 and 2008. The Gini coefficient,ⁱⁱ a measure of income inequality, as calculated from the IOF surveys, did not significantly change between 1997 and 2008. Inequality is significantly higher in urban compared to rural areas.¹² There is some evidence to suggest that inequality is bigger within provinces and districts rather than between them. One study found that between 83 per cent and 86 per cent of the total inequality in Mozambique occurs within districts rather than between districts.¹³

Poverty reduction in Mozambique between 1996/97 and 2002/03 did not equally benefit all segments of the population. Poverty was reduced much more significantly among male-headed households than female-headed households, which represent about 30 per cent of all households in Mozambique.¹⁴ While poverty was reduced by 26 per cent in male-headed households (it declined from about 70 per cent in 1996/97 to 52 per cent in 2002/03), it only went down by 6 per cent in female-headed households (down from about 67 to 63 per cent between 1996/97 and 2002/03).ⁱⁱⁱ

Households in Mozambique are vulnerable to shocks which can push them below the poverty line. Poverty levels among households have varied significantly over the last decade, especially at the provincial level. This underscores the vulnerability of a large proportion of the population. Mozambican households are extremely vulnerable to shocks such as the loss of an income or crop failure due to droughts or floods. Seasonal fluctuations can temporarily push households above and below the poverty line.

The factors identified by the Ministry of Planning and Development as primarily behind poverty stagnation between 2002 and 2008 include:¹⁵

- Very slow growth rates in agricultural productivity, especially with respect to food crops, observed since 2002;
- Weather shocks that impacted the harvest of 2008, particularly in the Central provinces;
- Declining terms of trade due to large increases in international food and fuel prices. Fuel prices, in particular, rose substantially over the period 2002/03 to 2008/09.

The consumption measure used in Mozambique is a per capita measure, with no allowance for differences between child and adult in the requirements of calories per day to satisfy minimum needs. At first sight, this implies that the poverty situation for children may be a little better than portrayed, as a working adult requires more calories per day, and hence greater expenditure, than a non-working child. However, since children require a higher intake of micronutrients than adults, maintaining the adult caloric requirement may be a reasonable proxy

ⁱⁱ The Gini coefficient is a measure of statistical dispersion commonly used as a measure of inequality of income or wealth. The Gini coefficient can range from 0 to 1. A low Gini coefficient indicates a more equal distribution, with 0 corresponding to perfect equality, while higher Gini coefficients indicate a more unequal distribution, with 1 corresponding to perfect inequality. The Gini coefficient was 0.41 in both 2002, and 2008.

ⁱⁱⁱ See Chapter 6, Cross-cutting issues, for a more detailed discussion of the feminisation of poverty in Mozambique.

for formulating a consumption-based child poverty line.¹⁶ Also, the proportion of children who work is high, the 2008 MICS reports that 22 per cent of children aged 5–14 years were engaged in some form of work outside the home (28 or more hours per week).¹⁷

All measures of poverty have their limitations and the consumption-based approach is no exception. One important limitation is that the consumption measure applies to households and not individuals. It is not possible with IOF data to estimate the consumption of each person within a household. The measure does not, therefore, capture variations in allocation among household members, including differences between adults and children. This could mean that some members of a non-poor household may in fact be consumption-poor, and vice versa. There is evidence in Mozambique that discrimination in terms of resource allocation does occur within households. For example, a 2005 study found that non-biological descendants of the household head are discriminated against in the intra-household allocation of resources in poor households.¹⁸ It is not possible to measure this discrimination through the IOF data. Further, consumption of all public

services is excluded. There is no attempt to value consumption of public services such as education, healthcare, and economic infrastructure.¹⁹ Given the significant investment in public services in recent years, the consumption of public goods had a significant impact on the well-being of children in Mozambique.

Children experience poverty, deprivation and rights violations differently from their parents and other adults, in terms of both the type of deprivation experienced and the relative degree of deprivation. Children are proportionally more vulnerable to extreme poverty than adults, and it is therefore vital to determine if the poverty situation described from a predominantly adult perspective is equally applicable to children.²⁴ This section presents estimates of childhood poverty using the Bristol Indicators for a deprivations-based measure, adapted for Mozambique.

Consumption-based child poverty headcount estimates, based on the 2003 Living Conditions Household Survey (IAF), indicated that the level of poverty among children was significantly higher than among adults. In 2002/2003, 58 per cent of children living in poverty compared to 49 per cent of adults.



Box 1.1. Methodology and Sources of Information

Research Methodology

The methodology employed in producing this Study on *Child Poverty and Disparities in Mozambique* consists primarily of a desk review of pre-existing publications, survey data and reports. Contributions to the analysis were solicited from Government, donor partners, UN agencies and a range of other stakeholders, and the process was managed through a steering committee chaired by UNICEF. The structure and content of the 2010 Study are based on that used in the original 2006 *Childhood Poverty in Mozambique: A Situation and Trends Analysis* in order to ensure consistency, facilitate comparisons and assess progress. A new chapter dealing with cross-cutting issues has been added.

The desk-based review of documentation was supplemented by consultations with civil society and other stakeholders. These consultations were instrumental in developing the causality, role/pattern and capacity analyses described below. Like the 2006 report, this update uses a deprivations-based measure of childhood poverty to complement the official consumption-based measure of poverty. Deprivations-based poverty analysis examines children's access to seven key aspects of development: water, sanitation, shelter, education, health, nutrition and information.²⁰

Sources of data and information

The 2010 Study on *Child Poverty and Disparities in Mozambique* draws on three important surveys, namely the 2008 Multiple Indicator Cluster Survey (MICS)²¹, the Household Budget Survey (IOF) 2008/09 and the 2009 National Child Mortality Study.²² The MICS was conducted and published by the National Institute of Statistics, with technical and financial support from UNICEF. The IOF 2008/09 was conducted and published by the National Statistics Institute and the Ministry of Planning and Development. The National Child Mortality Study was conducted by the Mozambican National Institute of Health in collaboration with the London School of Hygiene and Tropical Medicine and UNICEF. The data obtained from these sources were used to update information presented in the 2006 *Childhood Poverty in Mozambique: A Situation and Trends Analysis*. An important source of additional information and analysis was the joint Impact Evaluation of PARPA II, including the in-depth studies commissioned as part of the PARPA II evaluation process.²³

Through the eyes of a child^{iv}

A methodology known as photo-voice was used to better understand the ideas, perspectives and realities as projected by the girls. Photo-voice involves posing questions to children about the issues they face and having them respond through photographs taken followed by group debate and dialogue.

Through this process the girls seemed to undergo a transformation. At the beginning of the research, the girls were shy and timid. When one girl responded to a question in a very quiet voice, the other girls would mimic the response by changing the words slightly. If a follow-up question was asked, they would respond quietly using one or two words only. The girls confided that no one had ever asked them for their ideas. This was a new experience for them. Within a short span of time, through the use of participatory methodology, the girls were eagerly sharing their unique ideas. In fact, they were debating with one another and confidently voicing their thoughts. They were no longer passive recipients of knowledge, but were now active contributors to new knowledge, ideas and solutions. The girls shared practical solutions towards the challenges faced in their daily lives. Through the community interviews they conducted and the photos they took, they began to see for the first time the similarities in the lives of their grandmothers, mothers and aunties and how much they wanted their lives to be different.

The group produced more than 100 photographs and expressed their views on a wide variety of issues including poverty, health, water and sanitation and gender issues. Some of the pictures they took and the stories they told are included in this report.

^{iv} Zainul Sajjan Virgi, PhD Candidate at McGill University, undertook participatory research to uncover issues faced by children in Machava in the environs of Maputo city. The research involved the on-going consultation of a group of pre-adolescent girls over a period of 6 months.

THROUGH THE EYES OF A CHILD



"I remember clearly that in this picture I had eaten food that day."

"We never have enough food to eat. We normally have black tea and bread for breakfast. Whether or not we have a second meal depends on the adults in our lives. If our mothers and grandmothers have made money that day or have money left over from their monthly salary, then we eat. If it is towards the end of the month, we have probably run out of money and food, so we go to bed hungry. Often, we haven't eaten anything for one or sometimes even two days. We often cry, not just because we are hungry, but because we feel all alone when we don't have food to eat, like no one cares about us.

"We remember the days that we have eaten. Often, when we wake up in the middle of the night, we see our mothers worried about what they will feed us the next day. Even though our mothers and grandmothers work every day, they often come home with very little money. It makes us sad to see the difficult life our mothers and grandmothers lead. When we grow up, we will work hard to take care of our mothers and grandmothers."

—Lina, age 14

Source: Sajan Virgi, Zainul, 2010.

Consumption-based child poverty did, however, decrease significantly between the 1997 and 2003 surveys. But the gap between children and adults did not close between 1996/97 and 2002/03, with both groups witnessing a decrease of 22 per cent in poverty level. The decrease in child poverty levels was more pronounced in rural areas (24 per cent) than in urban areas (16 per cent).

2.2. Deprivations-based poverty

Mozambique's first Poverty Reduction Strategy Paper, PARPA I (2001–2005), defined absolute poverty as "the inability of individuals to ensure for themselves and their dependants a set of basic minimum conditions necessary for their subsistence and well-being in accordance with the norms of society."²⁵ Many observers subsequently proposed that this definition of poverty should be supported by more multidimensional measures in order to present a broader, more pluralistic and rights-based analysis.²⁶ This view was formally adopted by the Government in the country's second Poverty Reduction Strategy Paper, PARPA II (2006–2010).

While reporting on the consumption-based measure in its poverty analysis, PARPA II adopted a new definition of poverty: "Impossibility, due to incapacity or through lack of opportunity, for individuals, families and communities to have access to minimum conditions, in accordance with the norms of society." PARPA II also explicitly recognises that it is important not to be over-reliant on any one poverty measure, stating that, "For purposes of policy decisions, poverty was initially considered as the lack of income – money or negotiable goods – necessary to satisfy basic needs. Because this monetary definition did not cover all the manifestations of poverty, the definition was broadened over time to cover such aspects as a lack of access to education, health care, water and sanitation, etc."²⁷

UNICEF, along with a growing number of academics and policymakers, has chosen to adopt an increasingly multidimensional view of what it means to be living in poverty. Poverty has traditionally been measured using a narrow focus on household consumption. However, the level of a family's income does not create a full picture

Table 1.1: Deprivation in Mozambique, 2008

Deprivation	Proportion of children experiencing severe deprivation
Nutrition	20 per cent of children under five years of age are experiencing severe malnutrition. ^v
Water	39 per cent of children do not have access to safe drinking water within 30 minutes of their home.
Sanitation	43 per cent of children have no access to a toilet of any kind in the vicinity of their home.
Health	12 per cent of children under five years of age are not immunised or have suffered from an acute respiratory infection that was not treated.
Shelter	5 per cent of children live in a house with more than five people per room.
Education	12 per cent of children have never been to school.
Information	40 per cent of children without a radio, television or newspaper at home.

Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*. Maputo, 2009.

^v Proportion of children under five years of age whose nutritional index (weight-for-height, weight-for-age, height-for-age) is equal to or below -3 standard deviations from the median of the 2006 WHO standard.

THROUGH THE EYES OF A CHILD



“My great-grandmother worked on the field. My grandmother works on the field. I do not know what my mother does since she lives in South Africa. My aunties have food stalls. Now that I see the lives of my family, I hope I will do something different.”

— Aida, age 12

of the health and well-being of a child. A child's parents may earn a decent wage but live too far from a school for their child to attend class. Education, along with other basic services like health, sanitation and clean water are all necessary investments for a child to grow up to be a productive adult. Focusing on the basic needs and key public services of which a child is deprived allows for a multidimensional understanding of poverty. With the deprivations-based approach, the link between resource allocation, policy choices and the resulting changes in childhood poverty becomes much more explicit.

The analysis presented here uses a deprivations-based measure of childhood absolute poverty. The indicators used to quantify this measure were originally developed by a team at the University of Bristol, and are often referred to as the Bristol Indicators.²⁸ They are based on the deprivations approach to poverty, drawing upon the definition of absolute poverty agreed at the World Summit for Social Development: "a condition characterised by severe deprivation of basic human needs."²⁹

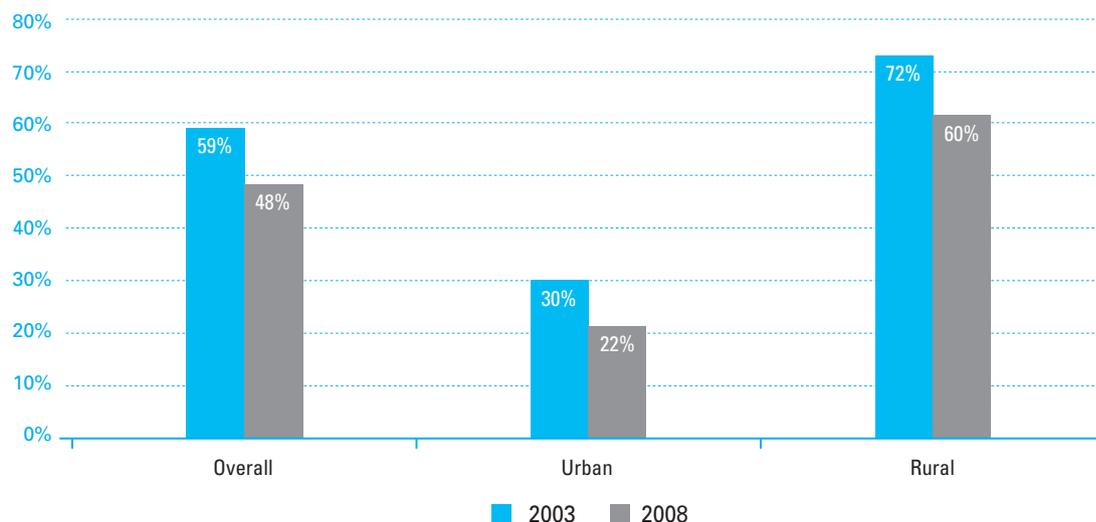
The indicators comprise seven measures of severe deprivation: nutrition, safe drinking water, sanitation facilities, health, shelter, education and information. The Bristol Indicator approach defines the proportion of children living in absolute poverty as those children facing two or more types of severe deprivation. The indicators constitute both causes and symptoms of poverty. Access to safe water, for example, is a symptom of poverty in that poor households are far less likely to enjoy safe water. It is also a cause of poverty in that individuals that do not have access to safe water are more likely to suffer from water-borne illnesses leading to an inability to engage in activities to provide income for their families.

An inherent strength of the deprivations-based approach is its inclusion of the consumption of key public services. This is particularly evident when contrasting results of deprivations- and consumption-based measures of poverty for rural and urban children. In 2003, 22 per cent of urban children were living in absolute poverty as measured by the deprivations-based approach versus 55 per cent as measured by the consumption-based approach, reflecting the increased access to social services in urban areas. With the deprivations-based approach, the link between resource allocation, policy actions and the resulting changes in childhood poverty is made much more explicit. For example, the increased allocation of funds to expand immunisation programmes would have an immediate and direct impact on child poverty under the deprivations-based measure (by demonstrating an increased number of children who had been immunised), but would show the effect more slowly under the consumption-based measure.

Using the deprivations-based approach, focused on a child's ability to access essential services, the proportion of children living in absolute poverty in Mozambique fell from 59 per cent in 2003 to 48 per cent in 2008.^{vi, 30} The proportion of children in rural areas living in absolute poverty decreased significantly, from 72 per cent to 60 per cent (Figure 1.1). In 2008, 22 per cent of urban children were poor, versus 60 per cent of rural children.

The reduction in children's absolute poverty levels was driven by significant improvements in the health and education sectors. The proportion of children experiencing severe education deprivation was halved between 2003 and 2008 (24 to 12 per cent). Severe health deprivation was reduced by one-third (18 to 12 per cent).³¹

^{vi} The figure quoted in *2006 Childhood Poverty in Mozambique: A Situation and Trends Analysis* for the proportion of children living in absolute poverty in 2003 (49 per cent) differs from that used here due to improvements in the methodology used to calculate several deprivations in the areas of water, health and nutrition. The 2003 data were therefore recalculated to reflect these improvements.

Figure 1.1: Proportion of children experiencing two or more severe deprivations, 2003 and 2008

Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

The proportion of children experiencing nutrition and sanitation deprivations registered moderate improvement between 2003 and 2008, but the proportion of children experiencing severe water deprivation increased. The most frequently experienced severe deprivations are water, sanitation, and information, which affect 39 per cent, 43 per cent, and 40 per cent of children, respectively. Only five per cent of children experience severe shelter deprivation (Figure 1.2).

At the provincial level, there has been a reduction in child poverty between 2003 and 2008 in Niassa, Cabo Delgado, Zambezia, Sofala and Inhambane provinces and Maputo City. Figure 1.3 shows the proportion of children experiencing two or more severe deprivations by province in 2003 and 2008.

Significant disparities exist in relation to provincial poverty rates. The proportion of children experiencing two or more severe deprivations was highest in Zambezia province in both 2003 and 2008 (80 and 64 per cent respectively). Maputo City has the lowest levels of absolute child poverty, with only 4 per cent of children experiencing two or more severe deprivations, reflecting the

relatively high level of access to essential services in the Capital. The second largest reduction in deprivation occurred in Niassa province, where the proportion fell from 58 per cent in 2003 to 35 per cent in 2008. Interestingly, both Maputo City and Niassa also experienced large reductions in the consumption-based poverty measure between 2002/03 and 2008/09.³²

A multivariate analysis, using as outcome the number of severe deprivations in children 0 to 17 years old, was conducted to obtain a better understanding of the relationship between a deprivations-based measure of poverty, the Bristol Indicators, and other relevant individual and household level variables available in the MICS 2008 dataset.

Asset-based wealth is a crucial explanatory variable in predicating deprivation. The model suggests that asset-based wealth is strongly (and inversely) related to the number of deprivations; as would be expected, children in wealthier households are far less likely to be deprived.

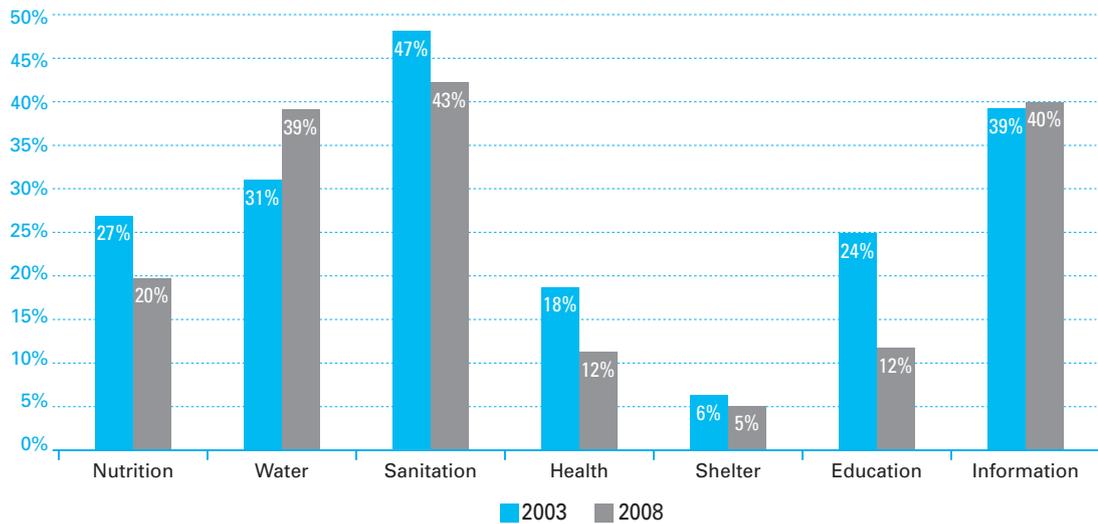
However, the analysis suggests that other factors also play an important role, such

as the level of education of the mother or caretaker, the dependency ratio at household level, the area of residence and the survival status of the parents of the child. The area of residence is likely to be a proxy for a number of unmeasured variables

that are linked to the disadvantaged status of rural populations.

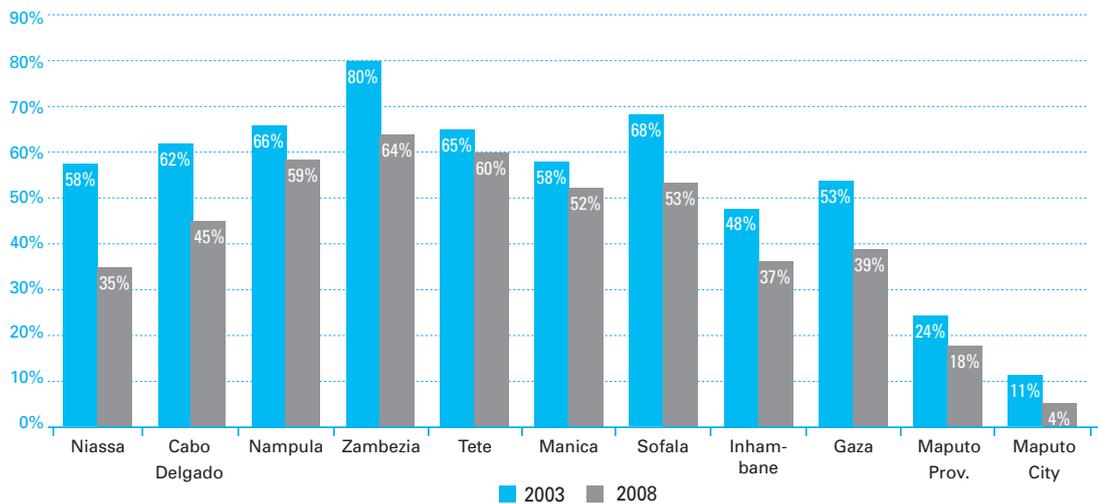
Outside of improving material wealth, the model suggests that the most important, and possibly the most straightforward, way to

Figure 1.2: Proportion of children experiencing deprivations, 2003 and 2008



Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

Figure 1.3: Percentage of children experiencing two or more severe deprivations by province, 2003 and 2008



Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

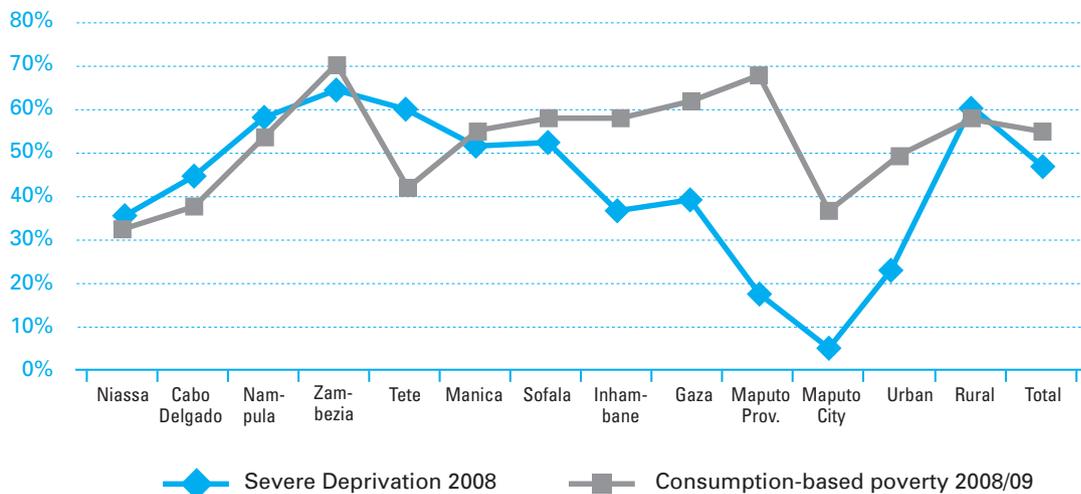
reduce child poverty might be to improve the education of future mothers.

2.3. Comparison of consumption- and deprivations-based poverty

In 2008, poverty levels were significantly lower as measured by the deprivations-based approach, as compared to the consumption-based measure. This is explained by the fact that there were significant improvements in non-monetary poverty measures of poverty between 2002 and 2008 but not accompanying improvements in terms of increased consumption. Poverty rates were relatively similar (by both measures) in the centre

and the north of the country but diverge sharply in the south. In the case of Maputo City, this is explained by the fact that the consumption-based approach does not directly take into account access to social services such as health, education, water and sanitation, which are likely to be concentrated in urban areas. By both measures, Zambezia is estimated to have the highest proportion of people living in absolute poverty. As discussed in chapter 6, Zambezia is allocated considerably less funds per capita than average and has is amongst the worst performing province in terms of human development indicators. The re-dress of this inequitable allocation of resources should be prioritised by the Government and its development partners.

Figure 1.4: Deprivations-based poverty compared to consumption-based poverty for children, 2008



Source: UNICEF, *Child poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009 and Ministry of Planning and Development, *Poverty and wellbeing in Mozambique: Third national poverty assessment*, Government of Mozambique, September 2010.

3. Analysis by deprivation

The following section presents an analysis of each of the seven Bristol Indicators.

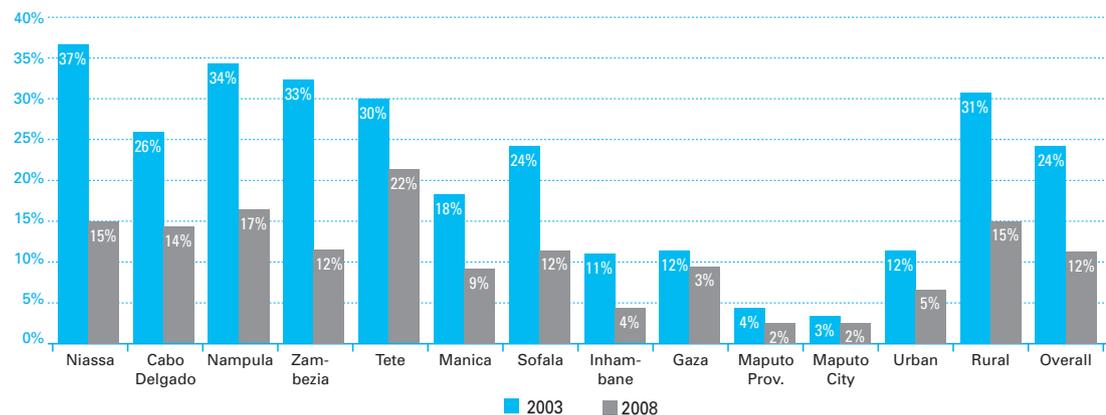
3.1. Severe education deprivation

Between 2003 and 2008, severe education deprivation has halved (24 versus 12 per cent). The education deprivation indicator is the proportion of children between 7 and 18 years old who have never been to school and are not currently attending school. The levels of severe education deprivation are three times higher for rural children (15 per cent) than urban children (5 per cent), although both groups experienced large improvements. Severe education deprivation is highly correlated with the wealth of the household. Children in the poorest households, based on a wealth index, are almost ten times more likely to experience

severe education deprivation than children in the best-off households.

Severe education deprivation has been reduced in all provinces, as shown in Figure 1.5 below. Niassa, Zambezia, Inhambane and Gaza provinces experienced large reductions. All four provinces saw a relative decline of over 60 per cent in the proportion of children experiencing severe education deprivation. Only three per cent of children in Gaza are experiencing severe educational deprivation. Despite these improvements, education deprivation still remains high in Niassa and Zambezia (15 and 12 per cent, respectively). It is highest in Tete (22 per cent), where children have the lowest primary school completion rate (5 per cent) and among the lowest levels of family support for children's education^{vii} and the lowest access to pedagogical materials in the home.³³ This suggests that the poor

Figure 1.5: Severe education deprivation among children by province, 2003 and 2008



Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

^{vii} The MICS survey calculates a family's support for a child's education through five indicators: a) Children whose household members are involved in four or more activities that promote learning and facilitate education; b) Average number of activities in which adult members participate with the child; c) Children whose father is involved in one or more activities that promote learning and facilitate education; d) Average number of activities in which the father is involved; and e) Children living in a household without their biological father.

educational outcomes in Tete are more complex than simply a lack of educational opportunities. The problem may also be related to the value parents there put on children's learning.

Girls are more likely to experience severe education deprivation than boys (13 and 10 per cent respectively).³⁴ Sofala province has the largest gender disparity in primary education attendance rates, with 87 per cent of boys and 77 per cent of girls attending primary school. Tete has the largest gender disparity in secondary level education: 12 per cent of boys are attending secondary school compared to 6.5 per cent of girls. Nationally, the education gender gap has been closing, as have disparities between provinces.³⁵

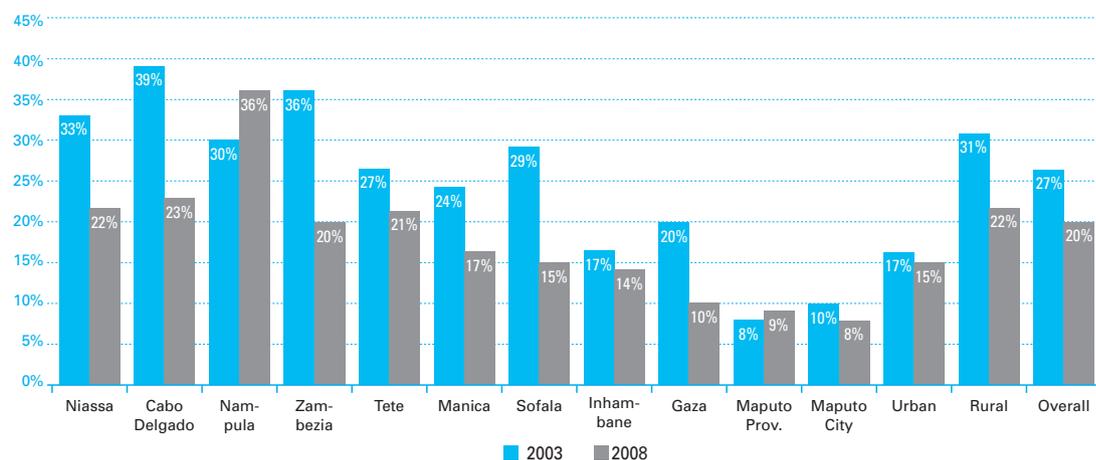
3.2. Severe nutrition deprivation

Undernutrition has wide ranging impacts on the lives of mothers and children in Mozambique. The most drastic of these

impacts is child mortality. Undernutrition is the main underlying cause contributing to the high level of child mortality in Mozambique. Proper nutrition is also important in its own right, since undernutrition (in particular chronic undernutrition or stunting) affects a child's physical and mental development and is closely linked to the ability to succeed in school and become a productive adult. The nutritional deprivation indicator is the proportion of children under five whose nutritional index (based on an equally weighted weight-for-height, weight-for-age, height-for-age composite) is equal to or below minus 3 standard deviations from the median of the WHO standard population, i.e., severe anthropometric failure.

There has been a reduction in the percentage of children in Mozambique experiencing severe nutritional deprivation,^{viii} from 27 per cent of children in 2003 to 20 per cent in 2008.³⁶ Severe nutrition deprivation is higher for rural children (22 per cent) than

Figure 1.6: Severe nutritional deprivation among children by province, 2003 and 2008



Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

^{viii} The difference between this figure and the figure reported in the 2006 *Child Poverty in Mozambique: A Situation and Trend Analysis* is due to the change in WHO standards for components of the nutritional indicator. The estimates in the DHS 2003 report were based on the NCHS reference population, developed in 1975. The estimates based on data from the 2003 DHS were recalculated using as base the 2006 WHO standard population. Please refer to WHO, *Growth Standards, Methods and Development*: <http://who.int/childgrowth/standards/en>.

for urban children (15 per cent). The higher rate for rural children is largely explained by differences in food availability, a lack of variation in diet and lower access to health services,³⁷ safe drinking water and sanitation facilities. Rural children may also be more likely to experience a reasonably prolonged food deficit at some point in time.

The reduction in the proportion of children experiencing severe nutritional deprivation was driven by improvements for rural children. Thirty-one per cent of rural children were experiencing severe nutritional deprivation in 2003 compared to 22 per cent in 2008. The reduction in the level of nutritional deprivation for urban children was not statistically significant. The gap between the rural and urban areas has thus narrowed from 2003 to 2008, although a disparity persists.

There is considerable inequity in terms of severe nutritional deprivation. Children in the in the poorest households (25 per cent) are significantly more likely to experience severe nutritional deprivation than children in the best-off households (9 per cent). However, poorer households have experienced more significant improvement in the proportion of children experiencing severe nutritional deprivation.³⁸

3.3. Severe water deprivation

Access to clean, safe water is vital for the survival and healthy development of children, reducing sickness and death due to diarrhoeal diseases and other major causes of child mortality. Use of safe water lowers the risk of water-borne diseases among children weakened by malnutrition and reduces the risk of opportunistic infections

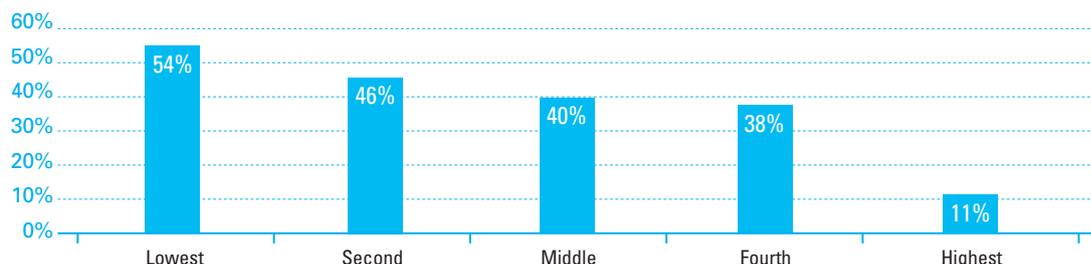
among children living with HIV or AIDS. In Mozambique, a lack of access to safe water is directly responsible for regular outbreaks of cholera. The water deprivation indicator is the proportion of children under 18 years of age who only have access to surface water (e.g. rivers) for drinking or who live in household where the nearest sources of water is 30 minutes away or more.

Severe water deprivation among children has increased in Mozambique between 2003 and 2008 (31 versus 39 per cent).^{ix} There is a large disparity between urban and rural children; rural children are more than two and a half times more likely to experience severe water deprivation than urban children (14 and 40 per cent respectively). Rural children experienced an increase in severe water deprivation between 2003 and 2008, while for urban children the level of deprivation remained reasonably constant.³⁹

In Gaza province, more than half of children are experiencing severe water deprivation (58 per cent). Gaza registered an increase in children's severe water deprivation between 2003 and 2008 (39 versus 58 per cent). The mean time to walk to a water source in Gaza province is over one and half hours.⁴⁰ There is no evidence of any province achieving a statistically significant reduction in severe water deprivation among children.

There is considerable inequity in access to safe water. Children from poor households are at a far greater risk of experiencing severe water deprivation. Severe water deprivation is nearly five times higher for children who live in the poorest households than for those who live in the best-off households (54 versus 11 per cent) (see Figure 1.7).

^{ix} Previous calculations of severe water deprivation among children used "time to go to and return from a water source is more than 30 minutes" as the indicator. The correct indicator, as per Gordon et al., 2003, refers to children who live more than 30 minutes away from a water source. The data from 2003 were recalculated to reflect this change.

Figure 1.7: Severe water deprivation among children by wealth quintile, 2008

Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

3.4. Severe sanitation deprivation

Poor sanitation and inadequate hygiene contribute to child mortality and morbidity.

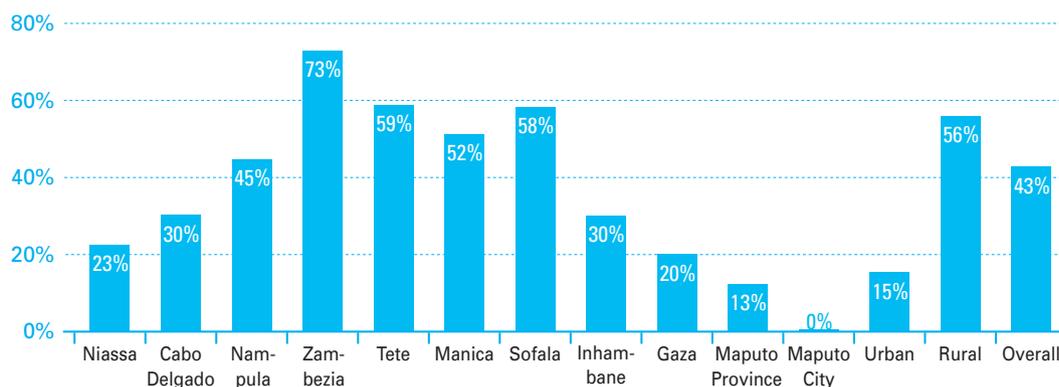
Water, sanitation and hygiene are also closely linked to childhood malnutrition.⁴¹ The sanitation deprivation indicator is the proportion of children under 18 years of age who have no access to a toilet of any kind in the vicinity of their dwelling, including communal toilets or latrines.

The proportion of severely deprived children in terms of sanitation remained reasonably constant between 2003 and 2008. In 2008, 43 per cent of children were experiencing severe sanitation deprivation. The urban/rural disparity is large. Fifty-six per cent of rural children are experiencing severe

sanitation deprivation, compared to 15 per cent of urban children.⁴²

Besides urban/rural disparities, there are also large disparities between provinces. In Zambezia, 73 per cent of children are experiencing severe sanitation deprivation compared to less than one per cent in Maputo City. A higher proportion of children in the central and northern provinces experience severe sanitation deprivation than in the southern provinces (see Figure 1.8).

There is also a large disparity depending on the wealth of the family. Data show that 92 per cent of children in the poorest households experience severe sanitation deprivation, compared to 3 per cent in the best-off households.

Figure 1.8: Severe sanitation deprivation among children by province, 2008

Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

3.5. Severe health deprivation

Severe health deprivation among children fell significantly between 2003 and 2008, from 18 per cent* to 12 per cent. The severe health deprivation indicator is the proportion of children under five who have never been immunised or who have suffered from a severe episode of acute respiratory infection that was not treated. As can be seen from Figure 1.9 below, there is a disparity between rural and urban children, with rural children twice as likely to experience severe health deprivation (14 per cent versus 7 per cent). Deprivation levels did however decrease significantly for rural children while remaining fairly constant for urban children. There are also disparities between provinces, ranging from five per cent in Maputo City to 19 per cent in Zambezia and Nampula.

Breaking down the indicator into its components (acute respiratory infection and immunisation) reveals some of the causes behind the severe health deprivation in Zambezia, Nampula and Tete.

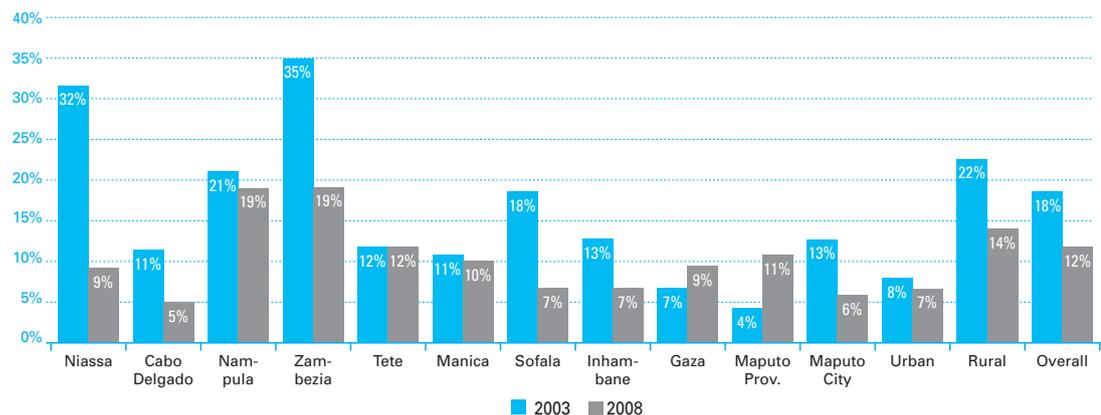
In all three provinces, mothers/guardians are less likely to recognise the symptoms of pneumonia than the national average, suggesting that severe health deprivation may be linked to the level of knowledge guardians have about diseases. Notably, only three per cent of children in Zambezia suspected of having pneumonia received antibiotics.⁴³

3.6. Severe shelter deprivation

Five per cent of children are experiencing severe shelter deprivation in Mozambique.

This level has remained fairly constant between 2003 and 2008. The shelter indicator is the proportion of children under 18 living in dwellings with more than five people per room (severe overcrowding). Cabo Delgado has experienced a large fall in severe shelter deprivation among children. Almost no children (0.2 per cent) in the province are now experiencing severe shelter deprivation, compared to 3 per cent in 2003. Severe shelter deprivation has increased in Gaza

Figure 1.9: Severe health deprivation among children by province, 2003 and 2008



Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

* The small difference between the value reported here for 2003 and the value reported in UNICEF 2006 is explained by the treatment of children without any information on health. In line with the established Bristol Indicator methodology, children without information on the components of the health indicator were excluded from the calculation.

and Inhambane. No other provinces show evidence of a statistically significant change in the proportion of children experiencing severe shelter deprivation.

Severe shelter deprivation is strongly correlated with wealth. Thirteen per cent of children in the poorest quintile are experiencing severe shelter deprivation compared to only one per cent of children in the best-off households.

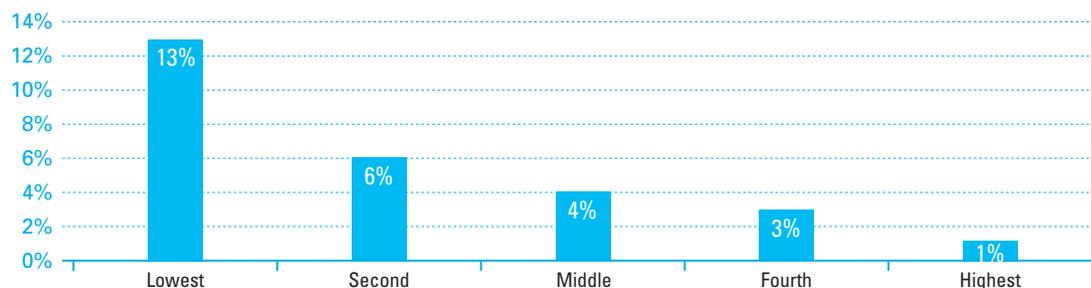
3.7. Severe information deprivation

There was no statistically significant change in the proportion of children experiencing severe information deprivation between 2003 and 2008. Forty per cent of children were experiencing severe information deprivation in 2008. The information

deprivation indicator is the proportion of children between 5 and 18 with no possession of or access to a radio, television or newspaper at home.

The information deprivation indicator does not take into account mobile phone ownership. It is likely that if access to mobile phones were included in the calculation of information deprivation, it would have caused a reduction in the proportion of children experiencing severe information deprivation, given the large increase in mobile phone ownership in Mozambique over the last decade (see Chapter 6, Cross-cutting issues). It is also possible that the rapid expansion of mobile phone ownership is actually reducing the demand for radios and televisions among the poorest households as they prioritise mobile phones over other communication assets.

Figure 1.10: Severe shelter deprivation among children by wealth quintile, 2008



Source: UNICEF, *Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

4. Conclusions

There have been significant improvements in levels of absolute poverty among children as measured by the deprivations-based approach. Advances observed in deprivation-based poverty are associated in part with the large efforts made by the Government in the provision of social services. The Government has invested strongly in education and health, and this has resulted in significant improvements in the proportion of children experiencing severe education and health deprivations. Although the proportion of children experiencing severe deprivation has decreased in recent years, almost half of Mozambican children remain severely deprived. Children are most often deprived of access to safe water, sanitation and information. Continued investment in essential services means a continued investment in the future of Mozambique's children.

The urban/rural divide is particularly evident through deprivations-based analysis. It is also clear from the results that levels of deprivations are significantly higher in the central and northern provinces than in the southern provinces. However, if we exclude Maputo City, the northern provinces experienced the largest reduction in levels of deprivation among children. Similarly, consumption-poverty estimates indicate a positive trend in northern Mozambique.

Poverty rates have stagnated as measured by the consumption-based approach with nearly 12 million Mozambicans living on 18.4 Meticaís (around \$US 0.50) per day. This is principally due to the poor performance of the agricultural sector, on which the majority of Mozambicans rely for their livelihoods. There is an unambiguous relationship between the wealth and the well-being of children. While continued investments in the social sectors are necessary to reduce deprivation levels, it is vital that the Government and its partners re-examine their approach to stimulating the agricultural sector.

Both the consumption- and deprivation-based measures underline the high levels of vulnerability of the Mozambican population, as evidenced by the fluctuating provincial poverty rates. These disparities are linked to inequitable allocation of Government resources. Provinces with the lowest human development indicators tend to receive a lower allocation of resources. The ability of households to withstand internal or external shocks is extremely limited. The most common shocks experienced are the death of a family member or weather related shocks such as drought or flood.⁴⁴ These shocks can push children and their families into severe deprivation and absolute poverty and have life-long impacts on the well-being of children.

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CHAPTER

2

THE DEVELOPMENT CONTEXT

THE DEVELOPMENT CONTEXT

1. Introduction

This chapter describes the political, social and economic context for human development in Mozambique. Since the signing of the Peace Agreement in 1992, Mozambique has experienced a period of strong, economic growth. Mozambique has a strong legal and policy framework that is rights-based and focused on economic growth and poverty reduction. However, Mozambique is heavily dependent on international cooperation and Official Development Assistance, and the influence of donors has raised concerns regarding public accountability and potential

weakening of the role of domestic institutions in governance. Budgetary and administrative decentralisation is ongoing and the potential to ensure that resources are equitably allocated to the provinces, taking human development indicators into account. But this reallocation has not yet been achieved. Provinces with the worst development indicators generally receive lower budget allocations than provinces with better indicators. This chapter reviews the recent history of Mozambique and gives brief economic and political overviews of the current development context in Mozambique.

2. Transition to peace, democracy and market economy

Mozambique gained independence from Portugal in 1975, but almost immediately entered a 16-year period of unrest characterised by armed conflict between the Government, led by the Liberation Front of Mozambique (FRELIMO), and the Mozambican National Resistance (RENAMO). The social effects of the war were dramatic, with as many as one million people killed, including an estimated 600,000 children. More than one third of the population was forced to abandon their homes, and much public infrastructure was destroyed, particularly schools. Thousands of citizens were left disabled, and many suffered the effects of starvation as well as psychological trauma.¹ The two parties signed a General Peace Agreement in October 1992. The country's first presidential and legislative elections were held in October 1994, resulting in the election of Joaquim Chissano as President of the Republic and the establishment of Mozambique's first multi-party parliament, the Assembly of the Republic.

Four successive rounds of general and presidential elections have now been held, in which FRELIMO won both presidential and parliamentary majorities and RENAMO led an electoral union of opposition parties. The fourth presidential election, held in October 2009, resulted in victory for incumbent

President Armando Guebuza, who secured an estimated 75 per cent of votes cast. The newly formed Mozambique Democratic Movement, led by Daviz Simango, Mayor of Beira, won the most votes in the city of Beira. The Election Observer Mission from the Southern African Development Community Parliamentary Forum concluded that the 2009 elections "were a true reflection of the will of the people of Mozambique."² While voter registration is consistently high, at around 80 per cent, voter turnout has fallen from 88 per cent in the first national election to an estimated 42 per cent in 2009.³

At the time the Peace Agreement was signed in 1992, Mozambique was ranked among the poorest countries in the world, according to both the United Nations Human Development Index and World Bank estimates of per capita Gross National Product.⁴ Despite nearly two decades of peace, political stability and strong economic growth, Mozambique remains one of the poorest countries in the world, ranking 165 of 169 countries in the terms of the Human Development Index.⁵

2.1. Demographic trends

Official population figures and projections are produced by the National Institute of Statistics, and are based on national

Table 2.1: Economic indicators, 2003–2009

Indicator	2003	2004	2005	2006	2007	2008	2009
Real GDP growth (%)	6.5	7.9	8.4	8.7	7.3	6.8	6.4
Inflation (%)	13.5	12.6	6.4	13.2	8.2	10.3	3.3
GDP per capita (USD)	256.9	301.6	334.5	352.8	398.7	476.9	453.9

Source: Republic of Mozambique, Report on the Millennium Development Goals, Government of Mozambique, Maputo, 2010.

census data.⁶ The most recent census was conducted in 2007, and results reveal that the total population of Mozambique increased by 28 per cent between 1997 and 2007, equivalent to an annual rate of increase of 2.4 per cent. Maputo province recorded the largest population increase in the period between the 1997 and 2007 censuses, increasing by 52 per cent. The population of Maputo City increased only slightly, as much of the migration was to the developing suburbs surrounding the city, rather than to the city itself. The majority of the population of Mozambique (almost 40 per cent) is concentrated in the two northern provinces of Nampula (approximately 4 million inhabitants) and Zambezia (3.9 million).⁷

The population of Mozambique is overwhelmingly young. In 2007, of a total population of 20.5 million, half were children under the age of eighteen years (10 million). Slightly more than half of the population are women, with a ratio of men to women of 91:100. Population density in Mozambique is low, at around 26 inhabitants per square kilometre,⁸ and the population is predominantly rural (69 per cent). The size of an average household is estimated in urban areas at 4.7 members and in rural areas at 4.2 members, giving a national average of 4.3.^{9,10} Dependency ratiosⁱ were estimated in 2006 at 72 per cent and 92 per cent for urban and rural areas respectively, with an overall national ratio of 85 per cent.¹¹

2.2. Economic growth and macroeconomic stability

Mozambique is a low-income economy, with per capita Gross Domestic Product (GDP) estimated at \$US 453 million in 2009.¹² GDP growth averaged an impressive eight per cent annually during the period 1993–2009 (see Figure 2.1). Strong real GDP growth

since 2000 has been underpinned by strong investment in large projects, particularly in the minerals and mining sectors. Economic growth has been accompanied by the development of a reasonably stable and predictable macroeconomic environment. In spite of the recent global financial crises, and the corresponding fuel and food costs crises, Mozambique continued to have relatively strong economic growth and a robust macroeconomic structure. The growth of the GDP in each one of the last five years was above 6.5 per cent. Per capita GDP has, however, fallen between 2008 and 2009¹³

Mega-projects are currently estimated to contribute more than 70 per cent of exports, compared to virtually none in the late 1990s. However, as a result of tax breaks, the foreign-owned mega-projects still do not contribute significantly to Government revenue, limiting public finances and shifting the tax burden to small and medium businesses.¹⁴ The reliance on mega-projects has also raised concerns among some observers of a possible two-tiered economy in which “capital-intensive export sectors continue to prosper without sufficient trickle-down to the rest of the private sector and with little impact on poverty reduction.”¹⁵

Mozambique has encouraged foreign investment by adopting open-market policies, and it has created an investment environment more accommodating to large investors than have many other African countries. However, rigid labour laws and governance issues continue to affect Mozambique’s attractiveness to investors. This is reflected in the World Bank’s 2011 ‘Doing Business’ report, which places Mozambique 126th out of 183 economies for ease of doing business.¹⁶ The African Development Bank also comments on the difficult business environment in the country,

ⁱ Dependency ratios for households are estimated by adding the number of children aged 0–14 and the number of older people aged 65 and above, and dividing this sum by the number of “active” people aged 15–64.

noting that domestic investors are faced with stifling regulation, corruption and poorly functioning public monopolies.¹⁷

Mozambique is Africa's largest recipient of grants in terms of percentage of GDP, at more than 9 per cent of GDP in 2007. The Government of Mozambique, in its Medium-Term Expenditure Framework (MTEF 2010-2012), estimates that external resources comprised 47 per cent of the state budget in 2010.¹⁸ To reduce this dependency on Official Development Assistance, the country has begun reforming its tax policy, expanding its fiscal base and improving the collection of customs duties. Tax revenue accounted for 17.8 per cent of GDP in 2009, up from 13.0 per cent in 2003.¹⁹

2.3. Millennium Development Goals

In its fourth and most recent national Millennium Development Goal (MDG) progress report, in 2010, the Government of Mozambique reasserted its commitment to achieving the targets.ⁱⁱ The Government noted that the country has "continued to record significant progress," highlighting the "expansion of health and education services."²⁰ Overall, Mozambique is considered likely to achieve four of the 21 targets, has potential to reach an additional nine targets and is unlikely to reach one target. Progress towards seven targets could not be assessed due to lack of data. Progress is summarised in Table 2.2.



ⁱⁱ At the 55th Session of the United Nations General Assembly in 2000, 189 of the world's countries and many leading development institutions committed to The Millennium Declaration, a reaffirmation by world leaders of their collective responsibility to support the principles of human dignity, equality and equity at a global level. The Millennium Declaration established a new global partnership to reduce extreme poverty and defined a series of time-bound targets with a deadline of 2015. These targets have subsequently become known as the eight MDGs. Twenty-one targets and 60 indicators are associated with the eight MDGs.

Table 2.2: Progress towards the Millennium Development Goals

OBJECTIVES/TARGETS	WILL THE GOAL/TARGET BE MET?			
	Probably	Potentially	Unlikely	Without data
EXTREME POVERTY AND HUNGER				
Reduce to half, by 2015, the proportion of people living under extreme poverty		Potentially		
Ensure, by 2015, decent work for all, including women and young people				Without data
Reduce by half, by 2015, the proportion of people who suffer from hunger		Potentially		
UNIVERSAL PRIMARY EDUCATION				
Ensure that, by 2015, all boys and girls will be able to complete a full course of primary schooling		Potentially		
GENDER EQUALITY				
Eliminate, preferably by 2005, gender disparity in primary and secondary education, and by 2015 in all levels of education.	Probably			
CHILD MORTALITY				
Reduce by two thirds, by 2015, the under-five mortality rate.	Probably			
MATERNAL HEALTH				
Reduce by three quarters, by 2015, the maternal mortality ratio				Without data
Achieve, by 2015, universal access to reproductive health.		Potentially		
HIV/AIDS, MALARIA AND OTHER DISEASES				
Have halted, by 2015, and begun to reverse the spread of HIV/AIDS		Potentially		
Achieve, by 2010, universal access to HIV/AIDS treatment for all those who need it			Unlikely	
Have halted, by 2016, and begun to reverse the incidence of malaria and other major diseases	Probably			
ENVIRONMENTAL SUSTAINABILITY				
Integrate the principles of sustainable development into national policies and programmes and reverse the loss of environmental resources		Potentially		
Reduce the loss of biodiversity, achieving, by 2010, a significant level				Without data
Reduce to half, by 2015, the number of people without access to safe drinking water and sanitation		Potentially		
By 2020, to have achieved a significant improvement in the standard of living of the slum dwellers		Potentially		
GLOBAL PARTNERSHIP FOR DEVELOPMENT				
Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. This includes a commitment to good governance, development and poverty reduction – both nationally and internationally		Potentially		
Address the special needs of the least developed countries				Without data
Address the special needs of landlocked developing countries and small island developing States and the outcome of the twenty-second special session of the General Assembly of the UN				Without data
Deal comprehensively with the debt problems of developing countries through nation and international measures in order to make debt sustainable in the long term				Without data
In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.				Without data
In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	Probably			

Source: Republic of Mozambique, Report on the Millennium Development Goals, Government of Mozambique, Maputo, 2010.

2.4. Decentralisation

Decentralisation is considered to be a driver for poverty reduction, as it encourages democracy, popular participation, responsiveness, accountability and equity at the local level. Decentralisation can give a voice to poor citizens and enhance their access to Government structures. In addition, it is assumed that local authorities better understand their situation and populace than central authorities, and so can more effectively target poverty-reducing investments. Decentralisation is a priority within the Five-Year Plan 2010-14.

The decentralisation process in Mozambique dates back to the adoption of the constitution in 1990, which establishes State Local Bodies. Law 2/1997 establishes municipalities as territorial units with their own representative bodies (municipal assemblies) and executive organs (the municipal council). The municipal assembly is composed of directly elected members. The municipal council comprises the mayor and town councillors. Decree 15/2000 recognises community authorities as the link between civil society and Local State Bodies and describes several duties of the recognised community authorities, including: (i) disseminating Government laws and policies to community members; (ii) collecting taxes; (iii) registering the population; (iv) enforcing justice; and (v) mobilising and organising communities for local development activities. Community authorities receive a monetary incentive for the taxes they collect. National guidelines for district development plans (adopted in 2003) reinforce the role of the districts as units for planning and budgeting and allow for the creation of local consultative councils to act as an interface between civil society and the district authorities in the planning process.

Law 8/2003ⁱⁱⁱ defines the structure and organisation of State Local Bodies and

establishes the district as a budgetary unit with power to plan and define its priorities. The district development plan is legally recognised as the principal instrument for planning and budgeting. Community consultation and participation is encouraged through district consultative councils, which are given a role in the preparation, approval and implementation of the plans at district level. The district consultative councils offer a potential avenue through which the voices of children can be heard and their rights realised.

Since 2006 the Government has allocated approximately seven million Meticaís to each district for investments in job creation and promotion of the private sector. This has provided a strong incentive to improve systems to ensure that these monies are effectively spent on local development projects. At its 17th Ordinary Session in 2007, the council of ministers decided to decentralise funding for roads, water, agriculture, and health and education infrastructures as a step towards effective implementation of Law 8/2003 and achievement of the strategic objectives of PARPA II and the Five-Year Plan.

A study commissioned for the PARPA II evaluation concluded, “(1) decentralisation of sectoral funds has not yet been effective; (2) involvement of planning institutions and community consultation is effective; (3) the accounting systems are complex, slow and counterproductive; (4) the monitoring and evaluation system at the district level would benefit from further improvement; (5) maintenance capacity at district level requires strengthening; (6) the private sector is only weakly involved in provision of services; (7) institutional divergence exists in relation to application of legislation; (8) the criteria for allocation of sectoral funds are inconsistent and not well known; and (9) at district level, a multisectoral perspective is lacking, as is a systematic planning process.” The

ⁱⁱⁱ Lei dos Órgãos Locais do Estado (LOLE).

study also revealed significant differences between the decentralisation processes in the two provinces visited (Nampula and Gaza). Differences were observed in relation to planning criteria, definition of priorities, allocation of resources and financial flows. These differences could at least partly be explained by differences in the level of experience in managing decentralisation processes between the two provinces.³⁹

Much of the local government reform that has taken place to date has focused on decentralising administrative functions (often termed 'deconcentration'), some fiscal elements of the public sector, and most notably planning and budgeting processes. Democratic decentralisation remains a distant prospect, and district participatory planning apart, accountability in the district tends to flow upwards to provincial and national level rather than downwards to local people.



3. Policy and institutional analysis

3.1. Policy and planning mechanisms

National-level planning in Mozambique is guided by the Government's Five-Year Programme. A Five-Year Plan (Programa Quinquenal do Governo) is produced by each new Government upon entering office^{iv} and establishes the Government's priorities and operational agenda until the next general election. The Five-Year Plan is the central long-term planning instrument that sets out the central priorities and objectives of the Government and describes the specific strategies for achieving them. The current Five-Year Plan 2010–2014 has the central objective of reducing absolute poverty to improve the living conditions of the Mozambican people in an environment of peace, harmony and tranquillity. The Five-Year Plan addresses: human and social development, good governance, economic development, and strengthening national sovereignty and international cooperation, as well as the cross-cutting issues of demining, environment, vulnerability, HIV and AIDS, gender, food and nutritional security, and rural development.

The PARP is the key instrument for putting the Government's Five-Year Plan into operation. Mozambique has to date produced two Plans of Action for the Reduction of Absolute Poverty or PARPAs (PARPA I 2001–2005²¹ and PARPA II 2006–2009).²² PARPA II reflected the goals and objectives of regional, African and international agreements, including the MDGs, the New Partnership for the Development of Africa and the Southern African Development Community. It was developed within the overall structure of the national vision document "Agenda 2025," and comprised four pillars: macro economy and poverty, governance, economic development

and human capital. Cross-cutting issues, including gender, HIV and AIDS, environment, food and nutritional security, and natural disasters, were mainstreamed throughout the document. PARPA II was considerably more child-friendly than PARPA I, setting time-bound and quantifiable targets for the further realisation of child rights, many of which contribute directly towards attaining the MDGs.

PARPA II focused on key sectors and strategies for economic growth and poverty reduction and gave greater detail on resource allocation and the setting of time-bound targets for monitoring and evaluating performance. PARPA II reaffirmed the Government's commitment to providing social services, but also prioritised the promotion of private sector development as a means of sustaining economic growth, reducing poverty and, in the long term, generating domestic sources of foreign exchange, increasing revenues and reducing aid dependency. PARPA II was subjected to a joint impact evaluation by Government and partners in October 2009,²³ which concluded that while there had been significant progress in implementing the objectives of the human capital pillar, especially in terms of expanding access to basic services, not all established targets were met. Areas in which insufficient progress was registered included: health service coverage, ensuring quality of education services, improving use of water and sanitation services, and reaching the poor with social protection programmes. It is expected that Mozambique's third generation Poverty Reduction Strategy Paper (the PARP) will be finalised in early 2011.

The Medium-Term Expenditure Framework (Cenário Fiscal de Médio Prazo)²⁴ is a medium-term planning instrument that

^{iv} Article 198 of the Constitution mandates that parliament should develop the Five-Year Plan at the initiation of the legislature.

Box 2.1. Planning and budgeting instruments in Mozambique

1. The PRSP (PARPA or PARP) is based on the Government's Five-Year Plan (Programa Quinquenal do Governo) and the Sectoral Strategic Plans (Planos Estratégicos Sectoriais) and presents the policies, objectives, goals and expected results towards the reduction of absolute poverty in the country over a five-year period.
2. The Strategic Sectoral Plans are medium-term planning instruments designed to harmonise global government policies with sectoral policies. They are aligned with the Programa Quinquenal and detail the strategies that will drive achievement of the Government's objectives.
3. The Medium-Term Expenditure Framework (Cenário Fiscal de Médio Praso) is a medium-term planning instrument used to allocate available financial resources according to the priorities outlined in PARPA and the Sectoral Strategic Plans.
4. The Economic and Social Plan (Plano Económico e Social) is the annual planning instrument in which the principal economic and social objectives and goals for the fiscal year are set out.
5. The State Budget (Orçamento do Estado) is the financial expression of the Economic and Social Plan.
6. The Provincial Strategic Plan (Plano Estratégico Provincial) is a medium-term planning instrument that describes the strategies for development at the provincial level, and takes its lead from the national objectives contained in the Programa Quinquenal. The Provincial Strategic Plan is translated into an annual provincial Economic and Social Plan and a Provincial Budget, both of which are submitted to the Ministry of Planning and Development for final approval. The Provincial Budget is then incorporated into the State Budget.
7. The District Development Strategic Plan (Plano Estratégico de Desenvolvimento Distrital) is a medium-term planning instrument that describes district-level development strategies. These plans are developed by the district governments with technical support from the provinces and with the participation of local communities. District Development Strategic Plans are implemented through annual Social and Economic Plans and Budgets (Plano Económico e Social e Orçamento Distrital).
8. The District Economic and Social Plan and Budget is the annual planning instrument that puts into operation the District Strategic Development Plan (Plano Estratégico Distrital de Desenvolvimento) and includes an estimate of expected district revenues and expenditures for the year.

sets out the financial resources necessary for the implementation of the objectives of the Five-Year Plan and PARPA. The Medium-Term Expenditure Framework (MTEF) also contributes to ensuring fiscal and budgetary aggregate discipline. Together, PARP and MTEF are the planning and budgetary instruments that jointly support harmonisation of national policies and priorities and set out the resources necessary for their implementation over the medium term. National plans are complemented by sectoral, provincial and district plans (see Figure 2.1), which together with PARPA and the MTEF constitute the medium-term

national planning framework. Preparation of Sectoral Strategic Plans is not subject to a prescribed methodology, and different sectors use different approaches.

The annual planning cycle commences with the preparation of the MTEF in February. A final version of the MTEF is made available by April/May as a contribution to the next phase of the cycle: budget preparation. Sectoral, provincial and district plans and budget proposals have to be submitted by end of July. These plans are consolidated into the national Economic and Social Plan and State Budget for submission to the Council of Ministers by

15 September, then passed to the Assembly of the Republic by 30 September, for final approval by 15 December.

The State Budget and the Economic and Social Plan translate PARP into annual plans.²⁵ The Economic and Social Plan is the annual embodiment of the Government's Five-Year Plan and PARPA.

3.2. Monitoring and Evaluation

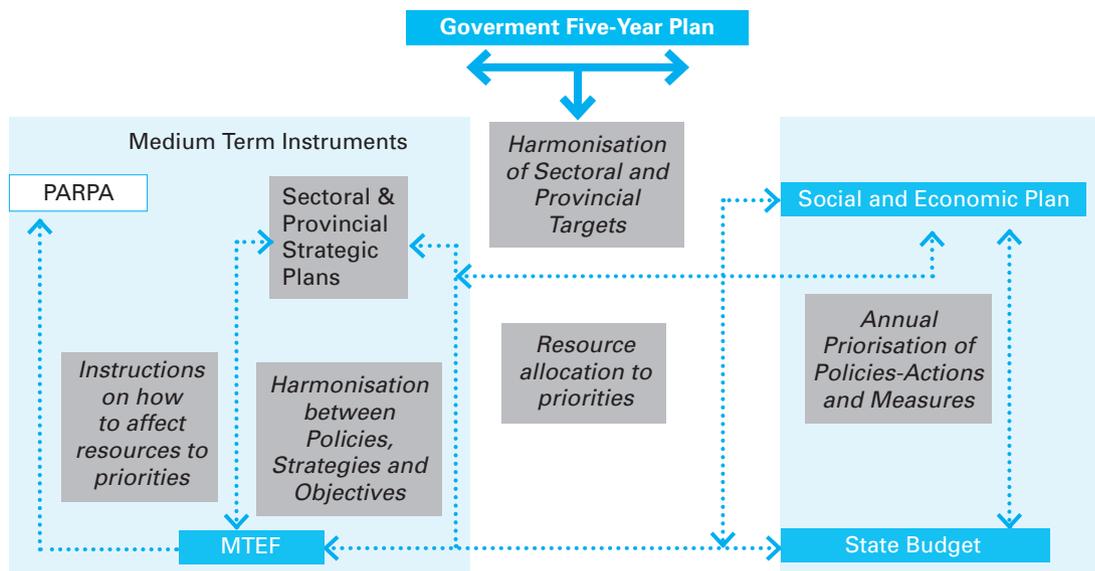
No single explicit source of normative guidance on planning, monitoring and evaluation processes exists in Mozambique. Rather, this guidance can be found dispersed across the constitution, in the law relating to SISTAFE (Financial Administration System of the State) and in the statute that created the Ministry of Planning and Development. Mozambique's constitution establishes the Economic and Social Plan as the principal planning instrument, and this is aligned with the Government's Five-Year Programme. The constitution requires that the Economic and Social Plan be developed using a decentralised planning process.

The State Budget is the financial expression of the Economic and Social Plan and is approved by the Assembly of the Republic. The SISTAFE Law (No. 9/2002, 12 February) requires that information on the execution of the Economic and Social Plan be presented to the Assembly of the Republic twice yearly.

A system of monitoring and evaluation exists for the State Budget, with reports published quarterly and annually. The State Budget is monitored internally by the Ministry of Finance through the State Budget Execution Report (Relatório de Execução do Orçamento do Estado) and externally via an audit of the Consolidated State Accounts (Conta Geral do Estado) by the Administrative Tribunal.

The need to monitor implementation and impact of PARPA I necessitated the development of a Monitoring and Evaluation framework. A concise version of this framework, known as the Performance Assessment Framework, was adopted as an annual monitoring and evaluation tool for General Budget Support (see below). The

Figure 2.1: Planning instruments in Mozambique



Source: Government of Mozambique, 'Plan of Action for the Reduction of Absolute Poverty 2006-2009,' Republic of Mozambique, Maputo, 2006.

PARPA II Monitoring and Evaluation Strategy aimed to develop an integrated national monitoring and evaluation system, operating as a routine component of the planning process. It established a matrix of strategic indicators that is more extensive than the Performance Assessment Framework matrix and is reported on in the Economic and Social Plan and its associated review report. PARPA II also introduced a distinction between medium-term, results-based indicators and annually measured, product-based indicators. The Monitoring and Evaluation Framework of the Five-Year Plan 2010-14, the PARP, is currently under development.

PARPA is also evaluated by means of mid-year and annual joint donor reviews and a final impact evaluation (Relatório de Avaliação de Impacto) that assesses progress in each of the pillars and in the cross-cutting thematic areas across the lifetime of PARPA. The Joint Review (Revisão Conjunta) is the mechanism through which Government, donors and civil society evaluate implementation of PARPA, with a focus on the Economic and Social Plan, the State Budget and their associated monitoring instruments (the Balanço do PES and the Relatório de Execução do Orçamento do Estado). The joint review of Government and donor performance takes place in April each year and reviews performance over the previous year. The Mid-Year Review (or planning meeting) takes place in September and focuses on setting targets for the following year and indicating whether key targets in the Performance Assessment Framework are likely to be achieved. The joint review meeting also evaluates the contributions of the Programme Aid Partners in achieving results in accordance with the principles of the 2005 Paris Declaration on Aid Effectiveness. PARPA monitoring data are primarily collected through sectoral contributions that quantify the input of the sectors. Surveys, including the Demographic and Health Survey, MICS, Inquérito aos Agregados Familiares, the Core Welfare Indicators Questionnaire (Questionário de Indicadores Básicos de Bem-Estar), and the Labour Force Survey (Inquérito Integrado

à Força de Trabalho [IFTRAB]) are used to quantify output and outcomes. The irregularity of surveys and lack of coordination between the medium-term planning cycle and relevant surveys have constrained the effective monitoring of PARPA.

Despite enormous progress in monitoring and evaluation in Mozambique in recent years, weaknesses remain as a consequence of the lack of consolidation of a multitude of processes and methodologies, according to a study commissioned by the Ministry of Planning and Development in 2008.²⁶ At the central level, three distinct systems exist for monitoring and evaluating the Economic and Social Plan, PARPA and the Sectoral Strategic Plans. These national systems are in turn supported by a multitude of sectoral and provincial systems that have not benefited from a consistent methodology or standardisation. There are multiple demands for monitoring and evaluation information from a variety of sources, both internal and external, and this places a significant burden on the systems. District planning instruments and processes including the District Economic and Social Plan, district budgets and adoption of the Law on Local State Organs (Lei dos Órgãos Locais do Estado [LOLE]) have been developing at pace, in line with decentralisation strategies; however, there has not been a concomitant development of instruments and processes for monitoring and evaluating implementation of these plans. The use of participatory processes in monitoring and evaluation in Mozambique is relatively new and somewhat underdeveloped.

Much of the monitoring and evaluation activity carried out in Mozambique appears to be in response to requests for information from external partners or higher administrative centres rather than providing input for policy making. Making General Budget Support disbursement conditional on performance against the Performance Assessment Framework indicators may have created incentives for sectors to set conservative, easily attainable targets and to prioritise actions that respond to the narrow scope of these indicators in order to maintain external funding.

3.3. Legal framework

The constitution of Mozambique was approved and enacted in November 1990 and revised in 2004. The constitution acts as the fundamental law for all political and social organisations in the country. Under Article 62 of the constitution, Mozambique accepts, observes and applies the principles of the Charter of the United Nations and the Charter of the Organisation of African Unity.³⁶

Mozambique ratified the United Nations Convention on the Rights of the Child without reservation, and the Convention was incorporated into the country's internal legal structure following its publication in the Government Gazette on 23 October 1990.³⁷ Prior to its ratification, the Convention was studied by national institutions, including the Supreme Court, the Attorney General's Office, the Ministries of Justice, Education and Health and other relevant sectors, and it was concluded that no major

incompatibilities existed between the Convention and the domestic legal order. At the same time, the need to improve internal regulations relating to the rights of the child was recognised.

The Government has also acceded to the two Optional Protocols to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography and on the involvement of children in armed conflict, in 2003 and 2004 respectively. In addition to the Convention on the Rights of the Child, Mozambique has also ratified the African Charter on the Rights and Welfare of the Child and other international legal instruments dealing with the development and welfare of children. Immediately after national independence and before the Convention on the Rights of the Child, Mozambique adopted its own Declaration on the Rights of the Mozambican Child, containing a set of 12 basic rights.³⁸ Domestic legislation concerning the rights of children is discussed in Chapter 5.

4. External development assistance

Mozambique is Africa's single biggest recipient of international development assistance. The United Kingdom is the single largest bilateral source of aid to Mozambique.²⁷ Increases in the amounts of Official Development Assistance committed by developed countries are generally considered to be positive, and the United Nations advocates an allocation of 0.7 per cent of GDP from developed countries. However, concentration of large amounts of overseas aid in certain countries raises the issue of aid dependency. The Committee on the Rights of the Child, in its concluding observations on Mozambique's Second Periodic Report,²⁸ notes with concern that despite the commendable economic growth sustained over the last decade, the State Party continues to be heavily dependent on international cooperation, noting that a significant proportion of the national budget came from development cooperation. The International Poverty Centre argues that a large and sustained flow of Official Development Assistance into a country can shift the focus of accountability away from state and society and onto the relationship between the Government and the aid donors, thereby weakening the role of domestic institutions in governance.²⁹ Other commentators have taken a more extreme view, asserting that because of the budget support process, donor representatives are now at the heart of decision-making processes within Government.³⁰

4.1. Aid coordination

Within the context of heavy aid dependency, there have been moves towards increased harmonisation and alignment of external assistance in recent years, particularly following PARPA II and the 2005 Paris Declaration on Aid Effectiveness.³¹ The

emphasis is now on sector Common Funds and General Budget Support mechanisms that give increased flexibility to the Government in terms of how it allocates the money received. General Budget Support should also reduce the Government's burden of monitoring, evaluating and reporting for multiple external funding sources. PARPA II supports the use of more flexible funding modes, and of General Budget Support in particular, and states, "although the ideal balance between aid modalities will probably contain a mixture of them, the Government wishes that the proportion of funds channelled through the Public Treasury Accounts, principally through General Budget Support ...be increased."³²

The move towards harmonisation, alignment and the use of increasingly flexible aid modalities has been led in Mozambique by the Programme Aid Partners (Parceiros de Apoio Programático) group. The Programme Aid Partners (PAPs), otherwise known as the Group of 19 or 'G19', comprises 19 bilateral and multilateral donors^v that provide General Budget Support. The Government of Mozambique and PAPs first signed a Memorandum of Understanding in 2004, in which the principles for the partnership were defined and commitments to improving the quality of Programme Aid were established. A second Memorandum of Understanding was signed in March 2009. The overall objective of PAPs' Budget Support to Mozambique is to contribute to poverty reduction in all its dimensions. Furthermore, the Memorandum of Understanding states, "The PAPs' Budget Support should help attain the mutual objectives of poverty reduction and the MDGs in Mozambique by providing budget financing to the public sector for poverty reduction, aligned with Mozambican

^v The 19 partners are: the African Development Bank, Belgium, Canada, Denmark, the European Commission, Finland, France, Germany, the Netherlands, Ireland, Italy, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, the World Bank, and Austria. The United States of America and the United Nations joined as Associate Members in 2009.

systems and clearly and transparently linked to performance.”³³ Direct Budget Support also provides an important avenue for coordinated and harmonised dialogue between Government and donors on development policies and public spending choices.

PAPs pledges for General Budget Support in 2009 amounted to \$US 485 million, and pledges for 2010 total \$US 472 million.³⁴

According to the MTEF 2010–2012, external funding accounts for approximately 44 per cent of the total State Budget, rising to 47 per cent in 2010 and 48 per cent in 2011 and 2012 (see Table 2.3).

4.2. Implications for children

Knowledge of the full extent of the available resource envelope is vital to ensuring policy-driven allocation of public funds for children. Off-budget funding, or funding that is fully or partially outside the formal budget process, undermines Government efforts to prioritise, plan, budget, monitor and evaluate effectively. Off-budget funds also damage the credibility of the budget

process, lead to costly and unnecessary duplication of reporting, and ultimately weaken the executive’s accountability to Parliament. The problem of off-budget funding is most severe in the social services and infrastructure sectors since they are the largest recipients of external aid.

The Committee on the Rights of the Child, in its concluding observations on Mozambique, recommends to the State Party that when negotiating development cooperation, and particularly any increases, funding should be targeted to programmes that can deliver the quickest or highest impact in implementing the rights of the child.³⁵ In particular, priority should be given to:

- Large-scale programmes that deliver clear benefits for children, such as comprehensive distribution of long-lasting, insecticide-treated nets;
- Large-scale health outreach programmes, including structured use of national Child Health Weeks to increase vaccination coverage, micronutrient supplementation and preventive care at the community level;

Table 2.3: Internal and external funding in the State Budget, 2009 – 2012
(in Millions of Meticaís, assuming GDP growth of 6.1 per cent)

	2009 (adjusted)	2010	2011	2012
<i>Internal resources</i>				
State receipts	43,100	49,981	56,826	64,230
Privatisation	1,044			
Internal credit	5,721	2,449	-1,595	-2,923
Total Internal	49,865	52,430	55,231	61,307
<i>External resources</i>				
Donations	31,991	34,770	37,488	40,368
Credits	7,148	11,673	14,171	17,304
Total External	39,139	46,443	51,659	57,672
Total Internal + External	89,004	98,873	106,890	118,979
Internal resources as % of total	0.56	0.53	0.52	0.52
External resources as % of total	0.44	0.47	0.48	0.48

Source: Ministry of Planning and Development and Ministry of Finance, *Cenário Fiscal de Médio Prazo 2010–2012*, Government of Mozambique, Maputo, September 2009.

- Continued and accelerated expansion of access to, and quality of, paediatric treatment, voluntary counselling and testing as part of antenatal care programmes, and drugs for the prevention of mother-to-child transmission of HIV;
- Use of funding targeted to AIDS programmes as an entry point for allocating resources to the wider health sector, strengthening expansion of facilities and improving quality of care;
- Large-scale social protection schemes and cash transfer programmes;
- Expanded rural and peri-urban water and sanitation programmes, building on rural water and sanitation initiatives such as the 'One Million Initiative'; and

- Campaigns to expand school construction in all districts, using both community-based or local labour and outsourced contractors.

The longer-term benefits of reforming how external development assistance is delivered are widely accepted by Governments of developed and developing countries, as evidenced by the 2005 Paris Declaration on Aid Effectiveness and the 2008 Accra Agenda for Action. However, both processes, both moving away from existing bilateral arrangements, which have substantial components of 'off budget' and project-based funding, and developing the capacity of national governments, are likely to take several years for full implementation. Capacity development is a key area that has been neglected in harmonisation and alignment reforms.



5. Conclusions

Despite a successful transition to peace, years of steady economic growth and a set of institutional processes focused on development, Mozambique continues to be one of the poorest countries in the world, ranking 165 of 169 on the 2010 Human Development Index. Since the signing of the Peace Agreement in 1992, Mozambique has made progress against a number of indicators relating to child well-being in Mozambique. Further investment is needed if the country is to reach many of the MDGs. Mozambique is currently considered likely to achieve only four of the 21 targets, with the potential to reach another nine.

The fiscal environment is one of heavy aid dependence. According to the MTEF 2010–2012, external funding accounts for approximately 44 per cent of the total State Budget, rising to 47 per cent in 2010 and 48 per cent in 2011 and 2012. Within the context

of heavy aid dependency, there have been moves towards increased harmonisation and alignment of external assistance in recent years, particularly following PARPA II and the 2005 Paris Declaration on Aid Effectiveness. An over reliance on aid may shift Government accountability away from state and society to focus instead on aid donors, weakening the role of domestic institutions such as Parliament.

The Government's Five-Year Plan and its operational plan, the PARP, focus national development priorities on human and social development along with other areas of economic and political development. In order to best make progress towards the goals laid out in the Government's planning and budgeting instruments, further efforts are needed towards consolidating national planning, monitoring and evaluation frameworks.

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- ³⁶ Government of Mozambique, *Constituição da República*, Government of Mozambique, Maputo, 19 November 2004.
- ³⁷ United Nations Committee on the Rights of the Child, *Consideration of Reports Submitted by States Parties Under Article 44 of the Convention: Initial report of States Parties due in 1996 – Mozambique*, CRC/C/41/Add.11, Office of the High Commissioner on Human Rights, Geneva, 2001.
- ³⁸ Ibid.
- ³⁹ Kulipossa, Fidelx Pius, and Eduardo Jossias Nguenha, *Relatório Final da Pesquisa sobre o Impacto da Descentralização dos Fundos Sectoriais de Estradas, Águas e de Construção Acelerada de Salas de Aulas nas Províncias, nos Distritos e nas Autarquias Locais*, Government of Mozambique, Maputo, 2009.

A young child is shown from the chest up, carrying a large, rough-textured wooden log horizontally across their head. The child is looking down with a focused expression. They are holding a clear plastic bucket with both hands, and a stream of water is dripping from the bottom of the bucket into their cupped hands. The background is a blurred outdoor setting with wooden posts and a dirt ground. The overall image has a blue-tinted, monochromatic aesthetic.

CHAPTER

3

CHILD SURVIVAL AND DEVELOPMENT

CHILD SURVIVAL AND DEVELOPMENT

1. Introduction

The rights of every child to life, survival and development are enshrined in the United Nations Convention on the Rights of the Child. Despite the commitments of nations throughout the world, almost 10 million children continue to die every year, with the majority of child deaths occurring in just 60 developing countries.¹ Around 40 per cent of child deaths occur during the child's first month of life, usually in the child's home and often because there is no access to health services and basic health commodities.² Many children die as a result of contracting easily preventable or treatable illnesses and conditions, including diarrhoeal infections, measles, malaria and pneumonia, among others. In up to half of deaths of children under five, undernutrition is an underlying cause.³ Unsafe water, poor sanitation and inadequate hygiene also contribute to child mortality and morbidity. Water, sanitation and hygiene are closely linked to childhood undernutrition.⁴ Research dating back to 1968 has confirmed the deleterious effect of diarrhoea on children's nutritional status. Eighty-eight per cent of all cases of diarrhoea globally are attributable to water, sanitation and hygiene.⁵ *Ascaris* (roundworm), *Trichuris* (whipworm) and hookworm infestation are attributable to inadequate sanitation and hygiene.⁶ More recent evidence has provided guidelines to prevent and treat these illnesses (e.g. promotion of breastfeeding, supplementation of micronutrients).⁷

Child survival is a major development priority, both internationally and within individual countries. Millennium Development Goal Four has as its target a two-thirds reduction in the under-five mortality rate between 1990 and 2015. Beyond the desirability of meeting international development targets, improving child survival and health is a crucial investment for future development and prosperity of nations. Well-nourished, well-cared-for, healthy children are more likely to survive and develop into healthy and productive adults able to make a meaningful contribution to the social and economic development of their families, communities and nations. Investing in the survival and good health of children is also cost-effective. The interventions with the strongest impact on the prevention of child death are appropriate infant feeding practices (preventing 19 per cent of deaths) and the use of insecticide-treated materials (preventing 7 per cent). The most effective treatment interventions are the use of oral rehydration therapy (resulting in a 15 per cent reduction in child mortality if applied universally), and the use of antibiotics for sepsis and pneumonia (each preventing 6 per cent).⁸

Cost-effective solutions are available that could bring rapid improvements, but urgency and commitment are required

to implement them and to meet the Millennium Development Goals (MDGs) related to maternal and child health.¹⁰

Maternal mortalityⁱ has generally received less attention from national governments and the international community than child mortality, and as a result successes have been more elusive. However, a growing body of research evidence shows that the necessary tools to make an impact in this previously neglected area are available. It is estimated that 80 per cent of maternal deaths could be averted if women had access to essential maternity services and basic health care.¹¹ There is a growing consensus that maternal and newborn health and survival can best be improved by establishing a 'continuum of care' for mothers, newborns and children that integrates programmes and interventions for reproductive health;

safe motherhood; newborn care; and child survival, growth and development, all delivered within a legal, institutional, and community and family environment that upholds and respects women's rights.

The emerging trends in under-five mortality, as in other indicators of children's well-being in Mozambique, show persistent geographical disparities.

The northern part of the country and rural areas are still far behind the southern parts of the country and urban areas (despite marked improvements in both urban and rural areas). Though there have been improvements in all segments of the population, there has been little reduction in the gaps between the poorest and the best-off.

This chapter is divided into two sections: health and nutrition, and water and sanitation.



ⁱ Maternal mortality is defined by the WHO as the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management.

2. Health and nutrition

2.1. Child survival

The principal indicator used to measure the level of child well-being in a country is the under-five mortality rate. The under-five mortality rate results from many factors: the nutritional status and health knowledge of mothers; childcare practices; the availability, use and quality of maternal and child health services; income and food availability in the family; the availability of clean water and safe sanitation; and the overall safety of the child's environment. The under-five mortality rate can be taken as a proxy of the health status of Mozambican children and of Mozambican society as a whole.

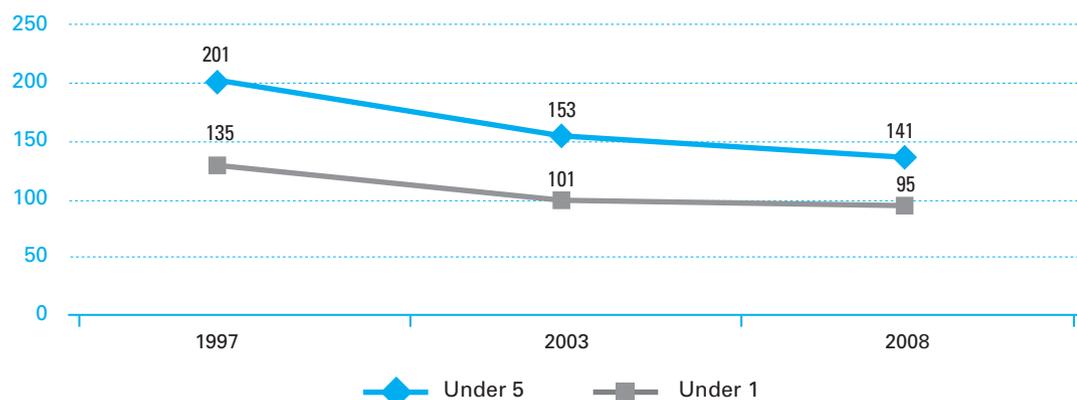
Results from the 2008 Multiple Indicator Cluster Survey indicate a reduction in the under-five mortality rate from 153 deaths per 1,000 live births in 2003 to 141 in 2008 (see Figure 3.1). This is significant progress in improving child and maternal health and survival in Mozambique, although the rate of decrease in the under-five mortality rate has slowed in recent years and will need to accelerate if the country is to achieve MDG 4.¹² Despite this progress, Mozambique has

the 22nd highest under-five mortality rate in the world.¹³ Furthermore, the improvement in child survival rates has been unevenly distributed across the country; children and women in some provinces have benefited less than those living in other provinces. The AIDS pandemic is increasingly taking its toll on children's lives and could negatively affect the recent encouraging trend.

In addition to the under-five mortality rate, measuring the rates of neonatal (less than one month) and infant (under one year) mortality are also critical, as these rates acknowledge the particular vulnerability of newborns and children in their first year of life. Neonatal mortality in particular indicates the circumstances of the entire pregnancy period and the birth of the child, such as the mother's health, the circumstances in which the child was delivered and the care the newborn received in the first few days of life.

Children face a barrage of diseases, all rendered more dangerous by undernutrition. The majority of deaths in children under five are due to a small number of common, preventable and treatable conditions, such

Figure 3.1: Mortality rates in Mozambique per 1,000 live births, 2003 and 2008 (five-year average preceding the survey)



Source: DHS 1997, DHS 2003, MICS 2008

as malaria, neonatal conditions, acute lower respiratory infections, HIV infection, infectious intestinal diseases, meningitis and undernutrition, occurring alone or in combination. A child's risk of dying is very high in the first month of his or her life (the neonatal period); almost a quarter of all under-five deaths occur during this period (38 per 1,000 live births in 2008).¹⁴

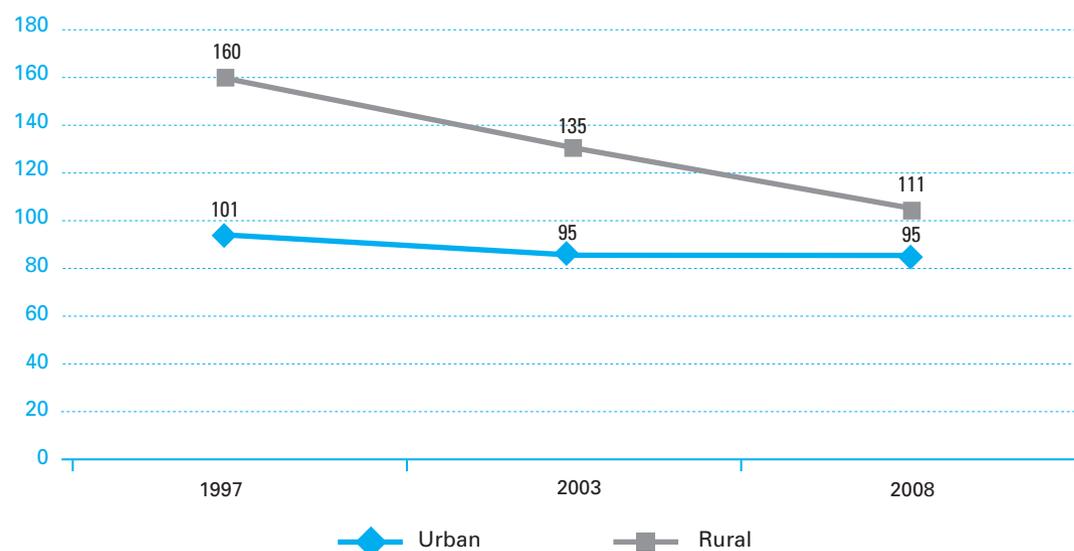
The observed reduction in mortality in Mozambique has been more pronounced in rural areas. The average mortality rate from 1987 to 1997, 237 deaths per 1,000 live births, was reduced to 164 deaths for the 1998–2008 period, equivalent to a 32 per cent reduction. In urban areas, the under-five mortality rate decreased from 150 in 1987–1997 to 138 in 1998–2008, a reduction of around 10 per cent. The marked improvement in rural areas is likely to be linked to improved access to health facilities and services. Geographical disparities remain acute, with a child in Cabo Delgado province being almost three times more likely to die before reaching age five than a child in Maputo City. A similar trend was observed in infant mortality (see Figure

3.2), which also fell much more rapidly in rural areas.

The marked improvement in child mortality rates in rural areas may be associated, at least in part, with increased access to health services in those areas. Rural areas saw a large improvement in terms of distance to the nearest primary health facility. In 2008/09 in the rural North, for example, 69.7 per cent of households are now able to access such a facility within a 45 minute walk compared to only 31.5 per cent in 2002/03. Access in the rural Centre and South has also improved, but not quite so quickly.

Access in urban areas to primary health facilities appears to have worsened, as a slightly smaller share of households report they are able to reach a facility on foot within 45 minutes. This may be due to a number of factors such as urbanisation, with higher population growth in the periphery of cities where access to public facilities is lower; and a greater reliance on hospitals and other medical facilities in urban areas, thus reducing demand for basic primary facilities.¹⁵

Figure 3.2: Infant mortality rates in Mozambique per 1,000 live births 1997, 2003 and 2008 (five-year average preceding the survey)



Source: DHS 1997, DHS 2003, MICS 2008

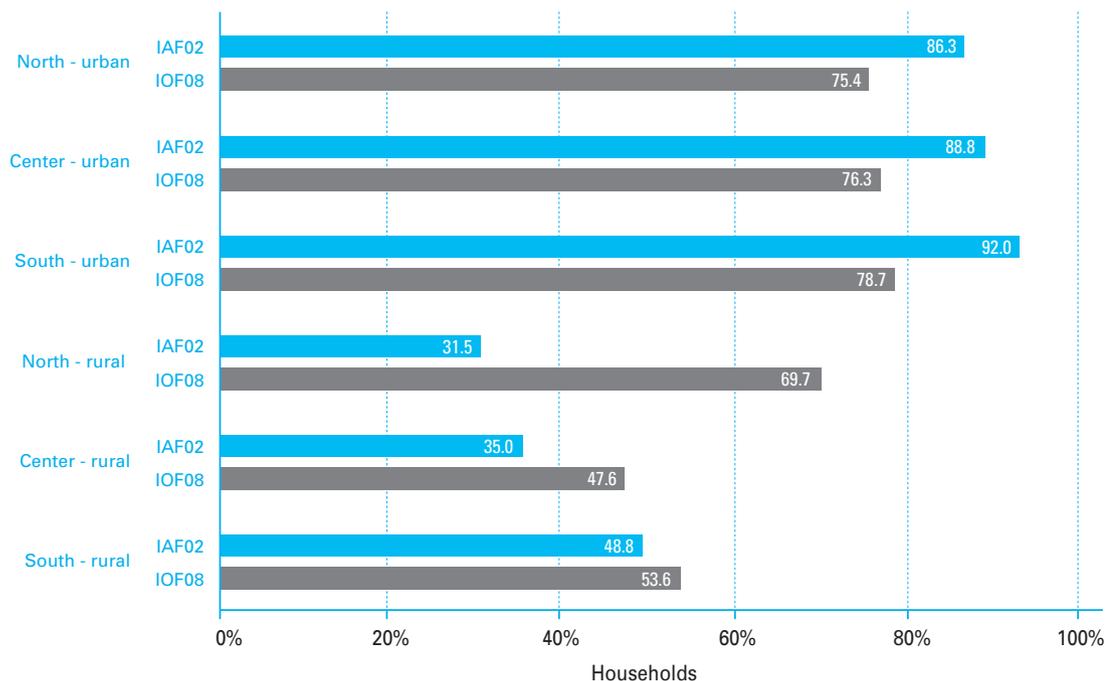
There is a significant difference in under-five mortality between the central and northern provinces and the southern provinces. The highest rates were recorded in Zambezia (206 deaths per 1,000 live births) and Cabo Delgado (181 deaths per 1,000 live births). Tete province has the third highest under-five mortality rate, 174 per 1,000 live births. Maputo province and Maputo City report the lowest under-five mortality rates (103 and 109, respectively).^{16, ii}

A household-level multivariate regression analysis was conducted to further explore which factors were related to the survival of

children (0–17 years) in the household, the dependent variable in the model taken as a proxy for child health.

Households where the head has secondary-level education or higher are less likely to experience a child death, as Figure 3.4 confirms. The observed relationship to the age of the head of household simply reflects the biological relationship between parent's and child's age. However, the gender of the head of household does not appear to be statistically correlated to child survival. Anti-mosquito spraying appears to reduce household child mortality by one per cent.¹⁷

Figure 3.3: Share of households with less than 45 minutes walk to nearest primary health facility, 2002/03 and 2008/09 (percentage)



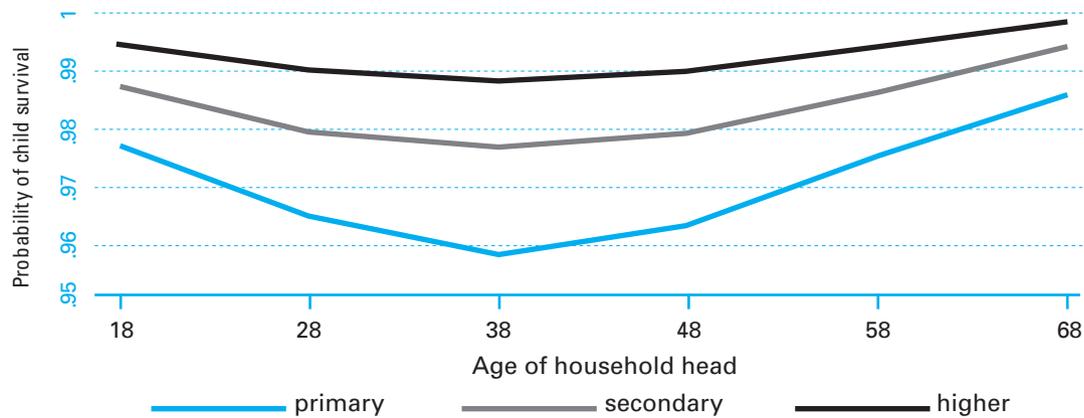
Source: Ministry of Planning and Development. 'Poverty and Wellbeing in Mozambique: Third National Poverty Assessment, Government of Mozambique, September 2010.

ⁱⁱ Average of ten years preceding the survey.

Malaria, neonatal causes and acute respiratory infections are the three major immediate causes of mortality among young children in Mozambique.^{18 iii} AIDS is also emerging as a major killer, with 10 per cent of under-five deaths attributed to

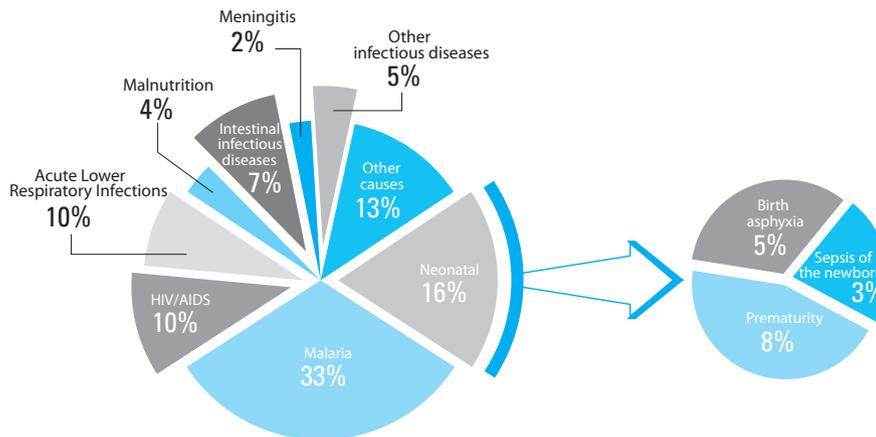
it. Undernutrition is a major underlying cause of child mortality, as are diarrhoeal illnesses. Many of the causes of child mortality are preventable by either vaccination or other simple prophylactic measures.

Figure 3.4: Probability of child (age 0–17) survival in the last 12 months by education level of the head of household, 2008



Source: UNICEF calculations based on MICS 2008

Figure 3.5: Causes of under-five mortality in Mozambique, 2008



Source: National Institute of Health, London School of Hygiene and Tropical Medicine and UNICEF, Mozambique National Child Mortality Study 2009, Maputo, 2009.

ⁱⁱⁱ These findings are derived from the Ministry of Health and UNICEF’s 2008 child mortality study. The aim of the study was to measure neonatal, infant and under-five mortality rates in Mozambique for all programme-relevant causes using data collected at community level. Verbal autopsies, i.e., interviews with family members or caregivers about the circumstances of death after the event has taken place, were used to determine the causes of child mortality.

The 2010 National Millennium Development Goal Progress Report found that if trends in reducing child mortality continue, the country has the potential to reach the MDG relating to child mortality by 2015. However, to reach the target for under-five mortality, equivalent to a mortality rate of 108 per 1,000 live births in 2015, the required annual reduction in the number of deaths is 4.3 per cent for the under-five mortality rate and 3.7 per cent for the infant mortality rate. This would represent an acceleration of the reduction rates recorded in the last five years, which are three per cent and slightly less than two per cent per year, respectively.

2.2. Child nutrition

Undernutrition is the main underlying cause contributing to the high level of child mortality in Mozambique. It is also important in its own right, since undernutrition (in particular, chronic undernutrition or stunting) affects cognitive development and is closely linked to future educational outcomes. The major manifestations of undernutrition are underweight (low weight for age), wasting (low weight for height), stunting (low height for age), and micronutrient deficiencies.

Figure 3.6: Chronic undernutrition rates by country, 2009

Ranking	Country	Stunting prevalence (%)	Number of children who are stunted (thousands, 2008)
1	India	48	60,788
2	China	15	12,685
3	Nigeria	41	10,158
4	Pakistan	42	9,868
5	Indonesia	37	7,688
6	Bangladesh	43	7,219
7	Ethiopia	51	6,768
8	Democratic Republic of Congo	46	5,382
9	Philippines	34	3,617
10	United Republic of Tanzania	44	3,359
11	Afghanistan	59	2,910
12	Egypt	29	2,730
13	Viet Nam	36	2,619
14	Uganda	38	2,355
15	Sudan	40	2,305
16	Kenya	35	2,269
17	Yemen	58	2,154
18	Mynmar	41	1,880
19	Nepal	49	1,743
20	Mozambique	44	1,670
21	Madagascar	53	1,622
22	Mexico	16	1,594
23	Niger	47	1,473
24	South Africa	51	1,425

Source: UNICEF, *Tracking Progress on Child and Maternal Nutrition: A survival and development priority*, UNICEF, November 2009.

Children's nutritional status

Using World Health Organisation (WHO) classifications, stunting prevalence among Mozambican children is very high (44 per cent), underweight prevalence is medium (18 per cent), and wasting prevalence is low (4 per cent), according to MICS 2008 data (See Figure 3.6).¹⁹ A slowly declining trend is observed across all undernutrition indicators from 1996/97 to 2008. Mozambique has one of the highest rates of stunting world-wide, with over 1.6 million children experiencing stunting.

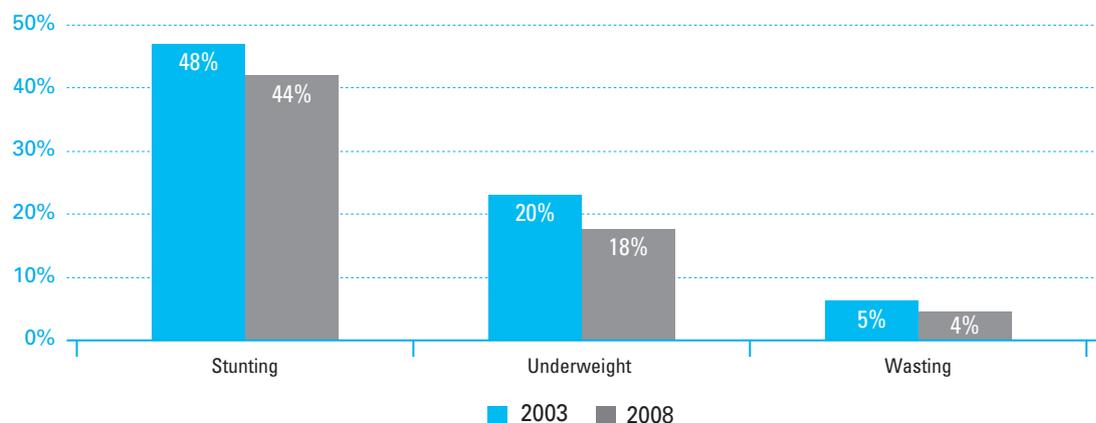
The IOF 2008/09 survey indicates slightly different levels of undernutrition to MICS 2008 – for example, chronic undernutrition is 46 per cent according to IOF 2008/09 versus 44 per cent in MICS 2008. Analysis conducted by the MPD restricted the analysis of MICS 2008 and IOF 2008 to households surveyed during the same period of 2008 (the MICS was conducted between September and November 2008 while IOF ran from September 2008 to August 2009). This analysis indicated no statistical differences between the national averages for the three indicators.²⁰

Acute undernutrition (wasting)

No significant difference was observed between the 2003^{iv} and 2008 rates of acute undernutrition for children under five, which were five and four per cent, respectively.²¹ Wasting or acute undernutrition, which is defined on the basis of weight for height, is a type of undernutrition that results from a recent excessive loss of weight due to severe illness and/or lack of food. It should be noted that the temporal and seasonal instability of this indicator makes meaningful comparisons between years challenging.

Although wasting at a national level is low (less than 5 per cent is considered low by the WHO classification), provincial variations are significant, ranging from nine per cent in Nampula to one per cent in Gaza (see Figure 3.8). Wasting prevalence is linked to wealth, with children in the poorest households over three times more likely to suffer acute undernutrition (six per cent) than those in the richest households (two per cent). Wasting rates are highest at six months of age (eight per cent) and then progressively decline. Wasting prevalence is similar in rural and urban areas (five and three per cent, respectively).²²

Figure 3.7: Undernutrition rates (moderate) in children under five, 2003 and 2008



Source: DHS 1997, MICS 2008.

^{iv} The anthropometric data from DHS 2003 were recalculated based on the 2006 WHO standard population.

Underweight

The prevalence of underweight among children under five reduced from 20 per cent in 2003²³ to 18 per cent in 2008.²⁴

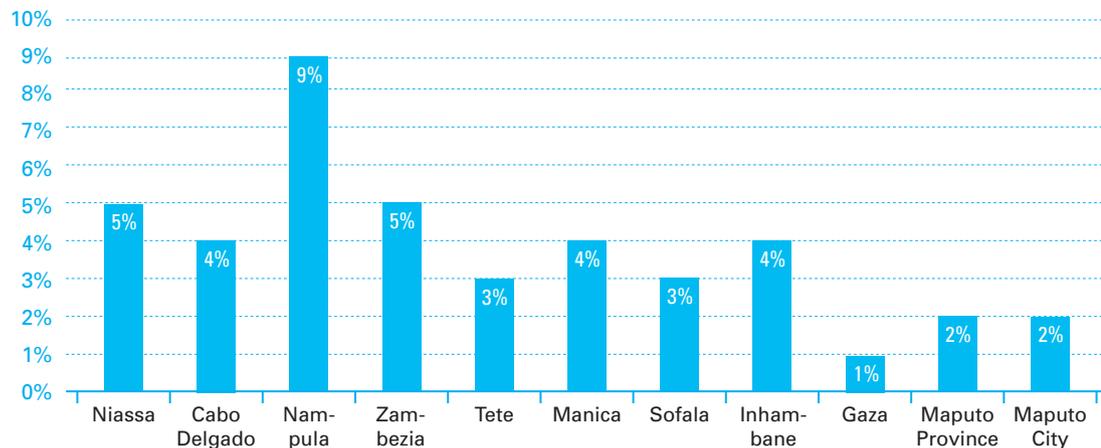
Underweight, which is defined as low weight for age, is a function of deficiencies in both current and past nutrition, health, and other care experienced by a child. The greatest improvements occurred in rural areas, where the prevalence decreased from 25 per cent in 2003 to 19 per cent in 2008; during the same time period, prevalence in urban areas remained static at 13 per cent. Larger improvements were seen among the

poorest households, in which prevalence of underweight children fell from 29 per cent in 2003 to 23 per cent in 2008.²⁵

A higher proportion of boys are underweight than girls (20 per cent against 15 per cent).

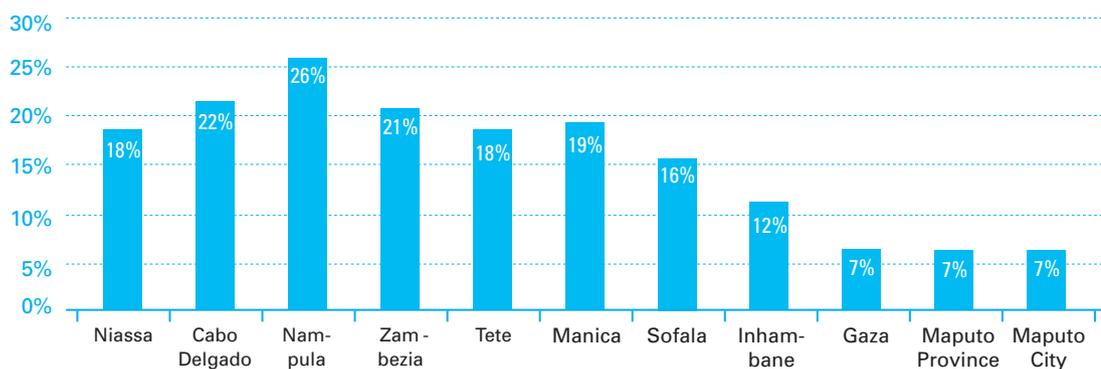
Underweight levels by age group are highest at ages 6–11 months (22 per cent), decreasing slightly as children get older, but still remaining close to 15 per cent as children approach their fifth birthdays. Provincial disparities are particularly acute, with more than one in four children underweight in Nampula province, compared with one in fifteen in Maputo City (see Figure 3.9).²⁶

Figure 3.8: Percentage of wasting in children under five by province, 2008



Source: MICS 2008.

Figure 3.9: Percentage of underweight in children under five by province, 2008



Source: MICS 2008.

The 2010 National Millennium Development Goals Report considers that is “potential” that the MDG target of reducing underweight prevalence by half will be met.²⁷ While this is an important achievement, there is no room for complacency, since levels of stunting (low height for age) are more than twice the levels of underweight. Even if Mozambique meets the underweight MDG, urgent action is needed to address the very high levels of stunting.

Chronic undernutrition (stunting)

The proportion of five-year-old children that are stunted has decreased from 48 per cent in 2003 to 44 per cent in 2008.²⁸

Mozambique’s stunting prevalence is still classified as “very high” by the WHO. Stunting, or chronic undernutrition, defined as low height for age, shows undernutrition resulting from cumulative inadequacies in the nutritional and health status of a mother before and during pregnancy and of a child in the first two years of life. Stunting is a good indicator of the well-being of a population, as it reflects the structural context surrounding undernutrition. Children who are stunted have compromised physical and mental development, and this growth opportunity is irreversibly lost. It cannot be

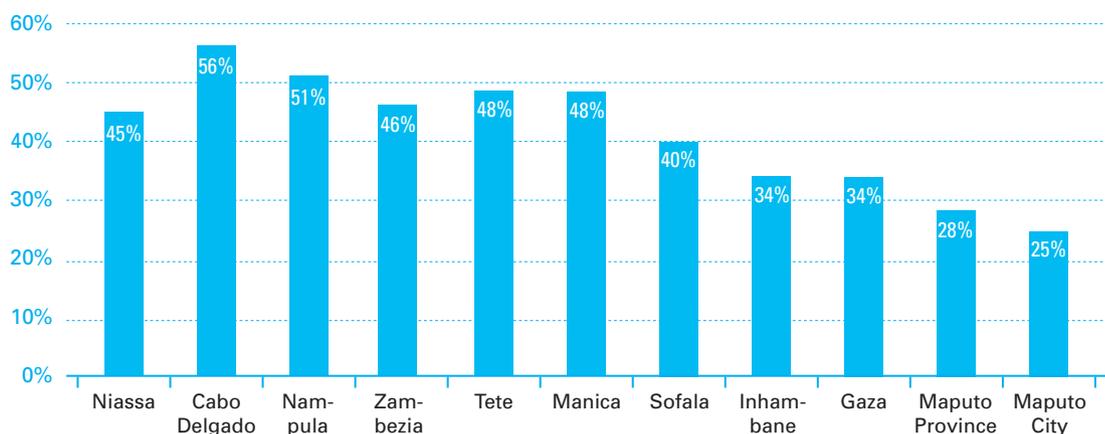
regained, even if nutrition conditions improve and a child gains weight.

The proportion of children with severe stunting decreased from 23 per cent in 2003 to 18 per cent in 2008. The observed reduction appears to have occurred predominantly in rural areas, where the proportion decreased from 52 per cent to 47 per cent.²⁹ In urban areas, where the prevalence of chronic undernutrition is lower, the reduction was less marked, with only an annual 0.2 percentage points reduction achieved between 2003 (36 per cent) and 2008 (35 per cent).³⁰

In Mozambique, stunting is observed among children at a very early age, even before six months, and increases up to 24–36 months. The high prevalence (slightly above 20 per cent) of stunting recorded among children less than six months old reported in the 2008 MICS is a cause for concern, as one would not normally expect to see such a high prevalence at this early age. Stunting rates increase with age from birth up to 24–36 months, reaching a peak of around 54 per cent, after which it decreases slightly.³¹

Provincial disparities in relation to stunting are particularly striking (see Figure 3.10). Stunting prevalence among children under five

Figure 3.10: Percentage of chronic undernutrition (stunting) in children under five by province, 2008



Source: MICS 2008.

is highest in the provinces of Cabo Delgado (56 per cent) and Nampula (51 per cent), and in Zambezia, Niassa, Tete, Sofala and Manica prevalence also exceeds 40 per cent.³²

Male sex, age (in months), a low education level in the mother, use of unsafe water, use of precarious sanitation, and living in central or northern provinces all have a negative effect on children's height for age. These results were derived by analysing some of the factors related to chronic undernutrition through multivariate regression (see Table 3.1) using data from MICS 2008. The effect of the province of residence remains, even when other variables, such as poverty and access to safe water and improved sanitation, are considered.

The introduction of the variable 'wealth'^v reduces the impact of the mother's education and the quality of water and sanitation, making these factors not significant. This demonstrates that the variable 'wealth' is the most important underlying cause of chronic undernutrition.

The p-value tests the probability of the regression coefficient taking the same value or a more extreme one if there is no association between the explanatory variable and height-for-age Z-score in children 0–59 months, using the same sampling and analysis methods repeatedly.

These high stunting rates have received increased attention since 2009. The nutrition component of the PARPA II impact evaluation highlighted this issue and recommended that it be addressed with a sense of urgency and that a multi-sectoral plan of action be developed to address it. A high-level national seminar held in March 2010, with participation of the Prime Minister, the Ministers of Health and Agriculture and other high-level Government representatives, served to craft inputs for this plan and the Multi-sectoral Plan of Action for the Reduction of Chronic Undernutrition 2011–2015 (2020) was approved by the Council of Ministers in September 2010. The plan aims to reduce stunting to 20 per cent in 2010.

Table 3.1: Multivariable linear regression on the height-for-age Z-score in children under five, 2008

Height-for-age of children 0–59 months Explanatory variables	Linear regression coefficient (b)	95% confidence interval of (b)	P-value ¹
a) Male sex	-0.188	-0.253 to -0.122	<0.001
b) Residence in Manica or northward	0.819	0.37 to 1.269	<0.001
c) Natural log of age in days	-0.132	-0.191 to -0.073	<0.001
d) Interaction factor: residence x age	-0.176	-0.246 to -0.106	<0.001
e) Mother's successful years at school	0.032	0.019 to 0.045	<0.001
f) Unsafe source of drinking water	-0.160	-0.255 to -0.064	0.001
g) Unimproved sanitation facilities	-0.191	-0.297 to -0.085	<0.001
constant	-0.266		

Source: UNICEF calculations based on MICS 2008.

^v The wealth variable is based on a wealth index. The Wealth Index is constructed based on information on household's possession of durable goods such as a television, a bicycle, a car as well as the characteristics of accommodation including electricity, source of drinking water, type of sanitation facility and material used for roofing. It is an indicator of the level of wealth that has been shown to be correlated with measures of expenses and incomes. For a full discussion of the methodology and its limitations see Gwatkins et al, *Socio-economic differences in Health, Nutrition and Population in Mozambique*, The World Bank, 2000.

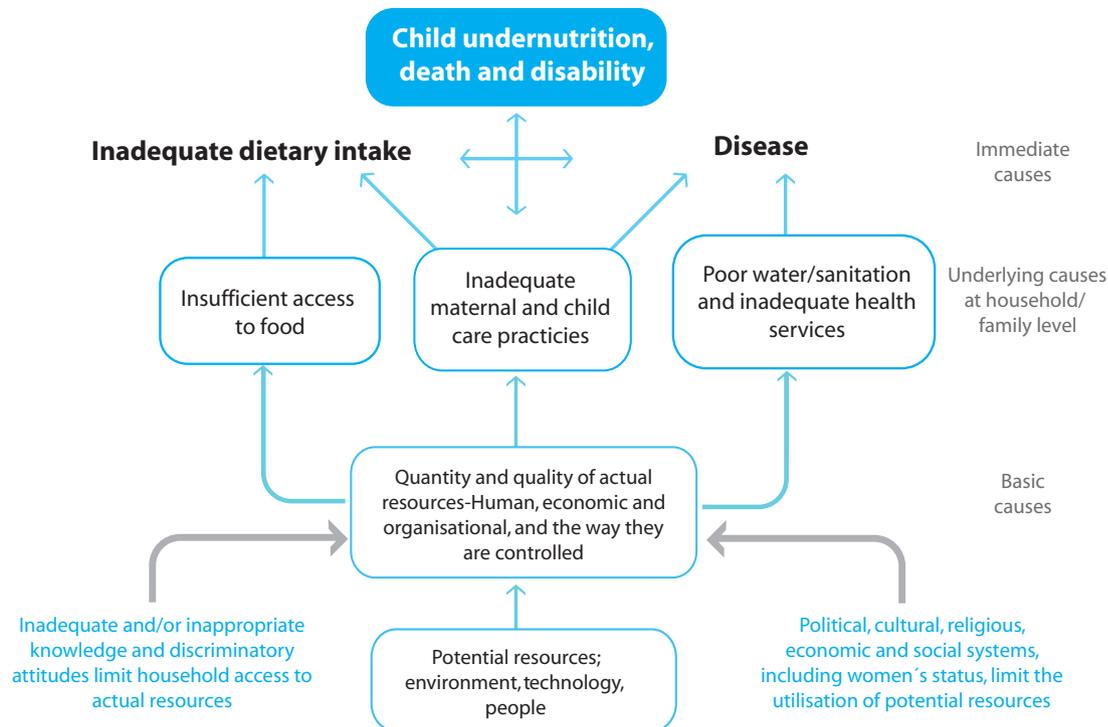
Causes of chronic undernutrition in Mozambique

The causes of undernutrition amongst children are interrelated. They are depicted in graphic form in the conceptual framework (see Figure 3.11) and can be grouped across three levels. The immediate causes are inadequate dietary intake (in quantity and quality) and diseases. The interaction between these two factors leads to increased morbidity and mortality. HIV infection is also a major cause of failure to grow and of undernutrition among children. Inadequate dietary intake and diseases in turn are caused by insufficient access to food, inadequate maternal and childcare practices (particularly poor breastfeeding and other feeding practices) and insufficient access to health care, safe water and

sanitation services. Basic causes include poverty, insufficient education (particularly of mothers) and gender inequities. The most visible examples of the latter are teenage pregnancies, which have a direct impact on both the mother's and her child's height. An analysis of the IOF 2008-9 data showed a significant difference in stunting levels between children whose mothers were younger than 19 when the children were born (54 per cent) and children whose mothers were older than 19 when they gave birth (46 per cent).³³

Across the world, stunting starts to manifest itself immediately after birth (unlike wasting and underweight, which start from about three months of age), and continues to increase in the first two or three years of life, after which it remains stable.³⁴ Chronic

Figure 3.11: The conceptual framework for undernutrition



Source: UNICEF, *Strategy for Improved Nutrition of Children and Women in Developing Countries*, UNICEF, New York, 1990.

undernutrition is an intergenerational phenomenon, since the child of a woman with a suboptimal nutritional status before and during pregnancy will have a lower potential height. Whether or not a child reaches its full growth potential depends on the food, health and other care it receives in the first two years of its life. The period before pregnancy up to two years of age is therefore referred to as “the window of opportunity.” Even when a child survives her or his early years, undernutrition and repeated infections can lead to lifelong developmental delays.

Infant and young child feeding

Appropriate infant feeding practices are crucial for child survival and development.

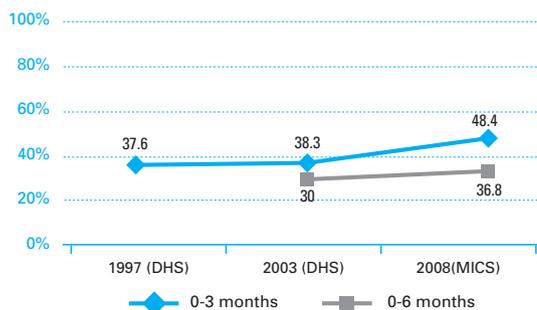
Exclusive breastfeeding is recommended for the first six months of life. After this, children should receive solid, semi-solid and soft foods in increasing frequency, along with continued breastfeeding. Breastfeeding can be continued to two years of age or beyond.³⁵ The WHO recommends that breastfeeding be initiated immediately after birth, when the newborn’s suckling reflex is strong. The Ministry of Health approved in early 2009 a comprehensive five-year communication and social mobilisation plan to promote, protect and support breastfeeding.

In 2008, 63 per cent of newborns were put to the breast within one hour after birth.

This compares with a figure of 65 per cent in 2003. Eighty-eight per cent of newborns were put to the breast within one day of birth in 2008.³⁶ Exclusive breastfeeding rates in children under six months old in Mozambique increased significantly between 2003 and 2008 (from 30 to 37 per cent), but the level remains low in absolute terms (see Figure 3.12). Exclusive breastfeeding decreases rapidly with age; from 57 per cent for the zero-to-one-month age group to 17 per cent in the four-to-five-month age group (see Figure 3.13).³⁷

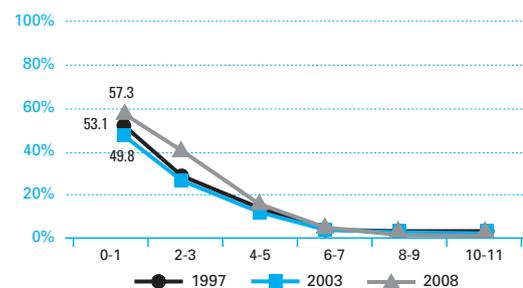
The main items given to newborns that interfere with exclusive breastfeeding are water and solid, semi-solid or soft foods³⁸ (see Figure 3.14). A qualitative study in Maputo City and the provinces of Gaza, Tete, Zambezia and Nampula³⁹ showed that mothers have heard of the recommendation to breastfeed exclusively, but they feel they are not able to put their knowledge into practice, since other family members insist that they should give their baby water, traditional medicines and/or solid, semi-solid or soft foods. This suggests that communication efforts should focus on eliminating these items from the diet and

Figure 3.12: Percentage of children of different age groups who are exclusively breastfed: 1997, 2003 and 2008



Source: DHS 1997, DHS 2003 and MICS 2008.

Figure 3.13: Exclusive breastfeeding in children under 12 months, 1997, 2003 and 2008



include family members and communities in efforts to communicate that breastmilk contains sufficient water and nutrients for children less than six months old, and that mothers need practical and emotional support for breastfeeding.

The median duration of breastfeeding in 2008 was reduced to 18 months, from 22 months in 2003.⁴⁰ This is a cause for concern, since breastmilk still provides key nutrients and protects against disease for children between 12 and 23 months of age. Continued breastfeeding is most important when children are sick and lose their appetite for other foods but continue to be breastfed.⁴¹

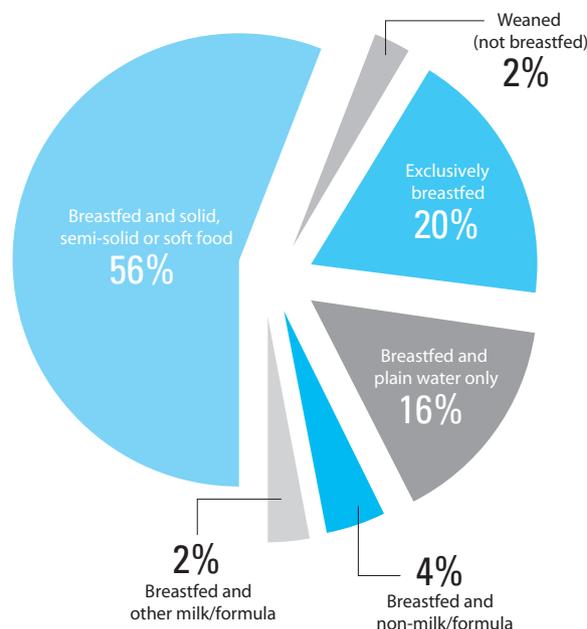
After six months, solid, semi-solid or soft foods need to be introduced into children's diet, with an adequate frequency. For children between six and eight months of age, this is two to three times per day for and for children between nine and eleven

months, it is three times per day in addition to breastmilk. On average, only half of children aged six to eleven months received the minimum recommended number of meals, as seen in Figure 3.15. There is considerable variability among provinces. Seventy-one per cent of children in this age group are being appropriately fed in Niassa, compared with 32 per cent in Inhambane.⁴²

Infant feeding and HIV transmission

One of the ways in which HIV can be transmitted from a mother to her child (in addition to during pregnancy and childbirth) is via breastfeeding. It has been determined that the total risk of mother-to-child transmission of HIV is about 30–45 per cent. Numerous studies have documented that the risk of non-breastfed children dying from causes that can be prevented by breastfeeding, including diarrhoea, undernutrition and infections, is similar to

Figure 3.14: Feeding patterns for children less than one year old, 2008



Source: MICS 2008.

the risk of breastfed children being infected with HIV. The so-called HIV-free survival rate at 18 months or two years of age is similar for both groups. The earlier guidance for mothers living with HIV recommended exclusive breastfeeding, unless replacement feeding was 'acceptable, feasible, affordable, sustainable and safe.'⁴³

WHO updated its guidelines at the end of 2009 to recommend the use of antiretroviral drugs (for either the mother or the child) during breastfeeding.⁴⁴ In this way, the child receives the benefit of breastmilk as well as protection against HIV transmission. The Ministry of Health of Mozambique, within the context of the Prevention of Mother-to-Child Transmission programme, adopted the latest WHO recommendations in mid-2010. This means that HIV-positive mothers will be advised to breastfeed exclusively for the first six months of their child's life and to continue breastfeeding with adequate complementary feeding up to 12 months longer. After this, breastfeeding can be stopped. Throughout the breastfeeding period and up to one week after that, children should receive a daily dose of the antiretroviral drug nevirapine. The new guidance are expected to be introduced in a fashion starting in 2011.

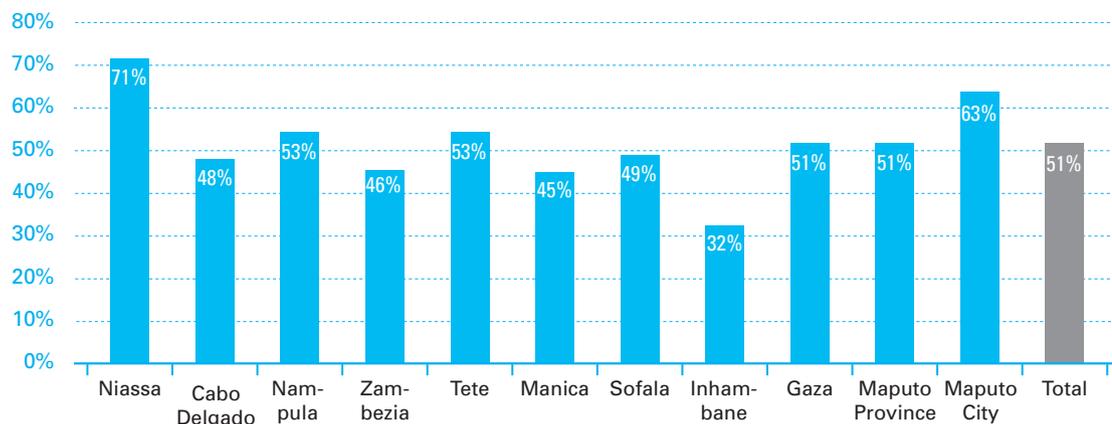
Micronutrient deficiencies: Iodine deficiency

Iodine deficiency is the single largest cause of preventable brain damage and mental retardation in the world.⁴⁵ Iodine deficiency also reduces child survival, growth and development. When pregnant women are iodine-deficient, they risk miscarriage, stillbirths and other complications. The visible and most severe consequences of iodine deficiency are goitre (an enlarged thyroid gland) and cretinism. The milder forms of iodine deficiency cause reduced mental development.

The most cost-effective strategy for preventing iodine deficiency is universal salt iodisation. Salt iodisation is the fortification of salt destined for human and animal consumption with iodine. In addition, iodised oil capsules can be distributed in areas with a high prevalence of iodine deficiency.

In January 2000, the Ministry of Health and the Ministry of Industry and Commerce issued the joint Ministerial Diploma No. 7/2000, which requires all locally produced or imported salt for human and animal consumption to be iodised. Enforcement, however, has been relatively weak to date.

Figure 3.15: Children 6–11 months old who received breastmilk and complementary food at least three times per day, by province, 2008



Source: MICS 2008.

The Ministry of Industry and Commerce has invested in training salt producers and providing salt iodisation and monitoring equipment, while the Ministry of Health supports promotional activities. The NGO PSI is also supporting the Government in creating increased demand for iodised salt.

The use of iodised salt increased slightly from 54 per cent in 2003 to 58 per cent in 2008.⁴⁶ The increase came from greater iodised salt use in urban areas. In rural areas there was a slight decrease. Differences between provinces in use of iodised salt and levels of adequately iodised salt are large. In 2008, only 25 per cent of households were using adequately iodised salt (more than 15 parts per million). This low percentage could be due to inappropriate iodisation and packaging practices in the factory and/or to inappropriate storage practices.

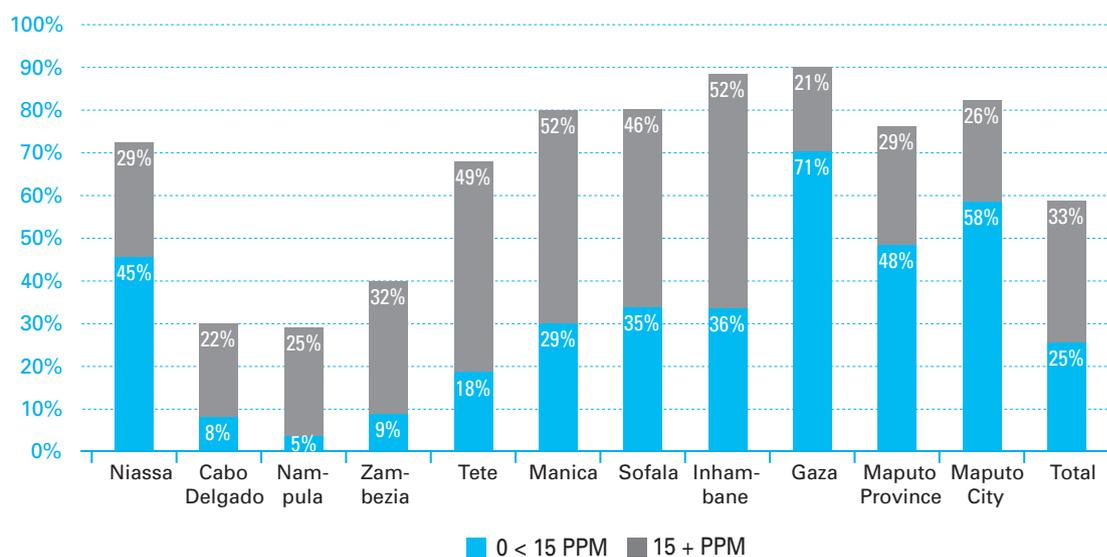
Notably, the salt-producing provinces of Cabo Delgado, Nampula and Zambezia have the lowest levels of salt iodisation. Levels of iodisation decreased in all three provinces between 2003 and 2008. This could be

because unprocessed, non-iodised salt is more easily available in areas where salt is extracted and can more easily make its way onto the local market.

Households in the wealthier quintiles more often use iodised salt and also more often use adequately iodised salt. This is probably because wealthier households can better afford iodised salt, which is often two or more times more expensive than non-iodised salt, and to the fact that households in the higher wealth quintiles may be better equipped to store the salt appropriately.

In 2007, the Ministry of Health started distributing iodised oil capsules in the provinces with the highest rates of iodine deficiency, namely Niassa, Nampula, Zambezia and Tete. The target group for this intervention was pregnant women and children 7–24 months old. In 2008, iodine capsules were distributed during the Child Health Weeks, achieving 89 per cent coverage. The intervention was discontinued in 2009.⁴⁷

Figure 3.16: Use of iodised salt by province, 2008



Source: MICS 2008.

Iron deficiency and anaemia

Anaemia can be caused by various factors: iron deficiency, diarrhoea, malaria, worm infections, tuberculosis and HIV infection.

Iron deficiency is the main cause of anaemia. Children with anaemia have lower physical and mental development and school performance, often have little energy and have a reduced appetite. Anaemia in pregnant women and mothers is a major contributory factor for maternal mortality. Women who are anaemic before and during pregnancy have a higher risk of bearing children with low birth weight (less than 2,500 grams), and anaemia in early pregnancy affects a child's potential height. A national study showed that 74 per cent of children under five were anaemic in 2002.⁴⁸

Vitamin A deficiency

Vitamin A is a crucial nutrient for the prevention of disease and deaths. The 2002 national survey referred to above found that 69 per cent of children 6–59 months old had vitamin A deficiency (low serum retinol).⁴⁹ The Ministry of Health provides supplementation with high-dose vitamin A capsules to new mothers in the first six weeks after delivery and to children 6–59 months old to prevent vitamin A deficiency.

A comparison of vitamin A supplementation coverage in 2003 and in 2008 shows a marked increase: from 50 per cent to 72 per cent.⁵⁰

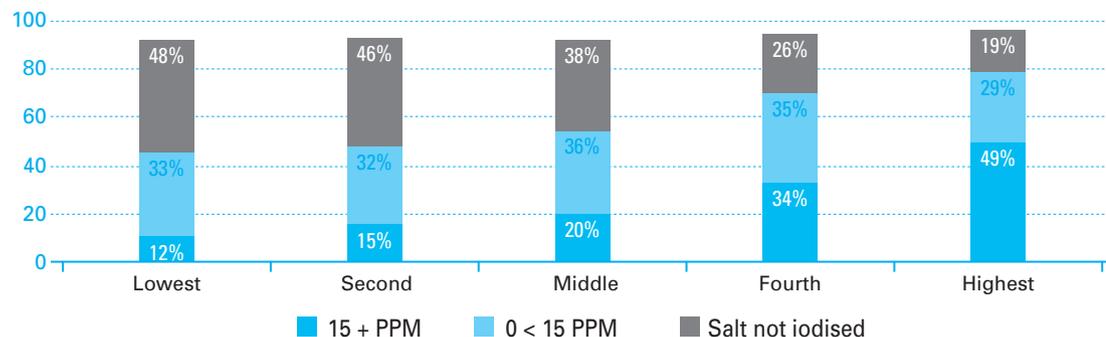
This increase is probably related to the introduction in 2008 of biannual Child Health Weeks, in which children receive vitamin A supplements and deworming medicines, and often also immunizations and other preventive interventions. The coverage rates of these campaigns have increased to over 95 per cent.

The 2008 MICS data show that children from wealthier families are more likely to have received vitamin A supplements: 81 per cent of children in the wealthiest quintile had received them, compared with 62 per cent of children in the poorest quintile. In rural areas, 69 per cent of children received vitamin A supplements compared with 78 per cent in urban areas.⁵¹

2.3. Maternal survival, health and nutrition

It is estimated that approximately 80 per cent of maternal deaths could be averted if women had access to essential maternity and basic health services.⁵² There is a growing consensus that improving maternal and newborn health and survival can be

Figure 3.17: Use of iodised salt by wealth quintile, 2008



Source: MICS 2008.

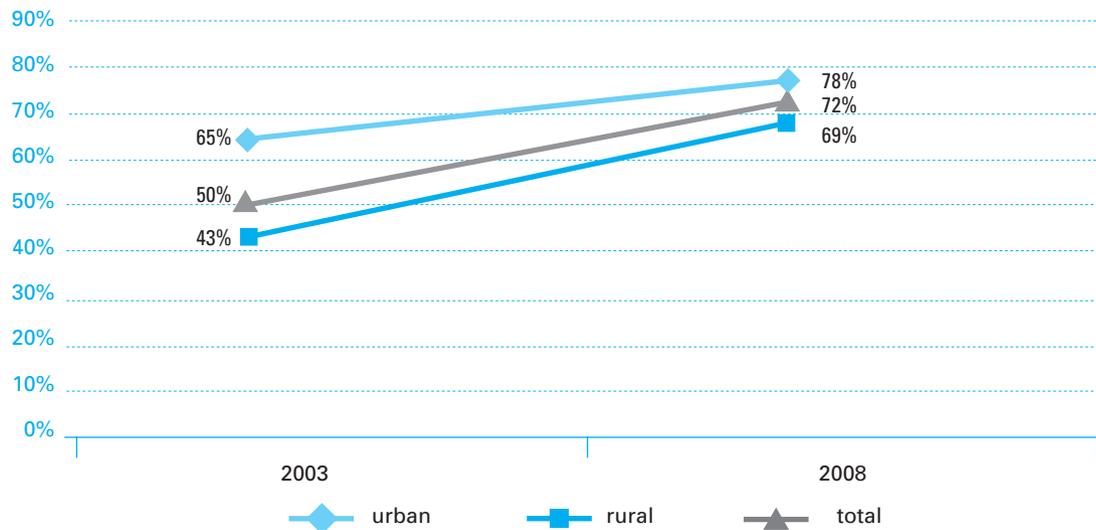
achieved through establishing a 'continuum of care' that integrates programmes and interventions for reproductive health, safe motherhood, newborn care and child survival, growth and development, delivered within a legal, institutional and community and family environment that upholds and respects women's rights (see Figure 3.19).

Estimates of maternal mortality ratios^{vi} in Mozambique indicate that maternal mortality has decreased substantially in recent years,

from an estimated 1,000 maternal deaths per 100,000 live births in the early 1990s to 408 per 100,000 live births in 2003.^{vii} By comparison, the estimated maternal mortality ratio for all of sub-Saharan Africa was 920 in 2005.^{53, viii}

The Institutional Maternal Mortality Ratio (IMMR), that is, the maternal mortality rate recorded in health facilities, has also declined, in Mozambique.^{ix} This reduction is largely due to improved access to health

Figure 3.18: Vitamin A supplementation coverage, 2003 and 2008



Source: DHS 2003, MICS 2008.

^{vi} Maternal health is usually assessed by measuring the maternal mortality ratio (MMR), which is an estimate of the annual number of deaths among women from pregnancy-related causes per 100,000 live births.

^{vii} Using the sisterhood method, the 2003 DHS estimates that the MMR during the 10-year period prior to the survey was 408 maternal deaths per 100,000 live births. The sisterhood method has wide margins of error, with the result that the 'real' MMR lies somewhere between 200 and 600 maternal deaths per 100,000 live births.

^{viii} Periodically, UNICEF, WHO, UNFPA and the World Bank evaluate reported maternal mortality data from countries and make adjustments to account for the well-documented problems of under-reporting and misclassification of maternal deaths, and to develop estimates for countries with no data. The estimated adjusted MMR for Mozambique was 520 per 100,000 live births in 2005.

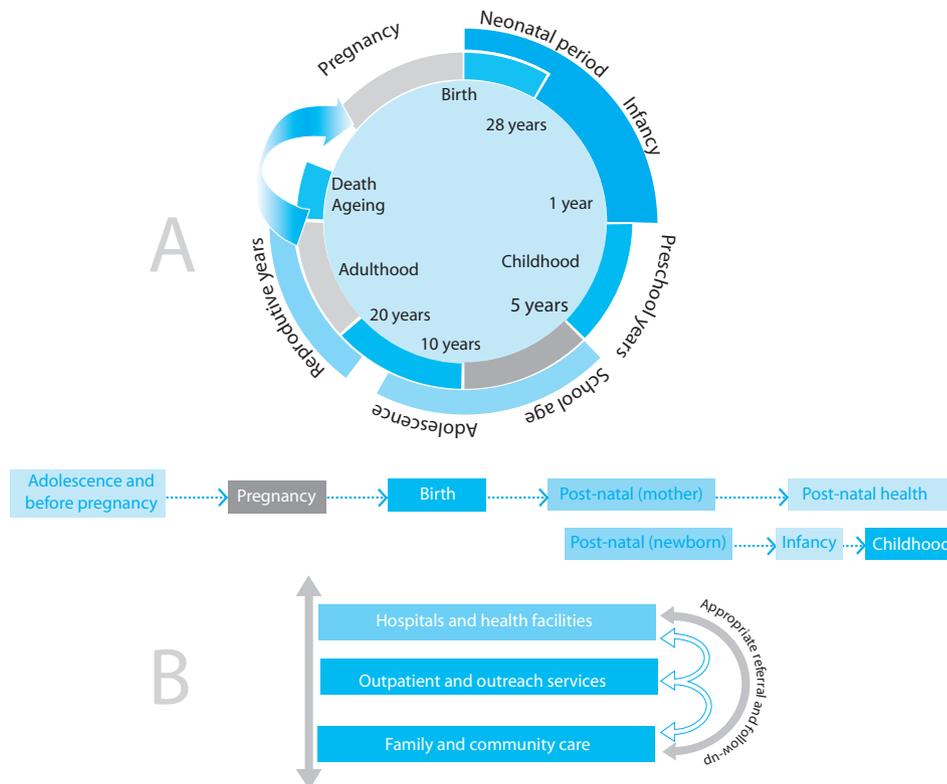
^{ix} The IMMR declined from 230 per 100,000 live births in 1993 to 177 per 100,000 live births in 2003, although significant disparities between provinces exist, with the 2003 IMMR estimated at 291 per 100,000 live births in Cabo Delgado and 26.5 per 100,000 live births in Maputo province.

services, particularly family planning, emergency obstetric and neonatal care and antenatal care, and improvements in equipment, communications material and transport since 2007. Health staff have been trained in Integrated Management of Neonatal and Childhood Illnesses with a focus on neonatal care, and 90 per cent of health facilities now implement Integrated Management of Neonatal and Childhood Illnesses services, compared with 50 per cent in 2005.⁵⁴

Mozambique has real potential to achieve the 2015 MDG 5 targets: a Maternal Mortality Ratio of 250/100,000 live births, and skilled birth attendance coverage of 66 per cent. Achievement of these targets will require: improved quality and coverage of reproductive health services; expansion and maintenance of quality emergency obstetric and neonatal care; timely diagnosis, treatment and referral of obstetric complications; improvement in the structure and functioning of the referral system;

Figure 3.19: The continuum of care for maternal and newborn health

Connecting care during the lifecycle (A) and at places of caregiving (B). Adapted from partnership for Maternal, Newborn and Child Health, with permission.



Source: Kevbes, Kate. J., et al., "Continuum of Care for Maternal, Newborn and Child Health: From slogan to service delivery," *The Lancet*, vol. 370, no. 9595, 13 October 2007, p.1360.

Box 3.1: Child Health Weeks

The delivery of an integrated package of relatively cheap preventive and curative interventions, when delivered at scale, can reduce under-five mortality by up to 63 per cent. Unfortunately, in many countries the children that are most in need of these interventions do not have easy access to quality services at health facilities. Child Health Weeks are designed as a mostly temporary measure to improve access by delivering a package of cost-effective health and nutrition interventions to children under-five years of age, using a campaign approach that reaches even the remotest areas of a country. Use of a campaign approach not only expands the reach of health services, but it can also strengthen routine and outreach service delivery as health staff often receive additional training and families receive additional information about services. Availability of an integrated package of effective, quality health services delivered at a single point in time and at a single location saves caregivers from making multiple (and costly) trips to health facilities with their children, and also creates demand for other routine health services, especially when effective social mobilisation has been carried out.

Child Health Weeks usually comprise at least two complementary health or nutrition interventions and may include a few more. Services and interventions that are delivered in Mozambique include:

Core Interventions:

- Vitamin A supplementation of children aged 6 months to 5 years;
- Routine or catch-up immunisation against measles, polio, tetanus, diphtheria and whooping cough, and tuberculosis;
- De-worming of children aged 1-4 years.

Other Interventions that have been added in Mozambique include:

- Screening for undernutrition (with the use of Mid Upper Arm Circumference tapes and referrals for management of acute undernutrition);
- Promotion and distribution of long-lasting, insecticide-treated nets;
- Promotion of healthy family and child-care practices, such as exclusive breast-feeding;
- Immunisation of women of reproductive age against tetanus;
- Vitamin A supplements for lactating mothers during first 8 weeks after delivery.

Key to the success of a Child Health Week is a well-integrated social mobilisation strategy that targets the universal participation of eligible families covered by the campaign. Designed and implemented at national, provincial and district levels under the coordination of the Ministry of Health, the strategy is twofold. First—and beginning well ahead of the Child Health Week—the strategy works to raise public awareness about the week. The strategy's second component works hand-in-hand with service delivery to ensure the promotion of critical messages on complementary health behaviours and hygiene practices. Social mobilisation for Child Health Weeks exploits mass and local media for the dissemination of public service announcements and—especially through community-based radio—the generation of discussion and participation through community dialogue and debates. Local activists penetrate media dark areas to disseminate information, using communication materials specifically produced for the campaigns, using local languages to reach the communities.

Throughout the week, strategic use is made of local and national influencers—opinion leaders and decision makers who have the trust and respect of their constituents—to reinforce messaging and maximise participation. Through community meetings and interpersonal communication at the household level, local leaders play a crucial role in rallying participation for these child health campaigns.

improvement of the Health Information System to better monitor emergency obstetric and neonatal care; ensuring reproductive health commodity security; and increased involvement of the community, particularly men, in reproductive health decisions.

There are five direct causes of maternal mortality: haemorrhage (usually occurring post-partum), sepsis, eclampsia, obstructed labour and complications of abortion. Most of the direct causes of maternal mortality can be readily addressed if skilled health personnel are on hand and key medicines, equipment and referral facilities are available. Indirect obstetric deaths occur as a result of either previously existing conditions or conditions arising in pregnancy that are not related to direct obstetric causes but may be aggravated by the physiological effects of pregnancy. These include such conditions as AIDS, malaria, anaemia and cardiovascular diseases. Teenage pregnancies also increase the risk of maternal deaths.⁵⁵

One of the most important factors affecting women's health is good nutrition. In Mozambique, about nine per cent of women of reproductive age are undernourished (as indicated by a low body mass index), according to data from the 2003 Demographic and Health Survey.^x In 2003, the prevalence of undernutrition was greater among women in rural areas than in urban areas and was twice as high among the poorest women (10 per cent) as amongst the wealthiest women (5 per cent).⁵⁶ Anaemia, which can be related to insufficient consumption of iron-rich foods, worm infestations, malaria or other infections, affected 70 per cent of

pregnant women and 48 per cent of non-pregnant women according to a 2002 study.⁵⁷ Despite the prevalence of anaemia, 39 per cent of pregnant women do not receive iron and folic acid supplementation during pregnancy.⁵⁸

The coverage of antenatal care in Mozambique has improved significantly in recent years, with the proportion of women attended at least once by skilled health personnel during pregnancy increasing from 85 per cent in 2003 to 92 per cent in 2008 (see Figure 3.20).⁵⁹ The largest gains were recorded in rural areas, where the proportion of pregnant women who reported receiving antenatal care at least once increased from 79 per cent in 2003 to 90 per cent in 2008. This increase is the result of expansion of health services into rural areas. Antenatal care coverage in urban areas remained almost universal, with a slight increase from 97 per cent in 2003 to 99 per cent in 2008.

Antenatal care coverage exceeded 80 per cent in all provinces of the country, ranging from 81 per cent in Zambezia to almost universal coverage in Gaza and Maputo City. Antenatal care coverage varies according to the socio-economic status of women, with 86 per cent of women in the poorest quintile reporting having attended at least one antenatal visit, compared with 99 per cent in the wealthiest quintile. Coverage among women in the poorest quintile has risen from 67 per cent in 2003 to 85 per cent in 2008.

Data from the 2008 MICS reveal that 58 per cent of births took place in health facilities. In rural areas the coverage reached 49

^x When the ratio of the height and weight of a woman, used to derive the body mass index, is less than 18.5, a woman is regarded as being malnourished.

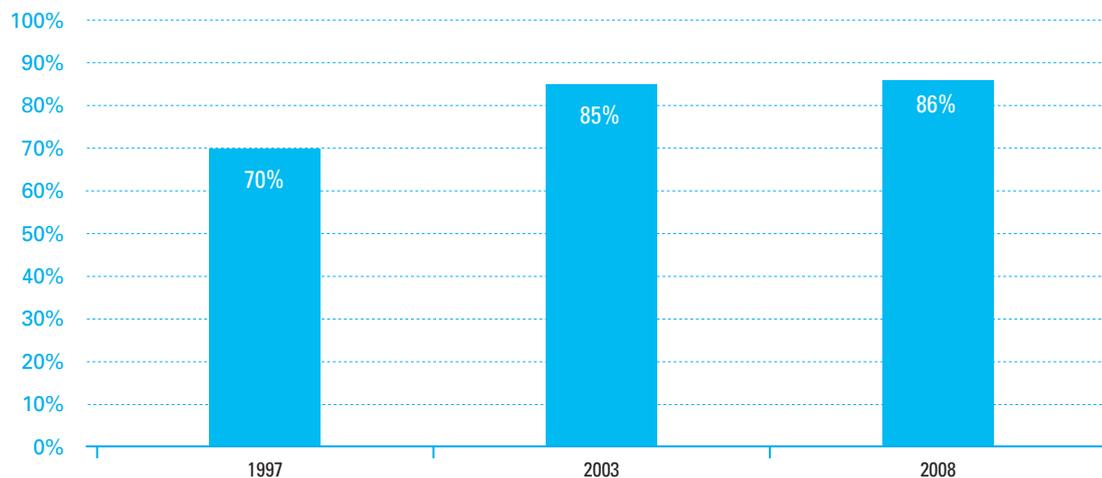
per cent. The proportion of institutional deliveries in rural areas has increased since 1997 (33 per cent) and 2003 (34 per cent). The proportion of institutional births in urban areas remained stable at 81 per cent. The relatively high proportion of births that take place outside of formal maternity or other health facilities is important, both in relation to women's access to emergency obstetric and neonatal care services, but also to their use of prevention of mother-to-child transmission interventions, which are delivered through health facilities. Outside of formal health facilities, there is no system in place to ensure that those who do not have institutional deliveries comply with, and therefore benefit from, this intervention.

The norms established in the national antenatal care programme recommend that all pregnant women receive information on possible health problems during pregnancy, including HIV infection and the risk of HIV transmission from mother to child. In addition, they should be weighed, have their height measured, have their blood pressure taken and be tested for syphilis. However, there appears to be little compliance with these norms. According to MICS 2008,

while the majority of pregnant women receiving antenatal care were weighed during consultation, only 52 per cent were informed about the symptoms of pregnancy-related health complications, only 48 per cent had their height measured, only 36 per cent were asked to provide a urine sample and only 47 per cent had their blood taken for HIV testing. In addition, only just above half of the women (59 per cent) were counselled about HIV and AIDS. These findings indicate the overall poor quality of the primary health care services in Mozambique and show the urgent need for training of mid-level and basic staff, in order to maintain acceptable levels of maternal health services.

In 2003, only 48 per cent of births were attended by skilled health personnel.⁶⁰ This increased to 55 per cent in 2008.⁶¹ The provinces with the lowest proportion of births attended by skilled personnel were Manica (33 per cent) and Zambezia (38 per cent). The vast majority of antenatal care is provided by nurses and midwives (53 per cent in 2008), with doctors accounting for only 2 per cent of antenatal care provided overall. Access to skilled health personnel

Figure 3.20: Women attended at least once by skilled health personnel during pregnancy, 1997, 2003 and 2008



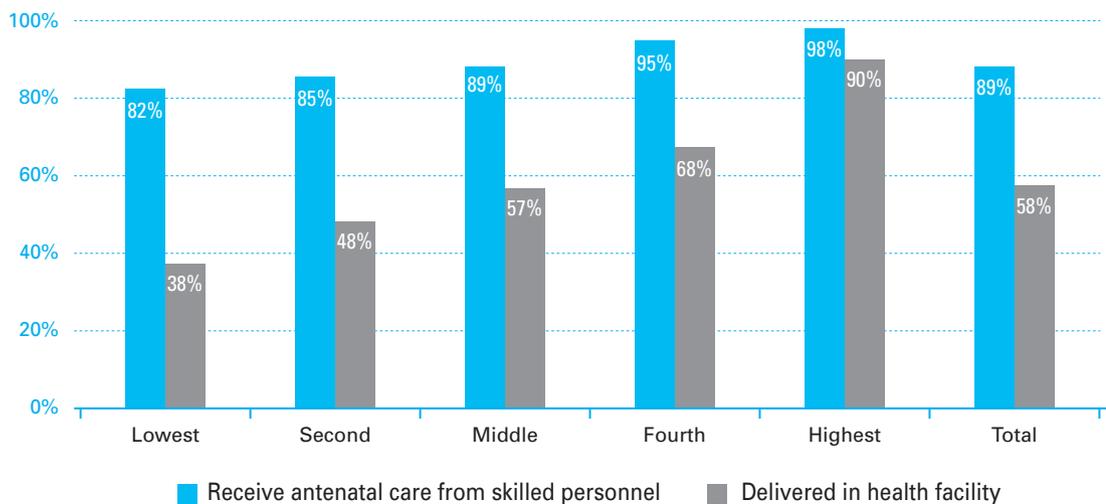
Source: DHS 1997 & 2003, MICS 2008.

during birth and institutional births is correlated with wealth. Ninety per cent of women in the highest wealth quintile gave birth in a health facility compared to 38 per cent of women in the lowest quintile (Figure 3.21).⁶²

Post-partum care also remains low. About 60 per cent of women who had non-institutional births do not receive any kind of post-partum care. Only 12 per cent of women who had non-institutional births attend some form of health facility up to two days after delivery.⁶³ Community interventions are needed to reach these mothers. Since 2008, a neonatal component has been included in the Integrated Management of Childhood Illness (IMCI) and Community-Integrated Management of Childhood Illness (CIMCI) packages, changing the acronyms to Integrated Management of Neonatal and Childhood Illness (IMNCI) and Community-Integrated Management of Neonatal and Childhood Illness (C-IMNCI), respectively. In order to scale up community-based preventive and curative health services, the

Ministry of Health in collaboration with its partners has developed training manuals to implement an appropriate model of comprehensive, community-based newborn care, with provision for home visits to be made on key days during the first month of life (days 3, 7, 14 and 28) to identify danger signs and provide early referrals. Training of trainers was conducted in all three regions of the country in 2008, and training of community health workers in the implementation of community IMNCI was initiated in some Reaching Every District (RED) districts of the country. In 2009, close to 450 community health workers were trained in C-IMNCI. As a result, over four thousand newborns (3 per cent of expected deliveries) in 21 districts of 7 provinces were visited at home in the first month of life. Among them, over 1,100 (28 per cent) were referred to health centres in 2009.⁶⁴ The ongoing revitalisation of the community health worker programme with paid workers will further strengthen and expand these interventions with comprehensive Home-Based Maternal, Child and Newborn Care.

Figure 3.21: Proportion of women receiving antenatal care and delivering in a health facility by wealth quintile, 2008



Source: MICS 2008.

Anaemia and vitamin A deficiency are among the major nutritional problems affecting women, particularly those who are pregnant and lactating. The 2002 national survey on vitamin A deficiency and anaemia and malaria in children under five and their mothers indicated that 70 per cent of pregnant women suffered from anaemia, against 48 per cent among non-pregnant women.⁶⁵ Only 61 per cent of pregnant women received iron and folic acid supplementation during pregnancy.⁶⁶ These findings illustrate low levels of compliance with existing national policy on iron and folic acid supplementation for pregnant women.

2.4. Childhood illnesses

A major public health intervention to address childhood illness has been the development of the IMCI programme, which has three components: building the capacity of health professionals, strengthening the health system and improving family and community health practices. IMCI was introduced to Mozambique in 1998, when the Ministry of Health began gradual implementation, starting in 29 districts. Since then IMCI coverage has increased. According to the 2008 Annual Joint Evaluation of health system performance, about 90 per cent of health services nationwide were implementing Integrated Management of Neonatal and Childhood Illnesses, compared with about 50 per cent in 2005.⁶⁷

IMNCI is one of the key pillars of the Accelerated Child Survival and Development strategy, with the potential, if implemented fully and including a community component, to prevent up to one third of all child deaths.

While important progress was made in reducing childhood illnesses, the overall situation remains daunting. Particular successes and challenges in combating

childhood illness in Mozambique in the areas of malaria, acute respiratory infection, diarrhoea and vaccine-preventable diseases are presented below in more detail.

2.5. Malaria

The 2008 National Child Mortality study confirms malaria as the leading killer of children in Mozambique.⁶⁸ Thirty-three per cent of deaths among children under five are attributed to malaria. Among children aged one to five, deaths attributed to malaria reach 46 per cent. As well as being the major cause of death among young children, malaria also accounts for 40 per cent of all out-patient consultations, and up to 60 per cent of in-patients in paediatric wards require treatment for severe malaria, placing a significant burden on health resources.

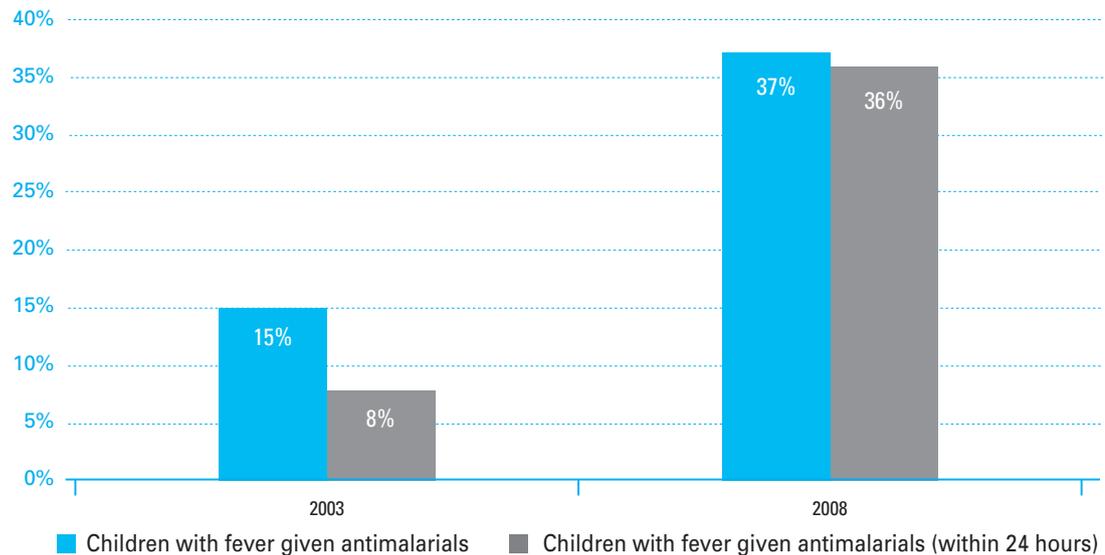
Prevalence of malaria has changed little during the period between a 2002 national survey and the 2007 Malaria Indicator Survey,⁶⁹ which recorded an overall prevalence of 51 per cent (27 per cent in urban areas and 58 per cent in rural areas).^{xi}

Thirty-six per cent of children with a fever were given antimalarial medicines in 2008, compared to 15 per cent in 2003 (see Figure 3.22).⁷⁰ While this still falls short of the revised Roll Back Malaria targets^{xii, 71} it does demonstrate significant improvement. Major reductions in infection were observed in areas of the country where scaling-up of malaria prevention and control interventions have occurred, for example in Maputo province, where malaria prevalence has dropped dramatically.

The low reported rates of appropriate treatment indicate, on the one hand, low awareness and demand among caregivers for treatment (only 60 per cent of children with fever were taken to a health facility,

^{xi} The Malaria Indicator Survey used the recently developed Rapid Diagnostic Tests to test for the presence of malaria parasites.

^{xii} The 2000 Abuja Roll Back Malaria summit set a target that by 2005, 60 per cent of those suffering from malaria should be able to access and use correct, affordable and appropriate medicines within 24 hours.

Figure 3.22: Proportion of children receiving appropriate treatment for malaria, 2003 and 2008

Source: DHS 2003, MICS 2008.

according to the 2007 Malaria Indicator Survey), and on the other hand low access to health facilities. Outside the formal health system, only registered pharmacies and a few specially registered shops can supply antimalarial medicines, making access to prompt treatment difficult, especially in underserved rural areas. Malaria treatment is also available at community level in selected parts of the country, where it is administered by community health workers known as APEs (Agente Polivalente Elementar). Village health workers, known as Socorristas and trained by World Relief, are also authorized to treat malaria at community level in Gaza. It is hoped that ongoing revitalization of the APE programme by the Government will improve the situation.

The situation regarding prevention and control of malaria is more positive than that for prompt and effective treatment. The Government of Mozambique promotes the use of two equally effective tools for malaria control and prevention: Indoor Residual

Spraying (IRS) of the interior surfaces of houses with long-lasting insecticides, and long-lasting insecticidal nets. The Government identified IRS as a key strategy for malaria control and prevention in PARPA II, establishing a target of 50 per cent IRS coverage by the year 2009, compared with about 18 per cent in 2005. This PARPA target has already been achieved, with over 50 per cent of the population being covered with IRS, although questions remain as to the quality of the spraying carried out and the accuracy of the coverage data.

In 2000, two major insecticide-treated net programmes were initiated in Zambezia and Gaza, and insecticide-treated nets were introduced into the public health system for the first time. By mid-2009, there were long-lasting insecticidal net programmes in all ten provinces and Maputo City. Long-lasting insecticidal nets are distributed to pregnant women through antenatal services and to children under five through campaigns, including Child Health Weeks. Since 2009, the

Government introduced a policy of universal access to long-lasting insecticidal nets. Coverage of children under five following campaign activities in 2009 is estimated at around 93 per cent in unsprayed districts and about 54 per cent nationally.⁷²

Mosquito-net ownership on a national scale has risen from 18 per cent of households owning at least one mosquito net in 2003 to 65 per cent in 2008.⁷³ However, only 31 per cent of households reported owning a net that was treated with an insecticide.^{xiii} The proportion of children who reported sleeping under a net the night before the survey rose from 10 per cent in 2003 to 42 per cent in 2008. Of the 42 per cent of children who slept under a net, 23 per cent slept under a treated net.⁷⁴ In 2008, 74 per cent of pregnant women throughout the country had received a long-lasting insecticidal net, up from only 46 per cent in 2007.⁷⁵

Due to the expansion of insecticide-treated net coverage and indoor residual spraying, the 2010 Roll Back Malaria targets for prevention could be met.^{xiv} However, while showing encouraging signs of progress, coverage with treated nets, which are twice as effective as untreated nets, remains far below national and international targets. In addition, household ownership of mosquito nets is not translating into effective use of nets by children under five and pregnant women; the two population groups most at risk of severe illness and death due to malaria.

As many as one million pregnancies in sub-Saharan Africa every year are thought to be complicated by co-infection with malaria

and HIV.⁷⁶ Both malaria and HIV infection in pregnancy are associated with maternal anaemia, low birthweight, and maternal and infant mortality, with HIV infection presenting an increased risk of malaria. In the presence of co-infection, the prevalence of anaemia and low birthweight may exceed 35 per cent.⁷⁷ The WHO now recommends the use of intermittent preventive treatment^{xv} and insecticide-treated nets for all pregnant women living in a high-risk malaria area. Accordingly, the Ministry of Health in Mozambique also strengthened preventive treatment and introduced intermittent preventive treatment in 2006. MICS 2008 recorded that 67 per cent of pregnant women had received intermittent preventive treatment, which is not far short of the 2010 target.

2.6. Acute respiratory infection

Like malaria, acute respiratory infection (ARI) is a leading cause of morbidity and mortality among young children in Mozambique, with pneumonia being the most serious such infection. The WHO estimates that 60 per cent of ARI deaths could be prevented by the selective use of antibiotics, but the success of treatment relies upon early detection and access to medical facilities.

The proportion of children under five with symptoms of pneumonia reduced from 10 per cent in 2003 to 5 per cent in 2008. In 2008, around 65 per cent of children with ARI symptoms were taken to a health facility.⁷⁸

The prevalence of ARI symptoms among children living in urban areas was higher

^{xiii} Prior to the introduction of long-lasting insecticidal nets that do not require treatment during their useful lifespan of three to five years, mosquito nets required re-treatment with insecticide every six months to ensure continuing efficacy. All mosquito nets distributed since 2006 are long-lasting nets.

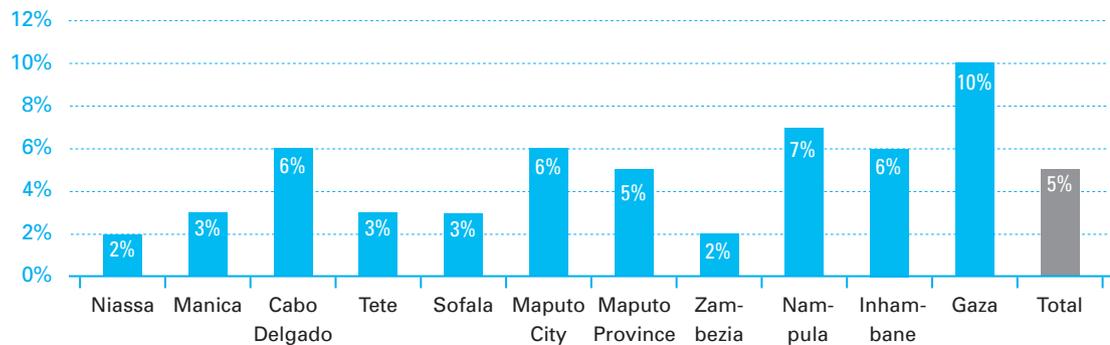
^{xiv} 2010 Roll Back Malaria targets are as follows: 80 per cent of the population protected from malaria by IRS or Long-Lasting Insecticidal Nets, 80 per cent of people able to receive effective treatment within 24 hours, and 80 per cent of pregnant women able to receive Intermittent Preventive Treatment against malaria in pregnancy.

^{xv} Defined as the provision of at least two treatment doses of sulphadoxine-pyrimethamine during routine antenatal clinic visits.

than among those living in rural areas (12 per cent and 9 per cent respectively). The percentage of children with symptoms in Maputo City was five times higher than in Tete (see Figure 3.23).⁷⁹ This could be explained by the higher population density in Maputo City, as ARI is likely to be spread or aggravated by overcrowded housing, poor-quality living environments or pollution. The lower prevalence among children from poorer or less well-educated families could be explained by the fact that the majority of more highly educated people live in urban areas.

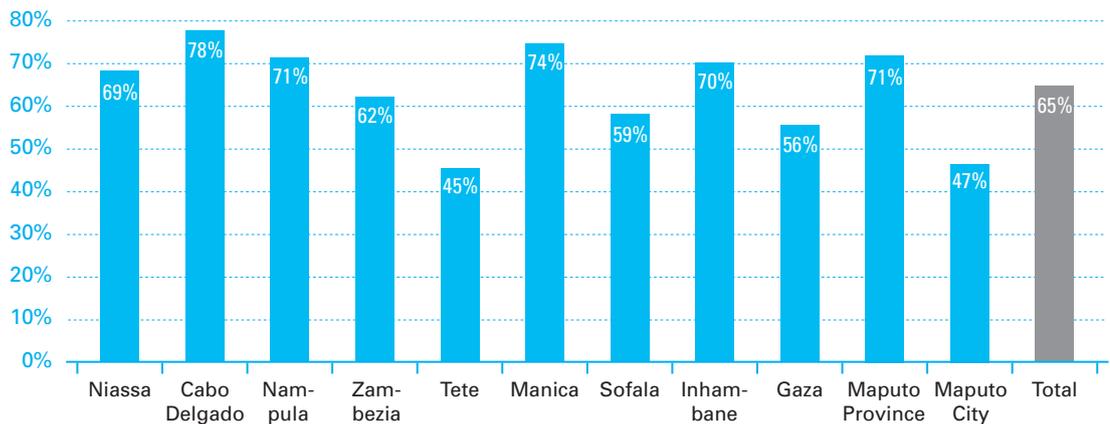
There is a wide disparity in the proportion of children receiving treatment for ARI (see Figure 3.24). Children from better-off families and children whose mothers had at least a primary-level education were much more likely to receive treatment for ARI symptoms than those from rural areas, those from poor families and those whose mothers had no education. No relationship was observed between a mother's level of education and her ability to recognise symptoms of pneumonia, suggesting that the education system should have a stronger focus on family health issues.⁸⁰

Figure 3.23: Prevalence of acute respiratory infection, by province, 2008



Source: MICS, 2008.

Figure 3.24: Proportion of children under five receiving appropriate treatment for acute respiratory infection by province, 2008



Source: MICS 2008.

2.7. Diarrhoeal diseases

Diarrhoea is another major cause of child morbidity and mortality in Mozambique.

It becomes more frequent in children six months and older, when they begin to crawl and to eat complementary food. Recent global estimates indicate that every year 1.5 million children die from diarrhoea.⁸³ The World Health Organisation estimated in 2007 that 26,900 deaths per year in Mozambique were attributed to water-, sanitation- and hygiene-related diarrhoeal disease.⁸⁴

Data from the 2008 MICS indicate that diarrhoeal disease is the fifth most important cause of under-five mortality.

This is supported by the 2009 National Child Mortality Study, which reports that gastrointestinal infectious disease contributes almost seven per cent to the total number of deaths.⁸⁵ Diarrhoeal disease causes a relatively higher proportion of total under-five deaths in Inhambane (12 per cent) and Cabo Delgado (11 per cent), and a slightly higher proportion of deaths in boys than in girls across all age groups, from post-neonatal to under five. The 2008 MICS also indicates that there has been an increase in diarrhoeal disease prevalence in children under five, from 14 per cent in 2003 to 18 per cent in 2008. The highest prevalence of diarrhoea was recorded in Nampula (23 per cent) and the lowest in Niassa (13 per cent). Stunted children appear

to have diarrhoea more frequently than non-stunted children, with 51 per cent of stunted children experiencing diarrhoea in the two weeks prior to the survey, compared with 37 per cent of non-stunted children.⁸⁶

Almost half (47 per cent) of children (aged 0-5 years) with diarrhoea received oral rehydration therapy and continued with normal breastfeeding. Zinc is not yet being used systematically to treat diarrhoea in Mozambique. Introduction of zinc and community case management by trained community health workers will further improve results and accelerate reduction of under-five mortality.

2.8. Cholera

Due to the low levels of sanitation coverage, a high number of cholera cases have been recorded over the years in Mozambique (see Table 3.2). From 1992 to 2004, cholera cases from Mozambique represented between one third and one fifth of all African cases.⁸⁷ In 1997/98, a cholera outbreak registered 50,000 cases and 1,353 deaths, with a case fatality rate of 3.2 per cent.⁸⁸ The factors contributing to cholera outbreaks in Mozambique are: lack of sanitation and poor hygiene conditions, scarcity and lack of access to potable water, inadequate waste disposal, poor economic conditions of the communities, recurrent droughts and floods, high population density and poorly planned urbanisation.

Table 3.2: Cholera cases in Mozambique, 2007–2010

Year	Number of cholera cases	Number of deaths	Case fatality rate	
2007	1,073	16	1.4%	From Week 41 (October–December 2007)
2008	12,306	157	1.3%	January–December 2008
2009	19,088	150	0.8%	January–December 2009
2010	4,129	56	1.4%	As of 21st epidemiological week

Source: Ministry of Health, *Manual de Prevenção e Controlo da Cólera e de Outras Diarreias Agudas*, Government of Mozambique, Maputo, 2009.

Box 3.2: Child-to-Child radio and school: getting the voice of children across

Designing effective rights-based messaging for children and young people is a challenge. Messaging that educates and also stimulates children's engagement and participation can facilitate their adoption of pro-social and health-seeking behaviours and attitudes. Children and youth are catalysts in creating demand for a rights-based society and can also become agents for community empowerment. Child-to-child programming is producing strong results as a behaviour development and empowerment strategy for young people.

The Child-to-Child Media Network was created in 2000 as a partnership between Radio Mozambique, Ministry of Education, UNICEF and, more recently, local civil society organisation N'weti (2007). Using an entertainment-education approach, the Child-to-Child Media Network actively involves children and young people in developing, producing and presenting radio and TV programmes by and for children, both to ensure their right to participation and to offer them an opportunity to express their opinions and aspirations. Programmes are broadcast in 16 national languages as well as Portuguese. Child-to-Child has increased opportunities for children and adolescents to express themselves, and has also increased their knowledge of child rights and health and education issues. Subjects like HIV infection, sexual abuse and child trafficking, usually taboo in Mozambican society, are being openly discussed by the child presenters of radio and television programmes for young people. The programmes are increasingly being linked to school curricula to reinforce messages and expand the impact of both school and media.

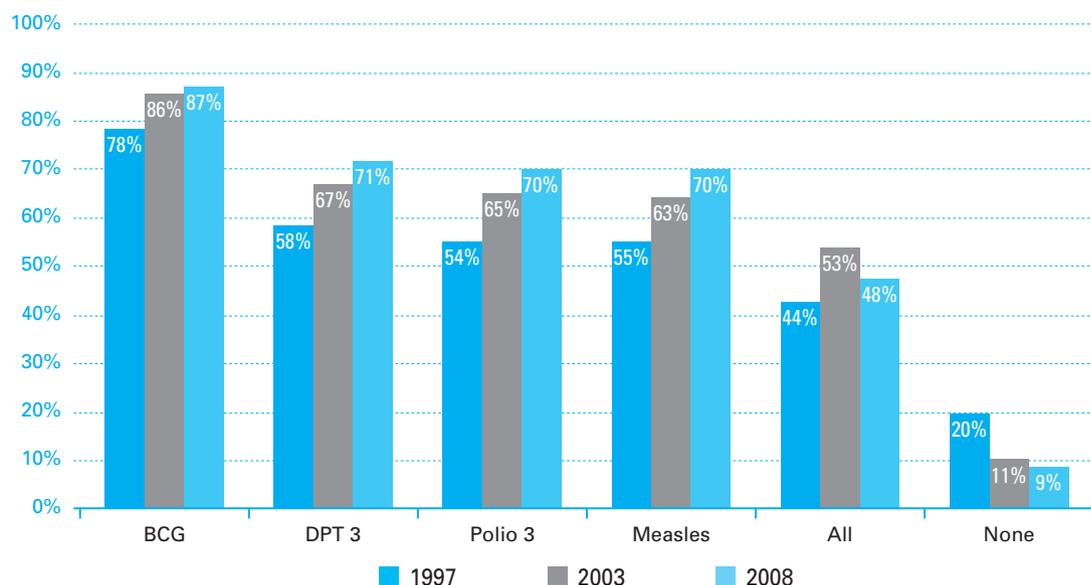
Radio Mozambique presenter Amelia Maisha Tunzine, 15, is one of several presenters who use the airwaves to talk frankly with their peers about subjects that matter to them but are often considered off-limits by parents. "I don't feel uncomfortable anymore talking about difficult subjects like HIV. It is no longer an adult problem; it also affects children. If the issue is only approached by adults, then kids will continue to believe it's something they don't have to deal with," she says.

A 2008 audience survey conducted by Radio Mozambique⁸¹ in 2008, in which 76 per cent of those surveyed were 10–13 years old, indicated that 55 per cent of those interviewed listened to the radio every day. Nearly half listened to Child-to-Child programmes. Among their main reasons for listening were the educational/informative nature of the programmes and the quality of information received.

Larsen Manjate, 17, who has worked on Child-to-Child radio shows since 2006 and has had his own show since 2007, sees Child-to-Child as a way to help children understand not only childhood problems but also the challenges of adulthood. He said, "I think that what we broadcast helps kids grow into adults who know how to make good choices. I think we help make good changes in kids' lives."

According to a study undertaken by the Community Radio Network, FORCOM, in 2008⁸², Child-to-Child community radio programmes facilitate easier communication between parents and children. Listening to the shows makes it easier for parents and caregivers to discuss difficult and sensitive issues with their children or wards, since these issues are often debated on the radio.

For children across Mozambique who do not have access to conventional schooling, the radio programmes can serve as a low-cost means of promoting children's participation, strengthening their access to life-saving information and promoting healthy behaviours.

Figure 3.25: Immunisation of children aged 12–23 months by antigen, 1997, 2003 and 2008

Source: DHS 1997, 2003 & MICS 2008.

To address the poor sanitation situation in the country, the Government of Mozambique launched a sanitation campaign in 2008 that focused on hand-washing, constructing and using latrines, providing safe water and waste disposal. A multi-sector, multi-year cholera prevention plan is being finalised.

2.9. Vaccine-preventable diseases and immunisation

The national Expanded Programme of Immunisation has made substantial progress in recent years. Mozambique has increased its immunisation rates for measles and diphtheria-pertussis-tetanus (DPT) 3 from around 50 per cent in 1991 to 70–80 per cent in 2007.⁸⁹ Two new vaccines, hepatitis B and *Haemophilus Influenzae*, have been introduced, and there are plans to introduce rotavirus and pneumococcus vaccines.

In order to address low coverage and the inequities in coverage between rural and

urban areas and among provinces and wealth quintiles, the Ministry of Health introduced the Reaching Every District (RED) approach, which focuses on building the capacity of districts, health workers and communities to improve immunisation and other maternal and child survival services. The RED approach is currently being used by the Ministry of Health as a platform for reaching MDGs 4 and 5.

In 2008, eighty-seven per cent of children under one had received vaccination against tuberculosis, and 71 and 70 per cent received DPT 3 and Polio 3 vaccines, respectively. Sixty-four per cent of children were vaccinated against measles. Children living in urban areas are still more likely to be vaccinated than those in rural areas. Fifty-five per cent of children 12–23 months old in rural areas received all the vaccines, as against 74 per cent of children living in urban areas. Eleven per cent of children in rural areas received no vaccines, compared to four per cent in urban areas.⁹⁰

THROUGH THE EYES OF A CHILD



"This picture shows where we fetch water. It is full of garbage, mud and dirty water. This is not good, because we may end up getting cholera and other diseases. Kids end up playing in this water, because we do not have playgrounds and parks. The children get sick."

"You will receive better care if you have a family member working at a hospital."

"The majority of us do not have a hospital inside our community. The closest ones are approximately 3.5–5 km from our home. Most of us have to walk to the hospital. Walking when you are sick is very tiring. Sometimes we can afford to go to the hospital, other times, we cannot afford the fees. A lot of us

have marks on our arms. We don't know why we have them, but we can't afford to go to the doctor to find out.

"At the hospital, they want money for every small thing. How much can we afford? And when we are sick and they are asking for money, we feel sad and upset. When we grow up and if we become doctors, we will always take care of the poor people first, because we know how it feels when someone doesn't take care of you just because you don't have money."

— Argentina, age 16

Source: Sajan Virgi, Zainul, 2010.

Measles vaccination coverage in Mozambique improved substantially in 2005 following implementation of a national immunisation campaign that reached 95 per cent of children aged 9 months to 14 years. A follow-up measles campaign during the second phase of the 2008 Child Health Weeks reached 99 per cent of children aged 9–59 months.⁹¹ As a result of these campaigns and strengthened routine services using the RED approach, the number of measles cases reported in the country has substantially decreased. Another follow-up campaign is planned for 2011.

Since 2008, biannual National Child Health Weeks have been implemented by the Government of Mozambique to give every eligible child an opportunity to obtain a basic package of child survival interventions. The specific objective of the biannual National Child Health Weeks is to reach at least 80 per cent of eligible children under five with vitamin A supplementation plus other child survival interventions. Since 2010, the package has been expanded to include elements of maternal health.

2.10. HIV and AIDS

The vulnerability of a country to the effects of infectious disease, including AIDS, depends to a large extent on the level of human development attained by that country. Individuals and society as a whole are better able to protect themselves against the impact of illness and disease in developed countries. This is because of constrained financial resources at the national and household level in developing countries, and reduced human capital arising from a lack of education opportunities and access to other basic social services. In Mozambique, HIV and AIDS adversely affect development and obstruct the fulfilment of human rights, as reflected in key indicators such as life expectancy at birth, child mortality, school attendance, literacy and household income, among others.⁹²

Because of the cross-cutting nature of AIDS in Mozambique, it is dealt with in Chapter 6, Cross-cutting issues.

2.11. Sector financing and budget allocations

The proportion of total financial resources available to the Government that are allocated to the health sector, including external funding, has shown a clear decrease over the period 2006–2010, falling from 13.4 per cent in 2006⁹³ to 8.4 per cent in 2010.⁹⁴ This level of funding is below the Abuja target of allocating at least 15 per cent of the State budget to the health sector.⁹⁵ The sector continues to rely heavily on external funding; the proportion of the sectoral resource envelope funded from external sources decreased from around 65 per cent in 2008 to almost 39 per cent in the 2010 budget proposal.⁹⁶ An analysis of 2008–2010 data reveals that both internal and external funding components of the health budget decreased in real terms.

Of the total allocation to the National Health System in 2010, 60 per cent was allocated to the Ministry of Health and 40 per cent to the Provincial Health Directorates. In terms of investment funding, the provincial level of the National Health System received only 22 per cent of the total investment funding envelope.⁹⁷

The disparities in funding between primary and tertiary or quaternary levels of the health care system are of particular importance for the health and development of children, as tertiary- and higher-level care facilities tend to be concentrated in urban areas, while many of the diseases and conditions that affect children (e.g. malaria, diarrhoeal diseases) are most prevalent in rural areas and are best managed at the primary health care level. In addition, tertiary and higher levels of the health care system tend to focus on less cost-effective curative care, rather than preventive care.

Funding from the 2009 proposed state budget equates to around \$US 10 per capita. If total health funding available to the sector from both the state budget and other off-budget sources is considered, spending increases to around \$US 17.7 per person, of

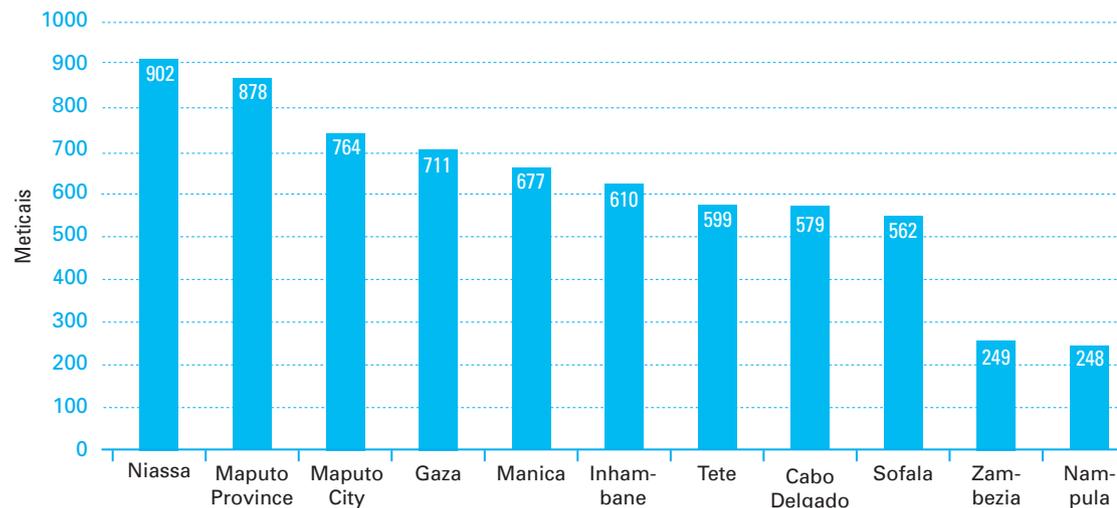
which \$US 10.4 was actually spent in 2008 (although vertical funding is not captured in the Budget Execution Report, reducing the recorded per capita spending, as discussed below).⁹⁸ This health allocation is in line with the stated PARPA II objective to increase health spending to \$US 15 per capita by 2009.⁹⁹ Despite showing improvement over time, per capita health spending remains below the recommended minimum to meet basic health needs in low-income countries, as proposed by the World Bank and WHO, and also below the sub-Saharan African average, which was estimated at \$US 31.9 in 2002.^{xvi}

In 2010, per capita allocations to the provinces varied from 266 Meticaís per person in Niassa to 74 meticaís per person in Zambezia and 73 in Nampula (see Figure 3.26). The Committee on the Rights of the Child has raised concerns “about the inequitable allocation of resources among

provinces, with the lowest expenditures being allocated to the provinces where child well-being indicators, including child poverty, are among the worst in the country.”¹⁰⁰ The G19 group of donors is also concerned and continues to advocate strongly that the Government introduce a provincial funding allocation formula or mechanism that takes into account the varying levels of social development indicators.¹⁰¹

Not all donor financing and internal revenues in the health sector are captured in the state budget. A high proportion of funding from some partners is directed towards projects and remains ‘off-budget’. According to the 2008 state budget Execution Report (Relatório de Execução do Orçamento do Estado), around 56 per cent of the 2008 total health sector budget consisted of vertical funding, executed outside of the direct control of the Government. The high degree of off-budget financing hampers sectoral

Figure 3.26: Per capita health allocations by province (Meticais), 2009



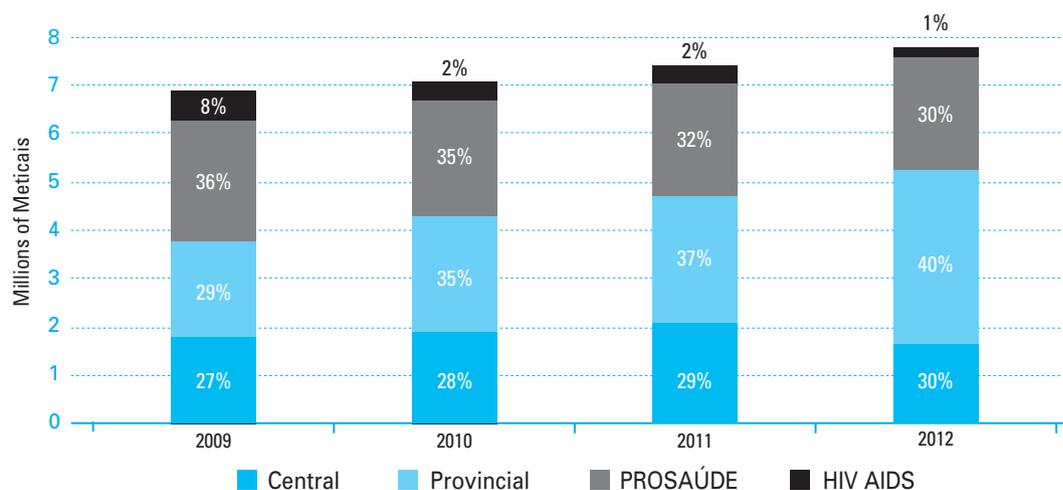
Source: FDC and UNICEF, *O Que Diz a Proposta de Orçamento do Estado 2010 Sobre a Previsão de Recursos no Sector de Saúde?*, Budget Brief 3, UNICEF, Maputo, 2010.

^{xvi} The World Development Report of 1993 recommended a minimum package of \$US 12.00 per capita for low-income countries. Other estimates are: \$US 9.24 standard under “Better Health in Africa” (World Bank, 1994), and \$US 35.00, prescribed by WHO’s Commission on Macroeconomics and Health (WHO, 2002) to meet basic health needs towards the year 2007. The figures for sub-Saharan Africa are taken from the World Bank (2005).

Table 3.3: Comparative analysis of health allocations, 2007 and 2008

Description	Annual allocation (\$US)		Variation
	2007	2008	
State Budget (internal component)	112,730,067	120,847,887	7%
Recurrent	107,166,049	115,039,479	7%
Investment	5,564,018	5,808,408	4%
State Budget (external component)	111,788,250	90,610,103	-19%
Global Fund	49,384,580	64,794,092	31%
Common Fund	96,750,494	93,956,010	-3%
PROSAÚDE - Central	24,979,244	30,675,029	23%
PROSAÚDE - Medicines	45,000,000	35,890,754	-20%
PROSAÚDE - Provincial	26,771,250	27,390,229	20%
Total	370,653,391	370,208,092	0%

Source: Ministry of Health, *Direcção de Administração e Finanças, 'Financial Reports,' (unpublished data), 2007, 2008.*

Figure 3.27: Allocations to health sector (by millions of Meticals), MTEF 2010–2012

Source: Ministry of Planning and Development and Ministry of Finance, *Cenário Fiscal de Médio Prazo 2010–2012, Government of Mozambique, Maputo, September 2009.*

planning and has prompted the Ministry of Planning and Development and the Ministry of Finance to attempt to improve the extent to which external assistance is reflected in Government public finance management systems.

Within the context of the introduction of a Sector Wide Approach in health in 2001, common funding mechanisms were created, culminating in a Memorandum of Understanding for the common fund PROSAÚDE in 2003. In 2004, this was followed by the creation of the Provincial Common Fund and the Pharmaceutical Common Fund. In 2008, the PROSAÚDE Memorandum was updated and the three Common Funds were amalgamated under the single Common Fund PROSAÚDE II. The PROSAÚDE Common Fund is on-budget and on-treasury. Increasingly, disease-specific

'vertical' funds are being channelled through the PROSAÚDE II common fund, and this has made quantifying the full resource envelope available to the Government significantly easier.

The 2009 State Budget Execution Report notes that health sector (minus HIV) budget execution has increased in recent years, from 69 per cent in 2008 to 75 per cent in 2009. HIV-related execution fell dramatically during the same period, from 79 to 55 per cent.¹⁰² Health budget execution remains lower than most other sectors. One reason cited for this decrease is that the sector benefits from vertical funding more than other sectors. Due to lack of information on expenditure of these funds, they are recorded as zero execution in the budget reports, thereby reducing overall budget execution levels.



3. Water and sanitation

Mozambique has made significant advances in the water supply and sanitation and hygiene (WASH) sector in recent years. Improvements have been realised in the institutional and policy framework. It has also created a regulatory structure and that incorporates the Government, the private-sector and consumers. Progress has also been made in the decentralisation of management.

Most reforms and investment, however, have targeted water and sanitation supply in the larger urban centers.¹⁰³ Rural and peri-urban water services remains fragile and sanitation access and hygiene promotion have largely stagnated, particularly in peri-urban areas. Institutional capacity remains limited, especially at the local levels.

The 2006 *Childhood Poverty in Mozambique: A Situation and Trends Analysis* noted that rural water supply coverage had not improved, due to the relatively high costs involved in Mozambique as compared to other countries in the region.¹⁰⁴ Since 2006, the Government of Mozambique, with support from partners, has standardised its procurement and contracting procedures and promoted strong private sector participation. Consequently, costs of construction of rural water supplies have been reduced by 36 per cent.¹⁰⁵

The Convention on the Rights of the Child requires States Parties to take appropriate measures to combat disease and malnutrition within the framework of primary health care, through, *inter alia*, the application of readily available technology and the provision of adequate nutritious foods and clean drinking water. Hygiene and sanitation are also covered: the Convention states that States Parties must “ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the

use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents.”

The primary international framework for the water and sanitation sector is the MDGs, specifically Goal 7: to ensure environmental sustainability.

The water and sanitation specific target is Target 7c: “halve by 2015 the proportion of people without access to safe drinking water and basic sanitation.” The indicators for assessing progress towards this target include: the proportion of the population using an improved drinking water source, and the proportion of the population using an improved sanitation facility.¹⁰⁶ Improving access to water and sanitation was a key Government priority within the human capital pillar of PARPA II, which recognises the importance of increasing access to improved water supplies and sanitation facilities in reducing poverty.

3.1. Institutional framework

The revised National Water Policy focuses on decentralisation; sustainability; effective user participation; the shifting of Government roles and responsibilities from implementer to facilitator and increased involvement of the private sector, Non-Governmental Organisations and Community-Based Organisations. The National Water Policy has the following key objectives:

- Satisfaction of basic needs of human water consumption. The medium-term goal is in accordance with the MDG target to reduce by half the number of people without access to a safe and reliable water supply. The long-term goal is to guarantee universal access to a safe and secure water supply and to increase service levels;

- Improvement of sanitation as an essential tool for the reduction of water-borne diseases (such as cholera, malaria and diarrhoea) improved quality of life and environmental conservation. Separate goals are set for urban and rural areas. The long-term goal is to contribute to attainment of universal access to sanitation services;
- Water efficiently used for economic development;
- Water used for environmental conservation. The Water Policy promotes conservation of water as part of water resources management;
- Reduction in vulnerability to floods and droughts through better coordination and planning, as well as preparedness of individuals, communities and institutions in affected areas;
- Joint management of shared river basins to promote regional peace and integration.
- Development of appropriate technologies and management models for rural water supply and sanitation;
- Capacity-building and human resource development in the rural water supply and sanitation sub-sector;
- Support to decentralised planning, management, monitoring and financing of rural water supply and sanitation activities.

The Rural Water Supply and Sanitation Programme recognises the necessity for a legal framework for community participation to enable community organisations to represent and act on behalf of community members in making binding commitments to public authorities and private entities, collecting and managing funds, operating a bank account, making purchases and payments and entering into agreements with local governments, dealers, suppliers, contractors and others. Two laws: Law 15/2000 of 20 June 2000 on defining community authorities and their relationship with state entities, and Law 8/91 of 18 July 1991 which defines conditions for creation of legally recognised associations provide a legal framework for the operation of community-based organisations. These laws could be applied separately or jointly to provide a legal basis for the operation of water and sanitation committees.

Through the National Water Policy, the Government has reaffirmed its political commitment to attaining the MDG targets relating to water and sanitation, which imply the provision of improved water and sanitation services for more than seven million Mozambicans in rural areas and three million in urban areas before the year 2015.

The 2009 National Rural Water Supply and Sanitation Programme¹⁰⁷ is the framework for putting into operation and implementing the Rural Water Supply Strategic Plan (PESA-ASR) 2006-2015 towards reaching the MDG target of 70 per cent coverage for rural water supply and 50 per cent coverage of rural sanitation at national level. The programme's development objective is to contribute to the satisfaction of basic human needs, improve well-being and contribute to the reduction of rural poverty in Mozambique through improved access to water supply and sanitation services. The programme consists of four components:

- Support to sustainable increase in rural water supply and sanitation coverage;

3.2. The National Rural Water Supply and Sanitation Programme

In 2010 a new Sector Wide Approach (PRONASAR-Programa Nacional de Abastecimento de Água e Saneamento Rural) for the water and sanitation sector was created with the objectives of meeting basic human needs, improving well-being and contributing to poverty reduction through the increased use and access to water supply and sanitation. The PRONASAR provides the framework for the operationalisation and implementation of the Strategic Plan of the ARSA (PESA-ASR). It aims to address imbalances in rates of

THROUGH THE EYES OF A CHILD

“Every morning, I wake up at 5 a.m. to fetch water. I carry at least 20 large containers of water, as shown in the photo. When I’m finished, I am very tired, very tired.”

“We do not have running water in our homes. It is mainly the responsibility of children, particularly girls to collect water. Some of us have to make 20 trips a day to the well. The water sources can be far away, some as far as 60 minutes. The water feels very heavy on our heads and our arms hurt from holding 20 litres of water particularly when we haven’t eaten anything from the night before.”

“We start collecting water between 4am and 5am everyday, including weekends. It is difficult carrying water while dodging cars and trucks as we try to cross busy streets. When we come back from collecting water, we are always very tired. When it is hot outside, and we haven’t had enough water to drink, we get very bad headaches.”

“It is not safe for girls to fetch water by themselves. Even when we are together, we have to be careful. A lady who went alone was killed last year when she went to fetch the water at 3am. Another young girl fell into the water well and died instantly. It makes us feel scared, that’s why it is important to go to the water well with a friend.”

— Enya, age 12

Source: Sajan Virgi, Zainul, 2010.



access and use within the provinces and districts and promote harmonisation of aid and institutional reform in the subsector with particular focus on capacity building at provincial, district and local levels. The implementation of PRONASAR began in 2010 will be implemented in two phases namely Phase I (2010-2012) and Phase II (2013-2015). A 2008 code of conduct for the water sector, signed by the Government and nine development partners applies the principles of the 2005 Paris Declaration on Aid Effectiveness to the water sector in Mozambique. UNICEF currently co-chairs the PRONASAR Sector Wide Approach.

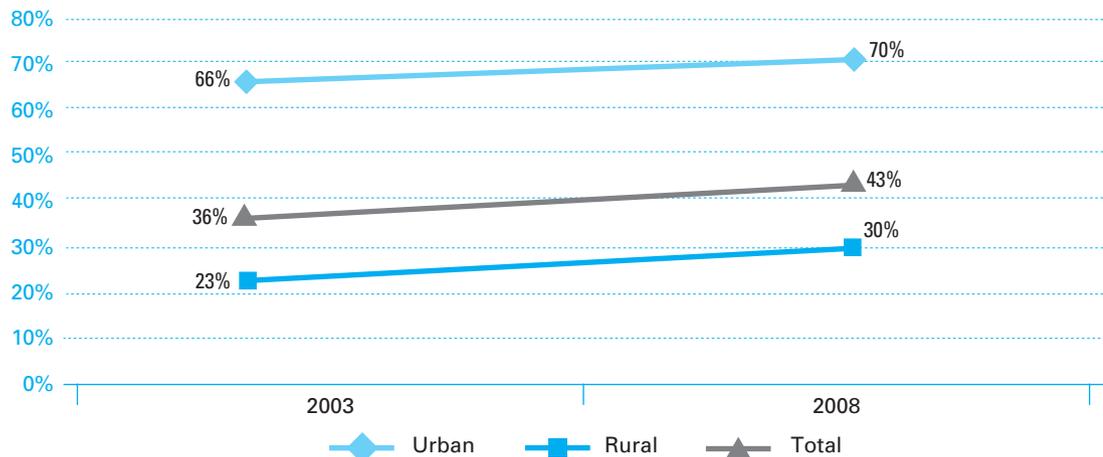
3.3. Water supply

The proportion of households in Mozambique with access to safe water increased from 36 per cent in 2004 to 43 per cent in 2008.¹⁰⁸ The most common water source is an unprotected well. Important disparities in access to safe water persist between urban and rural areas and among provinces. Almost all households in Maputo City (98 per cent) have access to safe water, compared to only 26 per cent of households in Zambezia and 36 per cent

in Cabo Delgado. Access to safe water also varies considerably across household wealth quintiles. Only 13 per cent of households in the poorest quintile have access to safe water, compared with 85 per cent of households in the wealthiest quintile.¹⁰⁹ Further, only 22 per cent of households without access to safe water use an appropriate method of treating their drinking water (e.g. boiling), thereby increasing the risk of waterborne diseases.¹¹⁰

There is a large urban/rural disparity as well: 70 per cent of urban households have access to safe water, compared to only 30 per cent of rural dwellers.¹¹¹ Despite the improvements in urban areas, a significant number of the population living in the peri-urban areas are lacking safe drinking water and adequate sanitation facilities. Estimates for water and sanitation coverage in some peri-urban areas in Mozambique are as low as 10 per cent.¹¹² Due to the lack of proper sanitation, drainage systems, waste management and poor hygiene practices, peri-urban areas are often an excellent breeding ground for gastroenteric diseases as well as malaria. People living in peri-urban areas in Mozambique are often among

Figure 3.28: Proportion of households with access to safe water, by geographic location 2004 and 2008

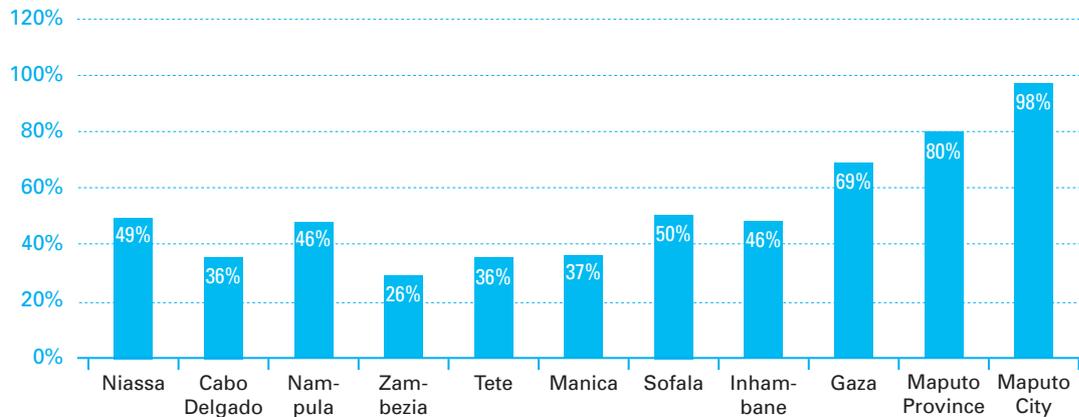


Source: National Institute of Statistics, 'Inquérito Integrado à Força de Trabalho (IFTRAB) 2004/05,' Government of Mozambique, Maputo, 2006 and MICS 2008.

the poorest and most vulnerable in society, as they do not have stable incomes, nor do they have arable land to provide for their own food consumption. Population density is high and often municipal authorities have limited funds to provide services for peri-urban areas. Cholera epidemics and malaria are more common in peri-urban informal settlements than in any other areas of Mozambique.¹¹³ "Because of geography and climatic conditions large parts of peri-urban

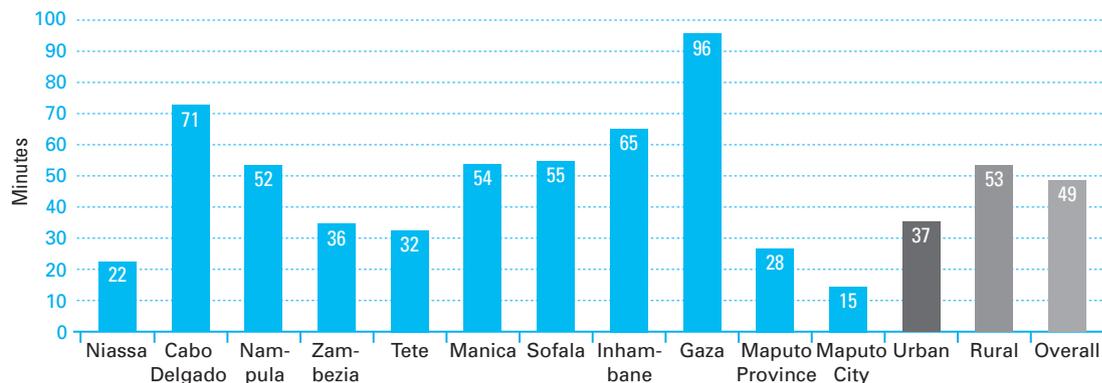
areas are on floodplains, situated below sea level annual floods and stagnant water after rains are common," which in combination with the practice of open defecation and unimproved latrines leaching content into the environment are main causes of disease. Unlike the rural water supply and sanitation sector, where a Sector Wide Approach has been introduced, focus on sanitation in peri-urban areas has not yet been prioritised.

Figure 3.29: Use of improved water source by province, 2008



Source: MICS 2008.

Figure 3.30: Mean time to water source (minutes), 2008



Source: MICS 2008.

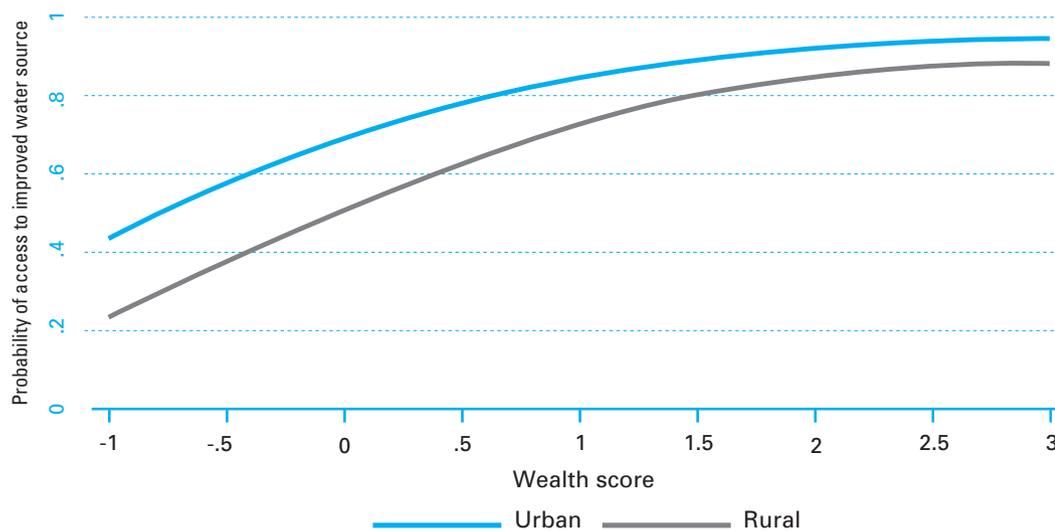
It is estimated 5 per cent of the population receives water supply via a small, piped system.¹¹⁴ No situational assessment has been performed, though it is widely considered that a large number of these systems are either non-functional or deficient, delivering water irregularly to only a small proportion of potential users. Most of these systems are managed by local government, and only function if water fees are subsidised.

For the vast majority of households (95 per cent) that do not have any access to running water in the home, it is an adult woman who normally collects water. The mean time to walk to water source is just under one-hour (49 minutes), and multiple trips per day are generally necessary. In households where children collect water, it is much more likely to be a girl than a boy who does so. Girls collect water in 11 per cent of households in both Nampula and Gaza, spending on average 52 and 96 minutes, respectively per trip. Men in the wealthiest households are five times more likely to collect water than men in the poorest households.¹¹⁵

A multivariate regression analysis was conducted to further examine the factors that influence whether a household has access to an improved water source, defined as taken from a source other than unprotected wells, lakes, rivers or lagoons (see Figure 3.31). Unsurprisingly, the results show that, besides location characteristics, household wealth is the most important explanatory variable in the model. However, other factors are also found to play an important role. Female-headed households are significantly more likely to have access to safe water than male-headed households. The presence of a well educated head-of-household (secondary or higher level) is also significantly correlated with access to safe water.¹¹⁶

It is worth noting how location characteristics, i.e., local infrastructure, have the major role in explaining water quality. Rural households are significantly less likely than urban households (17 per cent) to have access to an improved water source, as are all households living outside Maputo City, especially those in northern provinces.

Figure 3.31: Probability of access to improved water source, by wealth score 2008



Source: UNICEF calculations based on MICS 2008

3.4. Sanitation

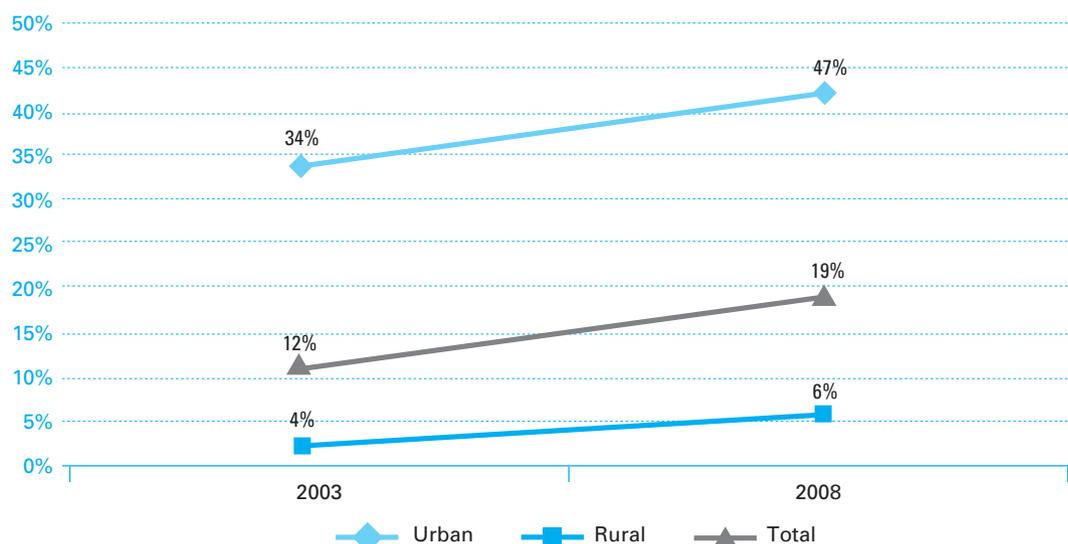
Access to improved sanitation facilities remains low, particularly in rural areas and the northern and central provinces. Access to safe sanitation increased from 12 per cent of households in 2004 to 19 per cent in 2008.¹¹⁷ There is a large discrepancy between urban and rural households: 47 per cent and 6 per cent, respectively (see Figure 3.32), with a much lower rate of improvement for rural households.

The WHO and UNICEF Joint Monitoring Programme notes that 74 per cent of the 11.7 million people living in rural areas in Mozambique practiced open defecation.¹¹⁸ Only 5 per cent had access to improved sanitation facilities and 21 per cent to unimproved facilities. However, improving access to sanitation remains a key Governmental objective. Reflecting this commitment, the ministries of Public Works and Housing and Health were awarded an African Ministers' Council on Water (AMCOW) AfricaSan award for their leadership in getting 185 villages to attain

Open Defecation-Free status in 2009.¹¹⁹ AMCOW was formed in 2002 in Abuja Nigeria, primarily to promote cooperation, security, social and economic development and poverty eradication among member states through the management of water resources and provision of water supply services. The AMCOW AfricaSan Awards are dedicated to recognising outstanding efforts and achievements in sanitation and hygiene in Africa which result in large-scale, sustainable behaviour changes and tangible impacts. They aim at raising the profile of sanitation and hygiene by drawing attention to successful approaches, promoting excellence in leadership, innovation and sanitation and hygiene improvements in Africa.

A regression analysis was conducted to further examine the factors affecting household access to good sanitation facilities, defined as the ownership or use of a non-traditional water closet. As with improved water sources, three factors are found to be positively and statistically significant for improved sanitation:

Figure 3.32: Access to safe sanitation, by geographic location 2004 and 2008



Source: National Institute of Statistics, 'Inquérito Integrado à Força de Trabalho (IFTRAB) 2004/05,' Government of Mozambique, Maputo, 2006 and MICS 2008.

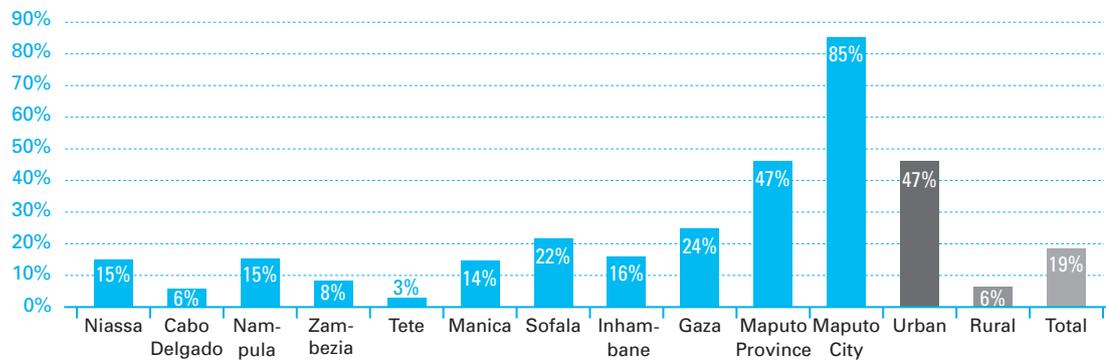
household wealth, head-of-household education, and location. Also, living in a female-headed household implies higher likelihood of improved sanitation, although the effect is lower than for education (2.5 per cent against 24 per cent for higher education levels).¹²⁰

Local infrastructure plays a major role, with all the provinces showing a lower probability of access than Maputo City, although the effects are lower than in the case of improved water source access (see Figure 3.34).

3.5. Sustainability of WASH infrastructures

Recent studies by the Water and Sanitation Foundation (Fairwater) indicated that there are 50,000 non-functioning water supply systems across Africa. This represents a failed investment of \$US 215–360 million.¹²¹ With the increased participation of the private sector and civil society in water point and household sanitation construction, the Government of Mozambique is shifting its focus towards ensuring sustainability and quality of infrastructure.

Figure 3.33: Access to improved sanitation facilities, by province 2008



Source: MICS 2008.

Figure 3.34: Probability of access to improved sanitation source, by wealth score 2008



Source: UNICEF calculations based on MICS 2008

THROUGH THE EYES OF A CHILD



"This picture shows the washroom. The water leaks from the washroom. As a result, the area is very smelly. Children play in this area as there are no places for children to play. It is not healthy for the children to play in areas that are not clean."

"The washroom leak causes health problems."

"We have washrooms in our yards, but they are not very well built. The washrooms are made of corrugated zinc sheets or reeds. They don't have electricity. Most washrooms have a capulana (sheet) instead of a door. When the wind blows the capulana, everyone can see me inside. I feel so embarrassed. Without electricity inside the washroom, some of us have fallen into the washbasins and gotten

hurt. We sometimes feel scared going to the washroom at night and will always try to take someone with us."

"When it rains, the water causes a lot of problems. It attracts flies that can cause cholera. The smells are unbearable. The washrooms become muddy and dirty with the water leaking both inside and outside the washroom. As a result, the waste and dirty water leak out into the yard. Children often play close to the washrooms because of limited space for play. As a result, they get sick from the contaminated water mixed into the mud."

— Marta, age 10

Source: Sajan Virgi, Zainul, 2010.

Box 3.3: Government access data versus household use data on water and sanitation

There are two main sources of information on access to and use of water and sanitation: the routine monitoring systems of the National Water Directorate (DNA) and household surveys conducted by the National Institute of Statistics. These two sources use different indicators. Both sources also use different definitions of urban and rural areas.^{xvii}

Water supply

DNA reports that in 2009, 52 per cent of the population in rural areas has access to water from an improved source, compared with 30 per cent reported in the 2008 MICS. The access data was calculated through the assumption that one water point serves, on average, 500 people. Recent Government analyses indicate that the average number of users per improved water point is about 287. This figure was shown to be in broad agreement both with the sustainable capacity of the hand-pumps used in the country, and the norms used by other African countries. In 2010 Government, with the support of development partners, agreed to adopt a new standard for planning of 300 people per water point within one kilometre walking distance providing 20 litres per person per day as the standard for planning. Further, estimation of rural water supply coverage will be based on data from household surveys conducted by the National Institute of Statistics or other national representative surveys, related to access to and use of water supply and sanitation.

Sanitation

Regarding the population with access to improved sanitation in rural areas the figure reported by DNA, is 40 per cent, whereas the figure reported in the 2008 MICS is only 6 per cent. This discrepancy is due to low use of existing facilities by individuals as a result of low levels of sanitation knowledge and ambiguities regarding the classification of sanitation facilities in household surveys. Improved definitions of sanitation facilities are slated to be included in subsequent surveys.

The sustainability of rural water supplies requires that special attention be paid to quality control throughout the rural water supply project cycle. This includes: during the preparation of bidding documents and technical specifications; during the construction of water points; during procurement of all materials and equipment; and during capacity building of communities. Recent sustainability checks undertaken by external auditors of rural water and sanitation facilities in Tete, Manica, Sofala and Zambezia indicate that up to 30 per cent of all rural water supplies are non-operational due to a lack of community ownership of facilities, a weak spare parts chain and lack of trained mechanics.¹²²

In 2010, UNICEF undertook the Midterm Impact Assessment and 2010 Sustainability Check of the One Million Initiative in Tete, Manica and Sofala Provinces.¹²³ The Mid Term Impact Assessment was a case controlled panel study undertaken in 80 control villages and schools and 80 treatment villages and schools. Results from the 1600 household surveys indicated a 27 per cent and a 9 per cent increase in use of improved water sources and sanitation respectively in the programme area (18 districts) between 2008 and 2010 and 6 per cent reduction in levels of self-reported diarrhoeal disease. Furthermore, the sustainability assessment noted increased levels of both institutional and infrastructural sustainability in the programme.

^{xvii} The water sector considers urban areas to include only 13 major cities, while the definition of urban areas used by National Institute of Statistics in the 2003 DHS was 13 cities and 68 secondary towns.

3.6. Water and sanitation in schools

In Mozambique, access to safe water and sanitation in schools is still not well defined due to a lack of agreed indicators and survey tools. However, in a recent baseline survey undertaken in five districts, it was noted that only 28 per cent of schools had access to safe water, and fewer than 28 per cent had access to sanitation.

To accelerate progress towards the MDGs, the Government of Mozambique is promoting a Child-Friendly Schools programme, with the aim of providing a minimum quality package to all schools in target districts. Amongst other interventions, the programme provides safe water and adequate sanitation facilities in all schools in the selected districts. By 2008, this effort had resulted in an increase in the proportion of schools with water from 28 per cent to 80

Box 3.4: Community Led Total Sanitation

The One Million Initiative is a six year programme partnership between the Dutch Government and UNICEF that aims to support the efforts of the Mozambique Government to ensure adequate water supply and sanitation and the adoption of improved hygiene practices for a million rural people in 18 districts, of which 6 are in Tete, 6 in Sofala and 6 in Manica.

After the use of the Participatory Hygiene and Sanitation Transformation methodology through non-governmental organisations contracted by the districts failed to bring the desired results in the programme's sanitation and hygiene promotion activities, it was decided to introduce Community Approach for Total Sanitation. In Mozambique, this has taken the form of a combination of Community Led Total Sanitation (CLTS) with a system of awards/prizes. CLTS is an innovative methodology for mobilising communities to completely eliminate open defecation. Communities are facilitated to conduct their own appraisal and analysis of open defecation and take their own action to become open defecation free. At the heart of CLTS lies the recognition that merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene. Earlier approaches to sanitation prescribed high initial standards and offered subsidies as an incentive. But this often led to uneven adoption, problems with long-term sustainability and only partial use. It also created a culture of dependence on subsidies. Open defecation and the cycle of fecal-oral contamination continued to spread disease.

In contrast, CLTS focuses on the behavioural change needed to ensure real and sustainable improvements – investing in community mobilisation instead of hardware, and shifting the focus from toilet construction for individual households to the creation of “open defecation-free” villages. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease, CLTS triggers the community's desire for change, propels them into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability.

WaterAid and UNICEF have become important disseminators and champions of CLTS. Today CLTS is in more than 20 countries in Asia, Africa, Latin America and the Middle East.

CLTS has a great potential for contributing towards meeting the MDGs, both directly on water and sanitation (goal 7) and indirectly through the knock-on impacts of improved sanitation on combating major diseases, particularly diarrhoea (goal 6), improving maternal health (goal 5) and reducing child mortality (goal 4).

In addition to creating a culture of good sanitation, CLTS can also be an effective point for other livelihoods activities. It mobilises community members towards collective action and empowers them to take further action in the future. CLTS outcomes illustrate what communities can achieve by undertaking further initiatives for their own development.

per cent in the five programme districts. The introduction of CLTS in schools and training of key implementing non-governmental organisations and governmental staff has led to a scale-up of sanitation in schools.

The UNICEF Child-Friendly Schools Annual Field Assessment Report¹²⁴ shows that considerable progress has been made in the enrolment, retention and educational performance of children in Mozambique. The net enrolment ratio at primary level has risen from 69 per cent in 2003 to 95 per cent in 2007. Table 3.4 illustrates progress in raising enrolment in the five school districts where activities are being implemented.

3.7. Sector financing and budget allocations

Approximately 85 per cent of sector investments over the last three years have come through official development assistance. Actual sector budgets for the period 2006-2008 have increased by 150 per cent as compared with the period 2003-2005 (from roughly \$US 46 million to \$US 116 million). Similarly, disbursements have increased over this same period by 155 per cent,¹²⁵ though the overall rate of disbursement has remained relatively constant at around 60 per cent. "On-treasury" funding is disbursed at a

Table 3.4: Number of pupils enrolled, by sex, in five Child-Friendly School districts, 2006–2008

District	2006			2008			Increase (%)
	Boys	Girls	Total	Boys	Girls	Total	Total
Maganja da Costa	31,579	18,335	49,914	41,485	26,707	68,192	36,6%
Buzi	17,448	13,007	30,455	19,779	16,260	36,039	18.3%
Mossurize	16,226	11,786	28,012	22,987	17,840	40,827	45.7%
Changara	20,706	17,836	38,542	22,240	20,045	42,285	9.7%
Chibuto	22,645	22,387	45,032	23,337	23,257	46,594	3.5%

Source: UNICEF, 'Assessment: Child-Friendly Schools initiative in Mozambique Annual Field Assessment Report' UNICEF Mozambique, Maputo, 2009.



rate of 82 per cent, as opposed to donor-managed projects which disburse at an average rate of 58 per cent.¹²⁶ Government of Mozambique disbursement rate improvement has been brought about by a combination of the elimination of the old “duodecimal” budget allocation system, the introduction of the new state financial management system (SISTAFE), improved procurement processes, more punctual donor disbursements, improved estimates of project start-up dates, and the allowance by some donors of payment of Government of Mozambique counterpart contributions or tax payments using the same projects’ credits or grants.

The annual average investment required to meet MDG targets in rural areas has been estimated at \$US 70 million.¹²⁷ The first phase of the National Rural Water Supply and Sanitation programme (2009–2011) will require an estimated \$US 200 million.

Although planned expenditure for urban water exceeds estimated required investment, there is a shortfall of approximately 35 per cent in relation to the rural water sector.¹²⁸ Current budget commitments for sanitation indicate that approximately five per cent of funds needed have been committed for rural sanitation, \$US 3 million has been committed per annum versus an estimated \$US 22 million

required. In urban sanitation approximately half of the amounts required have been committed.¹²⁹ Given the major funding shortfall, it is unlikely that the MDGs related to water and sanitation will be achieved. Resources for the funding gap are being mobilised by both establishing a common fund and improving coordination of programme funds.

In 2010, the Government of Mozambique reported that 7.6 per cent (\$US 241 million) of the total state budget was allocated to the water sector.¹³⁰ This is a significant increase over the 2.8 per cent in 2003 (see Table 3.5). In a move towards decreasing geographical disparities, the National Rural Water Supply and Sanitation programme will be implemented on a priority basis in provinces and districts meeting agreed criteria, which include present water and sanitation coverage, poverty, written commitments and adequate staffing, amongst others.

Despite this increase in the proportion of the total budget allocated to water and sanitation, the Government’s contribution has declined steeply. In 2006, 66 per cent of water and sanitation expenditures were covered by external financing.¹³¹ Analysis of the total investment in the sector in 2010 indicates that 85 per cent of funding now originates from external resources, although this is a slight decrease from 2009.^{132,133}

Table 3.5: Financing of the water sector as a proportion of state budget, selected years 2003–2010

2003	2004	2005	2008	2009	2010
3%	2%	2.5%	5%	4.5%	8%

Source: Ministry of Finance 2008, 2010.

4. Conclusions

There are a number of underlying causes for the high mortality rates and poor health status of Mozambican children and substantial barriers to improving child survival and development in Mozambique.

One of the main underlying causes of child morbidity and mortality in Mozambique is the lack of access to public services, both in terms of physical and economic access and the poor quality of these services. Barriers to accessing and using services are particularly acute for poorer households, for people living in rural areas, and for those with less education. This directly relates to higher mortality rates among children from these households.

There are significant disparities in the allocation of resources from central level to particular provinces and rural areas. This can partly be attributed to insufficient links between health policy instruments, which emphasise poverty reduction and the need to target vulnerable groups, and the sector planning and resource allocation systems.

Poverty remains a key underlying cause of child mortality. The mortality rates among children from poorer families are significantly higher than those from better off families. Data from the 2008 MICS survey show that child mortality levels start decreasing significantly only in the fourth wealth quintile.

Poverty contributes to the high rates of child mortality not only through the disadvantages faced by poorer families, such as lower access to services, lower levels of education and less healthy living environments, but also due to the immediate lack of money to pay for services or medication.

Care practices, including child feeding practices, hygiene and sanitation, and management of childhood illnesses, play an important part in the survival and healthy development of children. Care practices not only have a direct impact on the health

of children, but also shape the behaviour and treatment of their own children later in life. Due to low levels of education, limited access to information about the prevention and treatment of illnesses and the unhealthy environment of many households, the practices of care-givers are often inappropriate or even detrimental to children's health.

Access to safe water and particularly safe sanitation remain low. Safe water and sanitation are essential to improving the health of children and households due to the high prevalence of water-borne diseases. Lack of access to safe water also takes time away from productive activities as the mean time to walk to water source is just under one-hour, a trip taken most often by women and girls.

While progress has been made in setting up an enabling environment (sector institutional framework and related implementation guidelines and approaches), the capacity to implement interventions at the required scale and with the required quality is not always present at sub-national levels. Furthermore, sector assessments recently undertaken have shown that despite developments in the urban areas, a significant number of the population living in the peri-urban areas are lacking safe drinking water and adequate sanitation facilities.

Improved sanitation and hygiene practices, particularly at rural and peri-urban areas, should be a national priority and requires a strong multisectoral collaboration to address all underlying causes. Although actions are being taken towards to improving sanitation conditions (through sanitation campaigns), additional efforts still need to be made at all levels with a strong community approach focus. CLTS is an innovative methodology for mobilising communities to conduct their own appraisal and analysis of their own sanitation and take measures to improve their situation in a sustainable way.

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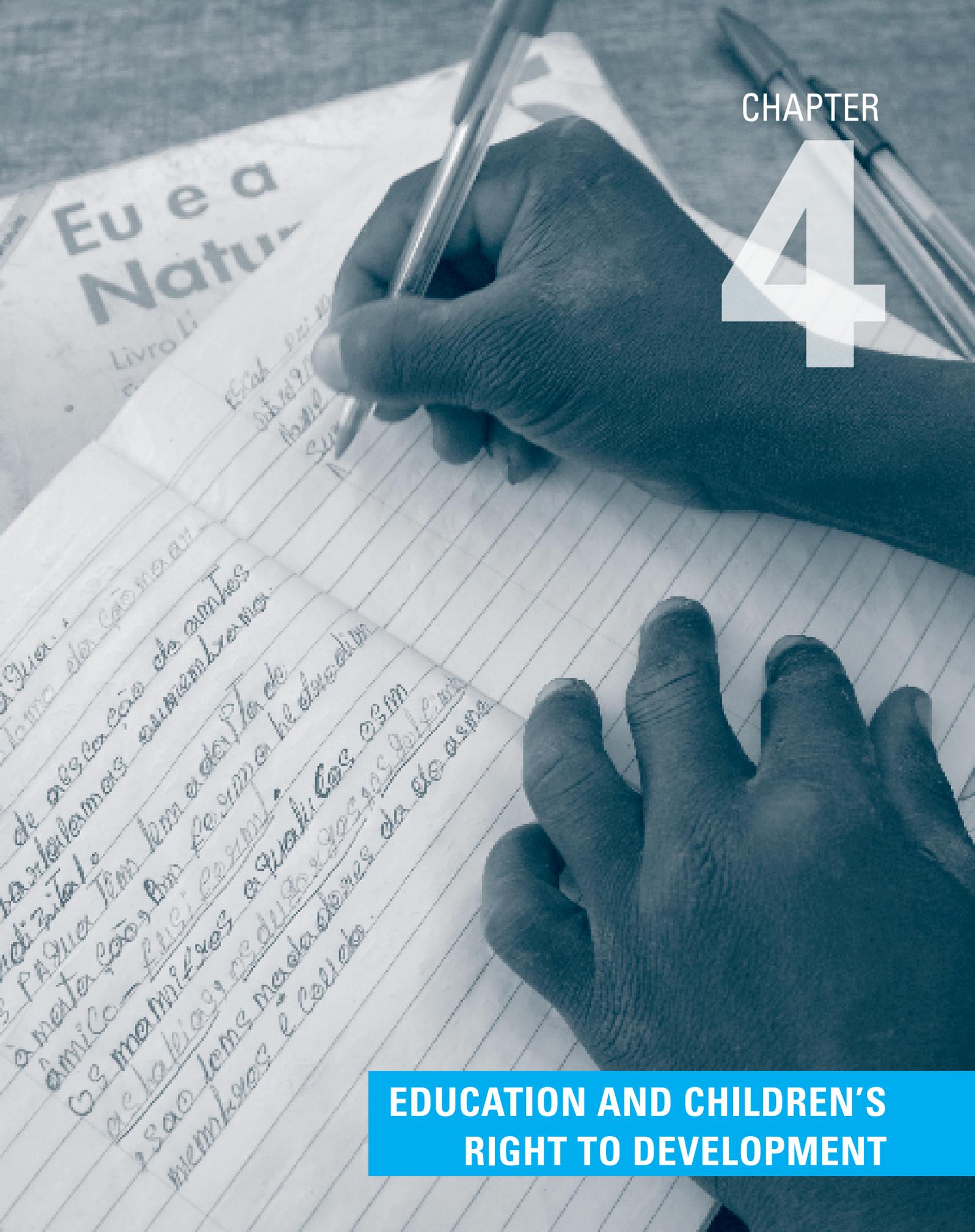
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**EDUCATION AND CHILDREN'S
RIGHT TO DEVELOPMENT**

EDUCATION AND CHILDREN'S RIGHT TO DEVELOPMENT

4

1. Introduction

Education is a fundamental right of all children. It is guaranteed by the constitution of Mozambique, which states that "education constitutes both a right and a responsibility of all citizens." According to the Convention on the Rights of the Child, the right to education encompasses not only the obligation to provide access to education, but also to eliminate discrimination at all levels, to set minimum standards and to improve quality. Education is also an important global development priority. Millennium Development Goals (MDGs) 2 and 3 aim, respectively, at achieving universal primary education and promoting gender equality, including parity in education.

As well as being necessary for the fulfilment of civil, political, economic and social rights, education is also one of the most powerful

instruments for advancing economic and social development and in reducing poverty, especially childhood poverty, and inequality. As noted in Chapter 3 of this *Study on Child Poverty and Disparities in Mozambique - 2010*, education also plays an essential role in child survival and development. This is especially the case for girls' education, which is highly correlated with reduced child mortality and improved child health and nutrition for subsequent generations of children.

This chapter analyses the education sector in Mozambique. The first section examines the current situation and recent trends in participation in the education system. The subsequent section focuses on barriers to participation, describes recent trends in sector financing, and draws some conclusions based on the analyses presented.

2. The current situation and recent trends in education

2.1. The education system in Mozambique

The legal basis for Mozambique's National Education System, which defines the principles, roles and objectives of each sub-system of education, including primary education, was established by law in 1992 (Lei nº6/92). School fees for primary education were abolished in 2004, but they remain in other levels of education.

The Ministry of Women and Social Action has primary responsibility for implementing Early Childhood Development (ECD); however, until now ECD has been provided mainly by private operators and some public institutions with a very limited coverage, with only about 61,400 children attending.¹

The general education system in Mozambique is divided into primary and secondary education. Primary education consists of seven years of schooling divided into two levels. The lower primary level comprises grades one to five (ensino primário do primeiro grau, or EP1) and should be attended by children aged 6 to 10 years. The upper primary level comprises grades six and seven (ensino primário do segundo grau, or EP2) and should be attended by children aged 11 and 12 years. In 2004, the Ministry of Education (MINED) introduced a new curriculum for basic education and reformed some critical aspects of the system, including a requirement for seven years of complete and integrated primary schooling, and semi-automatic promotion. As such, the two levels of basic education are currently in the process of being gradually merged into a single tier (ensino primário completa, or EPC), comprising a seven year cycle of primary education.

Secondary education consists of five years of schooling and is also divided into two levels: the first level comprises grades 8 to 10 (escola secundária geral do primeiro grau, or ESG1) and the second level comprises grades 11 and 12 (escola secundária geral do segundo grau, or ESG2). The first level should be attended by children aged 13 to 15 years, while the second level should be attended by children aged 16 and 17 years. The curriculum reform process for secondary education, introduced in 2007, as well as the Secondary Education Strategy drafted in 2008, intend to make secondary education more accessible and practical, and aim to develop life skills competencies in pupils.

Technical and professional education within the public education system consists of three levels: elementary, basic, and middle. These levels are equivalent to EP2, ESG1 and ESG2 and last for two, three and four years respectively. Within the basic and middle levels it is possible to specialise in agriculture or industry and commerce.

At the tertiary level, there are over 30 institutions in Mozambique, of which two are main public universities: the Pedagogical University (Universidade Pedagógica or UP) and Eduardo Mondlane University (UEM) as well as a number of other smaller higher education institutions. The requirements for entrance to these institutions are completion of ESG2 (grade 12) and passing entrance examinations.

Special education is intended to be mainstreamed through inclusive education, according to the objective set out by the Education and Culture Strategic Plan. Special education had been mainly provided in a few special schools, which are managed by the Ministry of Women and Social Welfare, catering for a limited numbers of children

with special needs in the areas of hearing, visual, mental or physical disability.

Adult education, which ceased during the war, has regained momentum in recent years, with new programmes, such as distance learning through radio and television, introduced to provide basic education to adults, particularly women in rural areas.

Disparities have been narrowing in primary education but progress in secondary education has been slow. Approximately 3.3 million of Mozambique's 4.1 million children aged 6–12 are now attending primary school² equivalent to net attendance rate of 81 per cent in 2008.³ Net attendance rate in secondary school remains low; only 20 per cent of children aged 13–17 were attending secondary school in 2008. Almost half of children of that age are still attending primary school.⁴

There is no significant difference in primary and secondary school attendance between girls and boys. The gender gap in primary,

as measured by the net gender parity index (GPI), has narrowed from 0.90 in 2003 to 0.97 in 2008.ⁱ In secondary, the GPI improved from 0.80 in 2003 to 0.97 in 2008.

Long-standing discrepancies in children's school attendance between urban and rural areas and between the poorest and richest households have also been reduced.

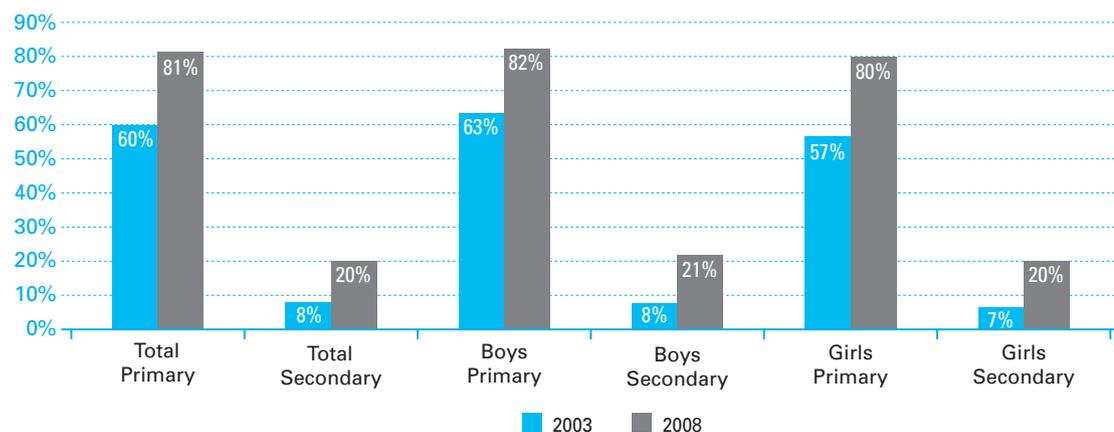
Although gaps remain, rural and poorer children saw a greater increase in net attendance rates in recent years than urban and better-off children, at both primary and secondary levels.

2.2. Children in school

More children are attending school today than five years ago. Primary school net attendance rates increased between 2003 and 2008 from 60 to 81 per cent. Secondary school net attendance rates also increased between 2003 and 2008, from an extremely low base, from 8 to 20 per cent.

A regression analysis was conducted to examine the factors that influence primary

Figure 4.1: Net attendance rates, 2003 and 2008



Source: DHS 2003 and MICS 2008.

ⁱ The GPI is calculated by dividing the female net enrolment ratio by the male net enrolment ratio for a given level of education. A GPI of 0.96 to 1.04 indicates that the percentages of boys and girls in school are roughly equal. A value of less than 0.96 indicates a lower percentage of girls than boys in school.

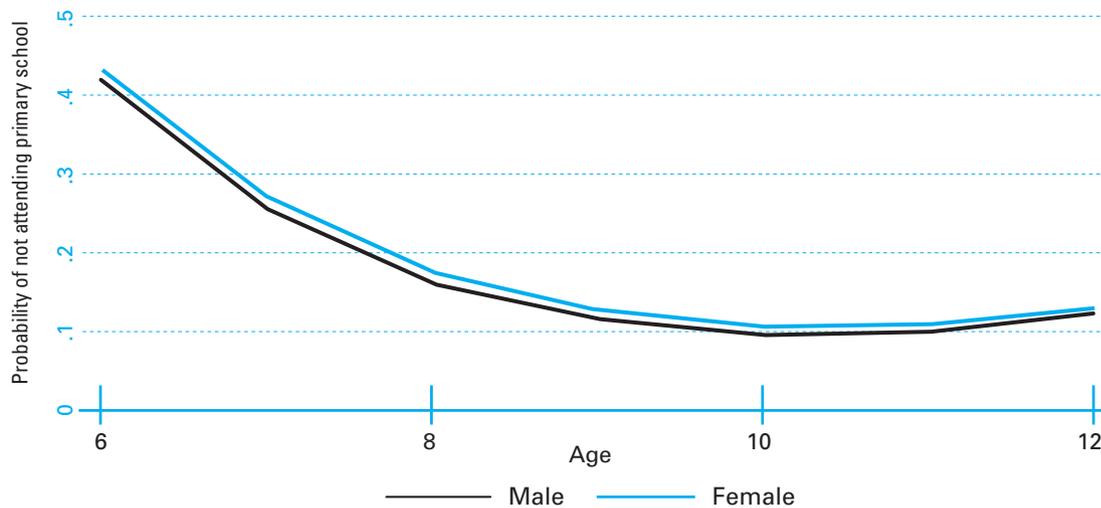
school attendance for children aged 6–12, based on the MICS 2008 dataset. Here, the dependent variable is whether the child is attending primary school. Results show that education of the mother seems to be one of the most important factors affecting primary school attendance. Household wealthⁱⁱ is also positively correlated to attendance. In addition, children in female-headed households and those with a father present are more likely to attend school. Age of the household head and household size do not seem to be correlated to attendance.

Given the relatively large proportion of children who start school late, the age of a child has a positive relationship with

primary school attendance, although dropouts start from age 10 (see Figure 4.2). The model also indicates that a child with a disability is 40 per cent less likely to be attending primary school than a non-disabled child. The gender of the child does not bear any statistically significant relationship with school attendance, as Figure 4.2 also confirms.

In terms of geographical differences, rural children have a slightly lower probability of attending primary school than urban children. Children living in the northern provinces show a higher likelihood of dropping out of school than children in Maputo City.

Figure 4.2: Probability of children 6-12 not attending primary school, 2008



Source: UNICEF calculations based on MICS 2008.

ⁱⁱ Measured through an asset score index, based on the methodology of Filmer and Pritchett, 2001.

2.3. Children out of school

In 2003, there were 1.5 million children not attending primary school. Five years later, that number has halved: 764,000 (see Figure 4.3). In absolute numbers, however, gender disparities persist. More girls are not enjoying their right to primary education: 399,000 girls versus 364,000 boys.⁵

Among children of secondary school age who are out of school, a reverse trend can be observed. The number of 13- to 17-year-olds out of school appears to have slightly increased between 2003 and 2008, from 31 to 36 per cent.⁶ More girls than boys (in both secondary and primary education) are out of school. Part of the reason for this is that more boys of secondary school age are found attending primary schools, that is, they are 'over-age' (49 per cent of boys versus 38 per cent of girls), while more girls are outside of the education system altogether (41 per cent of girls versus 30 per cent of boys).⁷

While urban children fare better than their rural counterparts, greater overall progress in education indicators was observed in rural areas between 2003 and 2008. Primary

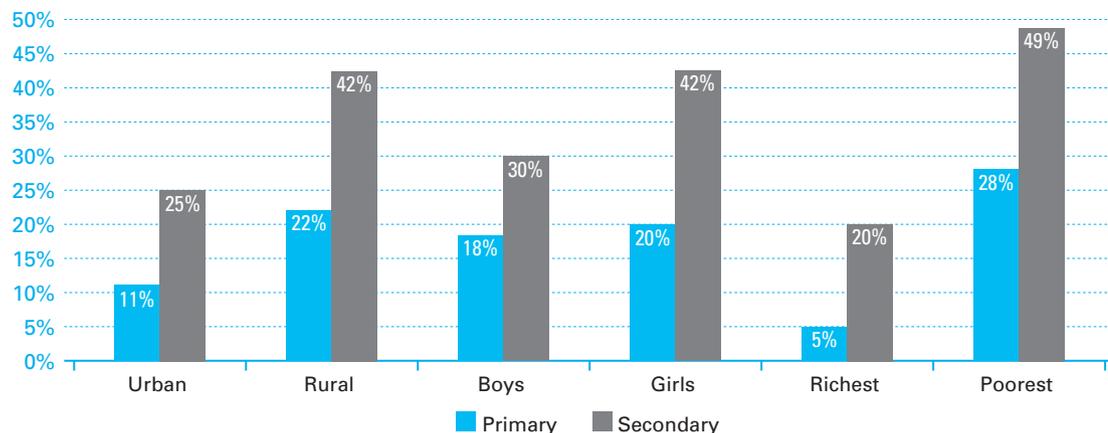
net attendance rates increased among rural children from 53 per cent in 2003 to 79 per cent in 2008, compared to an increase of from 76 per cent to 89 per cent for urban children in the same timeframe.⁸

2.4. Delays in starting education

Being over-age in school is a widespread phenomenon in Mozambique and is influenced by many factors. Although the Ministry of Education has been promoting the idea that children should start school at the right age, whether a child actually does so depends on several factors, one of which is the child's area of residence. Children in rural areas enter school later than children in urban areas. At six years old, 61 per cent of children in rural areas were attending primary school in 2008, compared to 73 per cent of urban children. Starting school at the right time is influenced by the level of education of the child's mother and level of wealth of the child's household. In 2010, 69 per cent of girls started school at the correct age, based on statistics from the MINED.

While progress has been observed over time, more children aged 13–17 are attending primary than secondary school.

Figure 4.3: Percentages of children aged 6–12 and 13–17 out of school, by sex, place of residence and socioeconomic background, 2008



Source: MICS 2008.

In 2008, 44 per cent of the total secondary-school-age population was in primary school, compared to 61 per cent in 2003. Gender disparities are evident: among 17-year-olds, 21 per cent of boys versus 12 per cent of girls were attending primary school in 2008.⁹

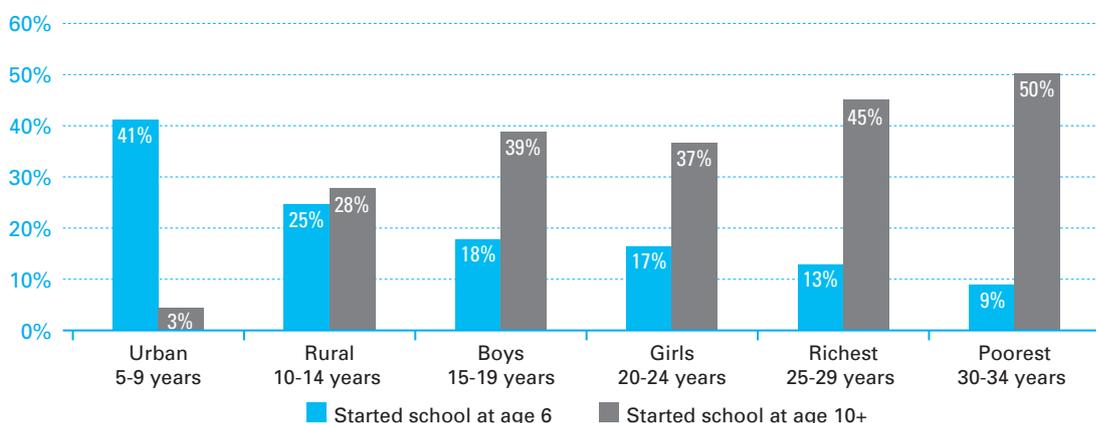
The age a child starts school clearly affects the proportion of over-age children in school. Children have tended to start their schooling earlier in recent years. Figure 4.4 shows how younger generations are more likely to start primary school at age six than older groups.

The over-age phenomenon in primary education has significant implications for children's learning outcomes, as the same curriculum is taught at the same pace to learners of very different ages and levels of cognitive development. It also poses serious challenges for school-based HIV and AIDS prevention programmes targeting children aged 10–14 in grades 5–8 (regarded as the *Window of Hope*, since most are not yet sexually active or are only just becoming sexually active). The more mature over-aged children require a different approach in such programmes.

2.5. Primary school completion and transition to secondary education

Participation in secondary school depends on completion of primary school. Primary school completion rates are low, at 15 per cent. There is a significant disparity between urban and rural primary completion rates (30 per cent versus 7 per cent, respectively, in 2008).¹⁰ Although completion rates are increasing in both urban and rural areas, the divide between the two has grown, with a five-fold increase for urban children compared to a two and a half times increase for rural children. It is possible that recent increases in attendance rates for rural children will translate into higher completion rates in the coming years. While a majority of children (73 per cent) who complete primary level progress to secondary school, completion rates there are even lower. The Ministry of Education estimates that the gross completion rate for secondary education was 6.5 per cent in 2009. Males are more likely to complete secondary than females (8 per cent versus 5 per cent respectively).¹¹ Secondary education is not free and there are inadequate numbers of secondary schools, especially in rural areas.

Figure 4.4: Distribution of population according to the age they started school, 2008



Source: MICS 2008.

While there has been a 100 percent increase in the number of secondary schools since 2004, this has occurred mostly in urban and peri-urban areas.¹² For the large majority of rural children completing basic education, access to secondary education is still a challenge. It is interesting to note, however, that a reduction in matriculation fees charged to girls enrolling in secondary schools has boosted girls' enrolment in secondary schools, although girls enrolment remains lower than that of boys, in most provinces.

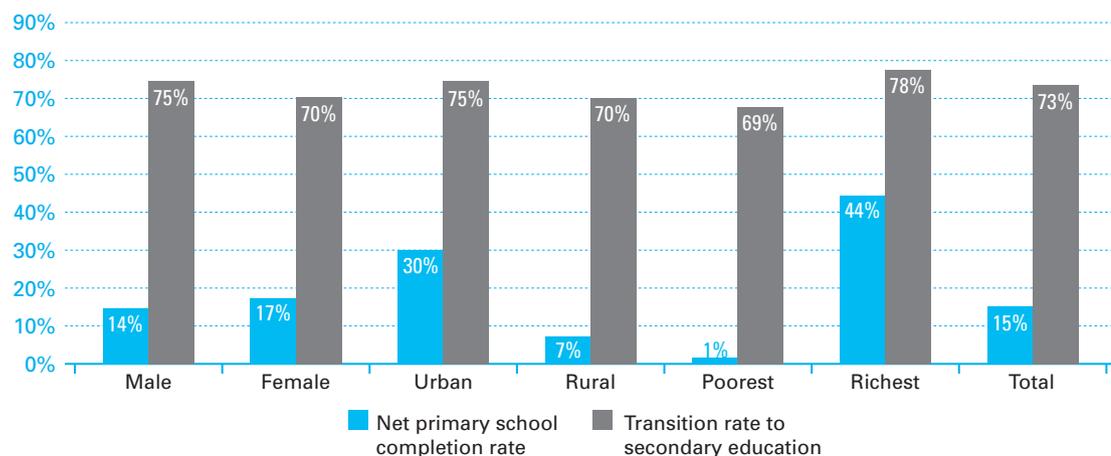
Primary school completion is directly influenced by a number of factors, including mothers' education levels, household wealth and province.ⁱⁱⁱ Children whose mothers have secondary education or more are more likely to complete primary school at the right age than children whose mothers have no education (see Figure 4.5). Forty-four per cent of children from the richest quintile complete primary education at age 12 compared to 1 per cent from the poorest quintile. Rural/urban disparities also persist, as children in urban areas are four times more likely to complete primary school than children in rural areas (30 per cent versus 7 per cent).¹³

2.6. Progression through grades

Low primary completion rates are due, at least in part, to the persistent failure of children to smoothly progress from one grade to the next. On average, around eight per cent of children fail to progress from one grade to the next every year, and this failure is reasonably constant through the primary cycle.¹⁴ Given that MINED's semi-automatic promotion policy allows children to repeat only the second, fifth and seventh grades, it would be expected that failure to progress would be higher from these grades. Data from MICS 2008 show that this is not the case. It should be noted, however, that repetition rates have fallen dramatically since 2003.

Only 60 per cent of children reach the last grade of primary school (see Figure 4.6).¹⁵ For some groups of children, the progress rate is significantly lower: girls, rural and the poorest children are more likely to fail to progress through the primary education system. Children failing to progress may be either repeating a grade (for grades two, five and seven) or dropping out of the education system, at least temporarily.

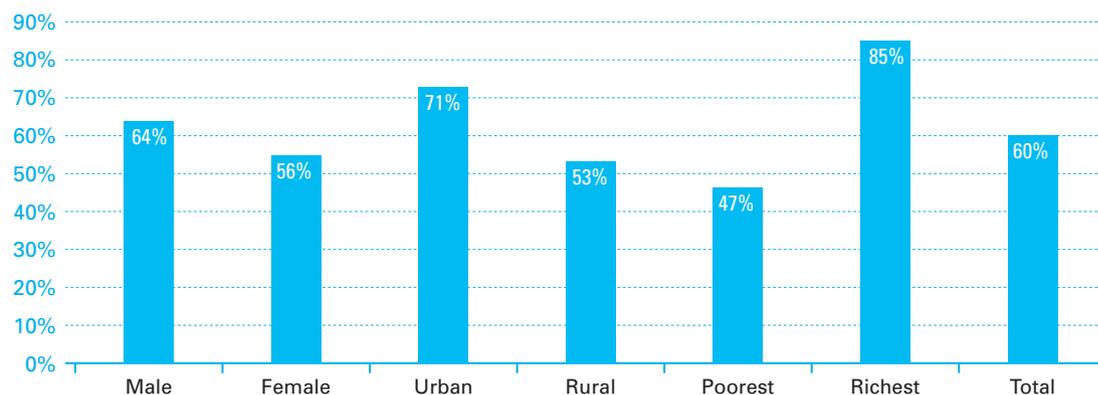
Figure 4.5: Primary school completion rates and transition to secondary education, 2008



Source: MICS 2008.

ⁱⁱⁱ It should be noted that education of the mother, household wealth and household location (urban/rural) are likely to be correlated with each other.

Figure 4.6: Percentage of children entering first grade who reach the last grade of primary school by selected characteristics, 2008



Source: MICS 2008.

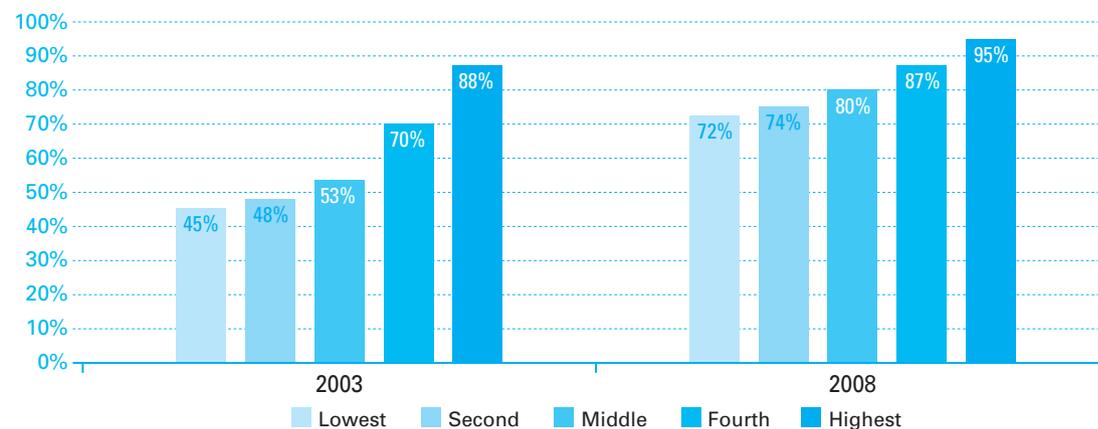
2.7. Equity in education

Inequity in primary education has narrowed between 2003 and 2008. As can be seen in Figure 4.7, net primary school attendance ratios increased for all wealth quintiles. The increase was larger for poorer children than richer children, closing the equity gap. The bottom three wealth quintiles all achieved absolute increases of around 27 percentage

points. The gap between the highest and lowest quintiles decreased from 43 percentage points in 2003 to 23 percentage points in 2008.

Inequity is more pronounced at the secondary level and has increased in recent years. In 2003, the vast majority of children in secondary school were from the best-off families. Most children in the bottom four

Figure 4.7: Primary school net attendance ratios by wealth quintile, 2003 and 2008



Source: DHS 2003 and MICS 2008.

wealth quintiles did not attend secondary school. By 2008, a considerable increase was seen in the top two quintiles. Access for children in the bottom three quintiles remains extremely low, however (see Figure 4.8). Increases in absolute terms were significantly higher for richer children. Attendance of children in the poorest quintile increased by only 2 percentage points between 2003 and 2008, while attendance for children in the richest quintile increased by 27 percentage points. The gap between the secondary school net attendance ratios of the richest and poorest children increased from 21 percentage points in 2003 to 46 percentage points in 2008.¹⁶

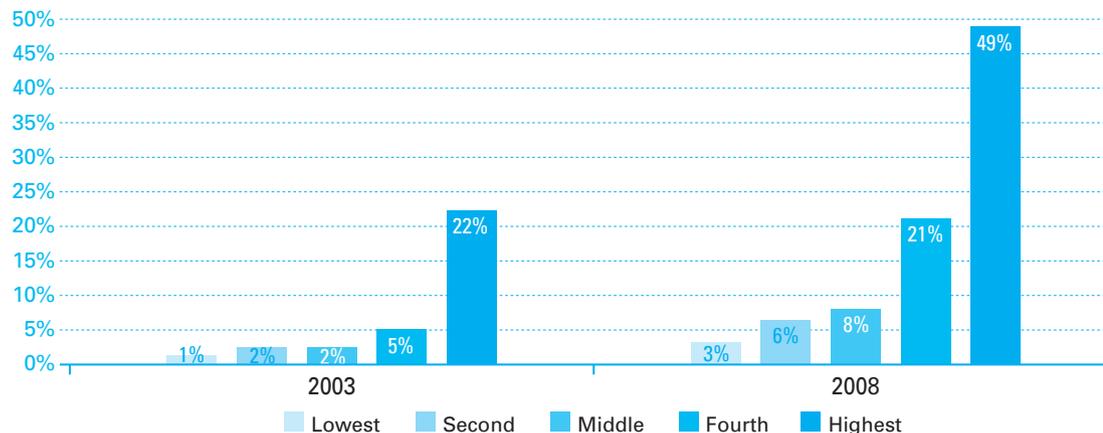
More pupils graduating from 7th grade have been unable to continue into secondary education or the first cycle of General Secondary Education (8th grade) due to lack of sufficient schools to absorb the surge in demand. The numbers of trained teachers and equipment are also inadequate, forcing families to send their children to private schools if they have the means. Meanwhile,

the majority of children, and especially those living in rural areas are compelled to stop their education. As a solution to the problem of spaces, Expanded Primary Schools (or *Escolas Primárias Expandidas* – EPE) have been appearing and providing secondary education, however, the teachers from the primary school are often the ones teaching the General Secondary Education classes, despite not having the requisite qualifications. In addition, the influx of secondary students places further pressure on the space available in primary schools.¹⁷

2.8. Literacy

At independence in 1975, Mozambique had an overall illiteracy rate in excess of 93 per cent, with even higher rates for women, which posed a tremendous challenge to the development of the country. Government and community efforts in the ensuing years were successful in decreasing the illiteracy rate to 72 per cent by 1980. Nevertheless, this progress was undermined by the onset of the war and the economic crisis in the

Figure 4.8: Secondary school net attendance ratios by wealth quintile, 2003 and 2008



Source: DHS 2003 and MICS 2008.

1980s and early 1990s, which virtually ceased progress in this area. The efforts resumed after the war, resulting in a reduction of the adult illiteracy rate from 61 per cent in 1999 to 54 per cent in 2005.¹⁸

Literacy rates remain low for women. In 2008, only 47 per cent of women were literate. However, a greater proportion of younger women are literate: 41 per cent of 20- to 24 year-olds compared to 53 per cent of 15- to 19 year-olds. There was no significant change in women's literacy rates between 2003 and 2008.^{19, iv}

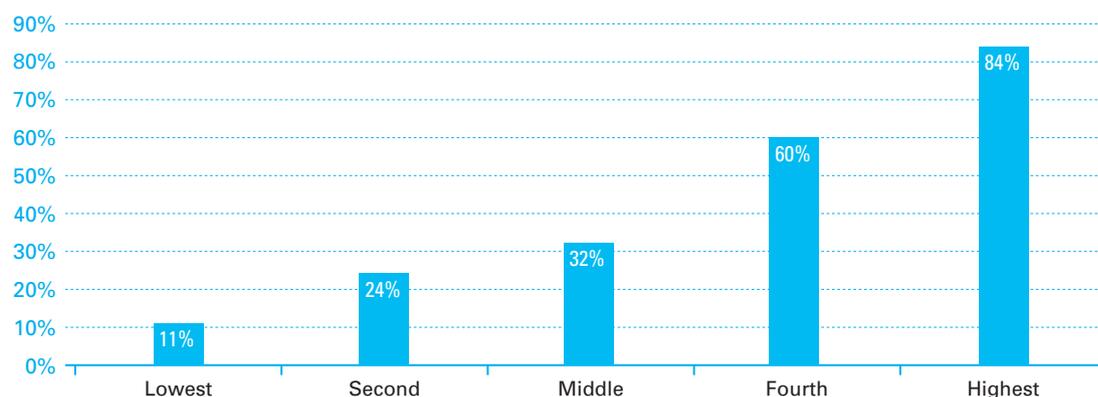
The level of household wealth is strongly correlated with the level of literacy, especially for women. Among women aged 15–24, only 11 per cent from households in the poorest quintile were literate, compared with 84 per cent from households in the best-off quintile (see Figure 4.9).

2.9. Tertiary education

The number of tertiary-level educational institutions has expanded from 9 to 38 between 2000 and 2009. These include the two main public universities: the Pedagogical University (Universidade Pedagógica, or UP) and Eduardo Mondlane University (UEM). The requirements for entrance to these institutions are completion of ESG2 (grade 12) and success in entrance examinations.

Enrolment in tertiary level educational institutions has also been expanding. The number of tertiary institutions increased from 9 to 38 between 2000 and 2009 and the number of students rose from 13,592 to approximately 80,000 in 2009.²⁰ There has also been improvement in terms of geographical equity, with either a fully-fledged higher education institution or a branch opening in all provinces.

Figure 4.9: Literacy rates for women aged 15–24 by wealth quintile, 2008



Source: 2008 MICS.

^{iv} Comparisons between literacy data in DHS 2003 and MICS 2008 should be interpreted with caution because the methodologies used in the two surveys are not compatible.

3. Barriers to participation in education

3.1. Direct costs in education

The direct costs of primary education are cited as a major barrier to children enrolling and staying in school.^{21,22} The abolition of school fees, which was introduced in 2004, coupled with the introduction of a new curriculum and provision of free textbooks and some basic school materials through the Direct Support to Schools (ADE) programme, have reduced the direct costs barrier to primary education. However, the cost of uniforms and other school materials continues to constrain access for the most vulnerable families. Thus, for very poor households, especially in rural areas, the sum of all direct costs still remains a significant factor when deciding whether, who or how many children they can send to school, particularly at the secondary level.²³

3.2. Opportunity costs to communities

In the context of poverty, investment in education becomes one of the choices that households must make in relation to other priorities affecting their lives and livelihoods. Household poverty often requires children to help with household chores or work in order to earn money to support the household or to buy school materials. MICS 2008 data show that 22 per cent of children 5–14 are involved in child labour.^v However, the majority of these children (78 per cent) do attend school.²⁴

When children do not perform well in school, their parents may not see the benefits of education in terms of getting a return on their investment, and as a result may withdraw their children from school.

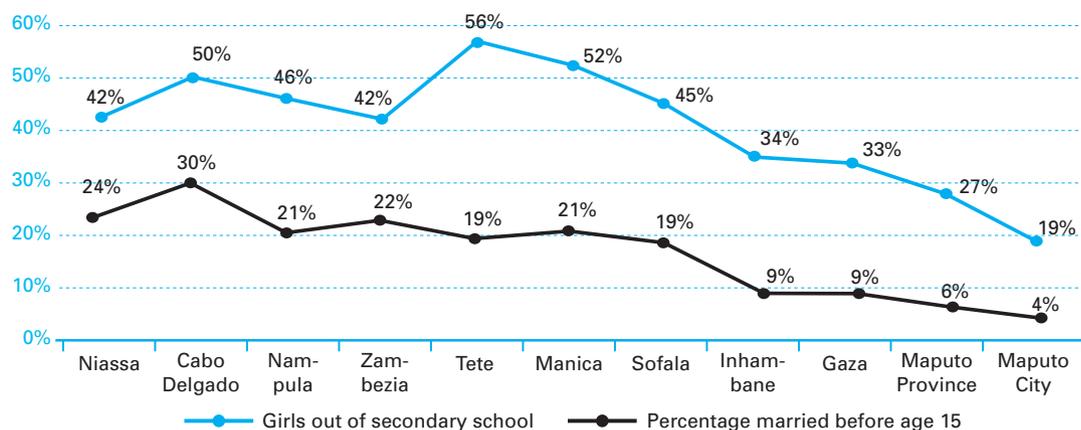
Perceptions of the benefits of education are also usually associated with other factors, including: the quality of education children are receiving, post-education job opportunities, distance to the nearest secondary school, availability of places in secondary schools, skills acquired in school and the availability of qualified teachers. The large increase in enrolment in Mozambique suggests that there is a demand for education, certainly at primary level and increasingly at secondary level. Apart from demand-side, supply-side constraints exacerbate barriers to education.

3.3. Impact of traditions and culture on the right to education

Cultural traditions can act as barriers to education. Early marriage among girls and initiation rites among both boys and girls tend to have a negative impact on primary school attendance rates. Rites of initiation still occur in some, mainly rural, parts of the country. Child marriage affects access to school, retention and completion. Respondents in a 2007 World Bank study noted child marriage as a reason why girls do not begin secondary school or later drop out.²⁵

There is a strong correlation between the proportion of girls out of secondary school and the prevalence of child marriage in a province. Figure 4.10 shows that child marriage is more prevalent in the northern and central provinces than in the south of the country. Child marriage is also highly correlated with household wealth. Girls from the poorest families are far more likely to get married than girls from wealthier backgrounds.

^v The definition of child labour includes children who are engaged in paid work, unpaid work, work for a family business or household chores for 28 or more hours per week.

Figure 4.10: Child marriage and girls out of secondary school by province, 2008

Source: MICS 2008.

3.4. Impact of violence and abuse in schools

The prevalence of violence, sexual abuse and harassment in schools affects pupils' attendance, especially girls', and has been identified by parents as a factor influencing their decision to withdraw their children from school. A study conducted by MINED in 2008 of children, school council members and gender unit members of provincial education administrations assessed the prevalence of all kinds of violence, harassment and sexual abuse in schools. Seventy percent of girls interviewed stated that some teachers require sexual intercourse before promoting students and that schools do not offer security against this, as the act is perpetrated with the complicit knowledge of school authorities. The study also noted that victims and guardians are not aware that sexual abuse is punishable by law. Fear of retaliation often induces silence amongst the victims.²⁶

In 2003, MINED issued a decree explicitly prohibiting teachers from having sexual relations with students. MINED has also declared a 'zero tolerance' policy for sexual abuse and in the annual 2010 Economic and Social Plan has strengthened the capacity of provincial gender focal points to monitor

and report cases of sexual abuse in schools. However, follow-up on abuse in schools and strict implementation of the decree and zero tolerance policy remain weak. The Committee on the Rights of the Child has expressed concern at the prevalence of sexual abuse and harassment in schools.

3.5. Educational quality

The quality of education remains an area of critical concern in Mozambique. Recent data from the Southern and Eastern Africa Consortium for Monitoring Education Quality (SACMEQ) indicate that between 2000 and 2007 levels Mozambique registered a substantial deterioration in achievement in both reading and mathematics.²⁷ SACMEQ concludes that Mozambique's decline of over 40 points in reading and mathematics was linked with rapid structural changes in the education system during the period under analysis that resulted in massive increases in Grade 6 enrolments without corresponding increases in human and material resources.

Quality of education can only be achieved when learning environments are child-friendly and foster a holistic approach to child development. This means they address children's multiple rights and

Figure 4.11: Pupil reading results, 2000 and 2007

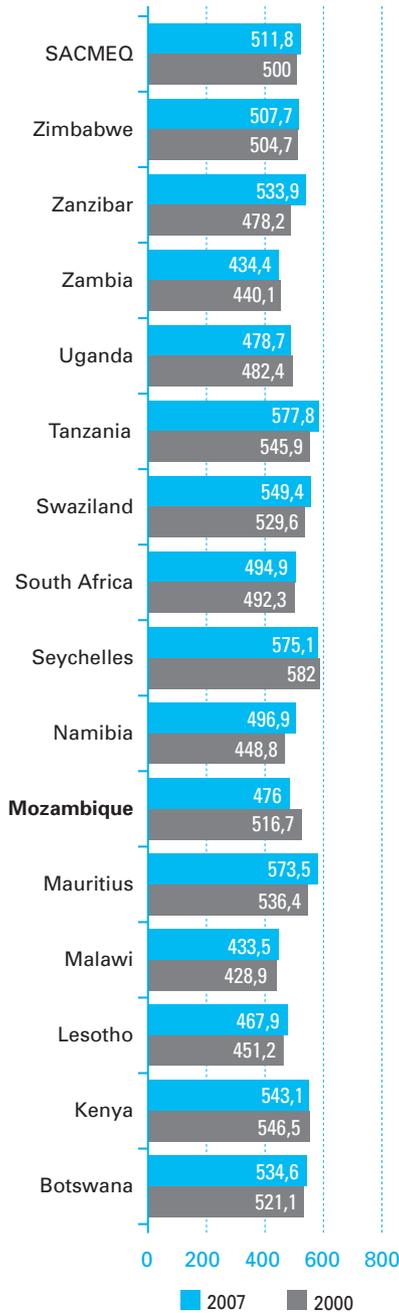
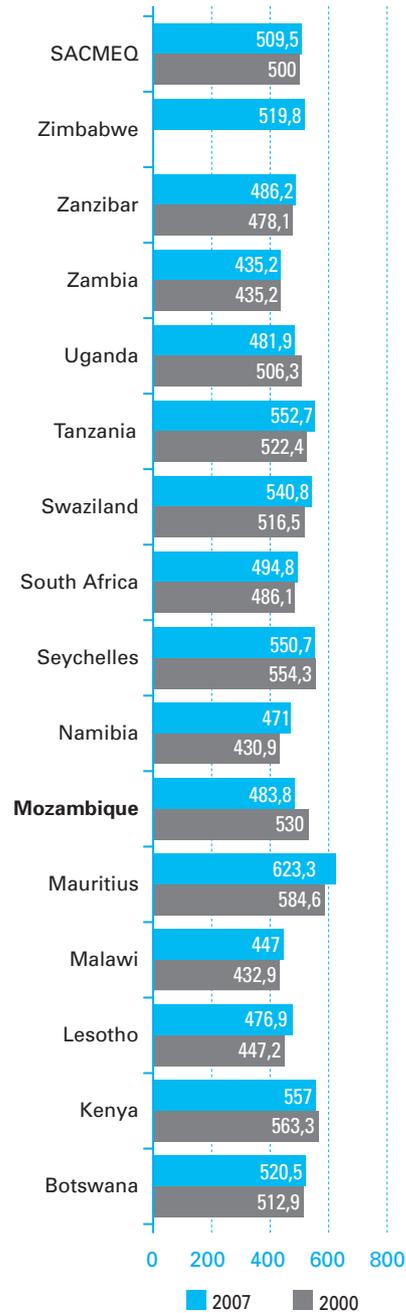


Figure 4.12: Pupil mathematics results, 2000 and 2007



Source: Makuwa, D., 'What are the levels and trends in reading and mathematics achievement?' Southern and Eastern Africa Consortium for Monitoring Education Quality, 2010.

link school, family and community. Child-friendly environments ensure that children have safe and appropriate learning spaces, access to water and sanitation facilities, and regular health check-ups. Children's ability to learn is adversely affected when learning environments are not child-centred, gender sensitive, inclusive, protective and free from discrimination.²⁸

To date, the approach to ensuring quality of education in Mozambique has been somewhat fragmented, with investments primarily directed towards recurrent costs and at best infrastructure development. Focus on improving the school environment tends to take a back seat.

The environment in Mozambican schools remains insufficiently conducive to promoting a rights-based approach to education that values children's views and promotes their critical thinking and creative faculties. Teaching is often conducted in two or more shifts per day. Classes often have as many as 75 students (see availability of teachers), mostly seated on the floor with an inadequate supply of textbooks, desks and learning materials. In many schools, classes are held under trees or in open yards with no access to water or sanitation facilities. Without a quality physical environment, conducive to learning, and child-centred classroom teaching-learning processes, children have little avenue for developing their potential, life skills or appropriate attitudes.

Mozambique has a strong school curriculum that describes the competencies (knowledge, skills, attitudes and appropriate daily life practices) that students should develop, positioned within a rights-based framework. However, the type of learning that actually takes place in schools does not always match the vision or expectations established in the curriculum. This has contributed to high dropout rates, low levels of performance and low rates school completion. Other factors, such as lack of health care and nutrition, further diminish the ability of

children in Mozambique to commence and continue schooling. A consolidated set of basic and minimum standards can act as norms for schools to ensure that children are provided a supportive learning environment.

Very limited didactic materials are available for teaching. MINED provides free textbooks to children in grades 1–7 based on projected enrolment figures. In 2007, 53 per cent of grade 6 children had sole use of a reading textbook. Fourteen per cent shared a textbook with one classmate while 25 shared a textbook with two or more classmates. No reading textbooks were available in 8 per cent of grade six classrooms.²⁹ While progress was made in distributing large quantities of books following the introduction of the new primary curriculum in 2004, several challenges remain. Textbooks delivered by the Government tend to arrive very late, and there are frequent leakages into the informal market.

The average school in Mozambique has large numbers of untrained teachers, and facilities need improvement. Lack of professionally strong teacher training programmes and teacher trainers, both pre-service and in-service, has perpetuated low teacher quality. Failure to prepare teachers to deliver the new curriculum, and for teachers to prepare students to acquire basic learner competencies, is contributing to high levels of school dropout, low levels of performance and school completion, and exclusion of the most vulnerable.

Few schools in Mozambique currently provide an optimum teacher-pupil ratio or space to deliver and sustain learning.³⁰ The phenomenon of 'access shock' is pervasive, in which massive increases in student numbers lead to an overburdened system that simply cannot keep up.³¹ In 2008/09, over 40 per cent of all adults and children (not counting infants) in urban areas were engaged in some study, while in rural areas the share is around 33 per cent.³² More

than 1.2 million more people were in the education system in 2008/09 as compared with 2002/03.³³ While this is a significant increase in access to education, it puts a great deal of pressure on the education system.

Access shock exacerbates the problem of low completion rates, primarily because school construction is incomplete, and schools are therefore unable to offer places to all students eligible to move into the EP2 level every school year. According to MINED data, approximately 7,000 EP1 schools were unable to offer EP2 places to all eligible students in 2009 (see School infrastructure).

There is no basic framework of school quality standards. While a number of regulations exist aiming to establish quality education, the lack of a consolidated system that defines minimum educational requirements means that neither teachers nor the community are clear on the goals to be achieved for the schools. There are no clear reference points or indicators for school monitoring, nor is progress measured or gaps identified to enable appropriate planning and systematic prioritising of goals at decentralised levels.

3.6. School infrastructure

School infrastructure is important in ensuring the quality of the learning environment. Overcrowding is a serious problem in Mozambican schools. The large increase in the numbers of students in the education system in recent years has exacerbated overcrowding in schools and classrooms. A lack of adequate school furniture (desks, chairs, etc.) can affect students' ability to write properly and in the long term may even affect their posture and physical health. Children thus face unhealthy conditions in which learning becomes difficult. Furthermore, the lack of water and sanitation facilities adversely affects pupils' attendance, particularly that of girls (see Chapter 3, Child survival and development).

Three types of schooling spaces exist in Mozambique: conventional schools, improved schools and thatched schools (Escola Precária). Schools constructed from bricks with zinc sheets for roofing are the conventional type of building constructed by the Government. However, due to the slow pace of construction, a large number of schools are built by communities using locally available materials; these are basically temporary structures, inappropriate for children's learning. All existing secondary schools are of the conventional type, though grossly inadequate in numbers.

In 2005, an accelerated, low-cost, school construction programme was launched with community involvement. By June 2010, 4,601 primary school classrooms had been constructed.³⁴ While a new approach for school construction will be piloted in 2010, the quality and adequacy of school infrastructure in Mozambique remains a challenge, falling short of planned targets.

There is a particular shortage of secondary schools. According to projections for 2010, the number of children completing grade 7 is likely to exceed the estimated intake for ESG1 by almost 185,000.³⁵ To cope with the shortage of secondary schools, primary schools in some areas are being expanded. However, secondary classes are sometimes taught by primary teachers who do not have the required training in secondary education instruction. New secondary schools are being constructed, but the pace of construction is not keeping up with demand. Cuts in external funding are likely to exacerbate this problem in the coming years.

3.7. Availability of teachers

Mozambique faces a severe shortage of teachers and the rapid increase in primary school enrolment has placed a significant strain on the teachers in the system. The pupil-teacher ratio deteriorated between 2004 and 2006 due to the significant increase

of students in the education system (see Figure 4.13), but improved between 2006 and 2009. The number of pupils per teacher in primary education has not improved in response to the numbers of new teachers hired, mainly because of delays in replacing staff who leave the sector (for reasons including death, dismissal and abandoning their jobs), reflecting problems in human resource management.³⁶ In 2009, there was an average of 68 pupils per teacher in primary school, up from 65:1 in 2000.³⁷ The international benchmark set by the Fast Track Initiative is 40 pupils per teacher. Significant disparities in pupil-teacher ratios exist across provinces, ranging from 55:1 in Gaza to 91:1 in Zambezia.

Despite a considerable increase in the number of female primary school teachers, from 16,922 in 2005 to 25,947 in 2008, the proportion of female teachers remains low:

In 2008, only 37 per cent of EP1 teachers and 29 per cent of EP2 teachers were women. Significant disparities between provinces also exist: in Cabo Delgado, only 17 per cent of teachers at EP2 level were women, compared to 38 per cent in Maputo City.³⁸ Female teachers serve as valuable role models to young girls, while setting a good example for boys to see women in a professional role. Evidence also shows the presence of female teachers lessens the likelihood of violence and sexual abuse in schools.

Absenteeism is common among teachers, partly due to the impact of HIV and AIDS and partly as a result of low morale.

Teacher salaries are often paid months late, especially for newly recruited teachers, leading them to abandon their posts or to prioritise non-teaching activities.

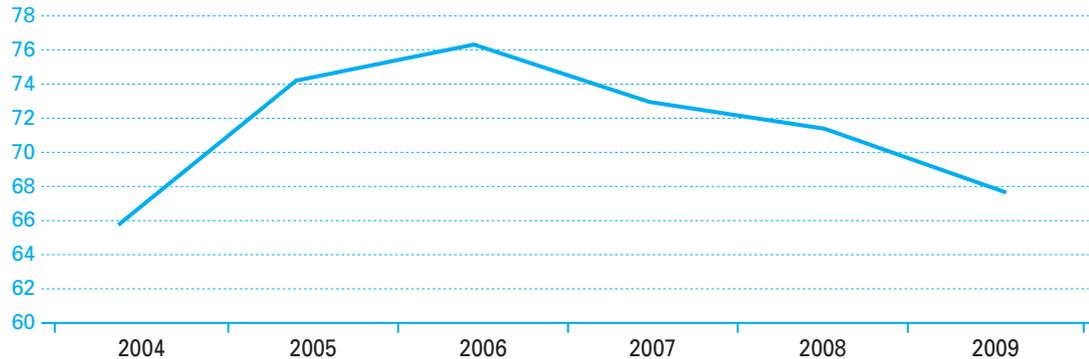
Table 4.1: Pupil-teacher ratio by province, 2008

Province	EP1 Pupil-Teacher Ratio	EP2 Pupil-Teacher Ratio
Maputo City	62	59
Cabo Delgado	71	37
Gaza	55	44
Inhambane	56	48
Manica	63	45
Maputo	56	48
Nampula	83	45
Niassa	68	41
Sofala	75	58
Tete	75	45
Zambezia	91	44

■ Best four □ Middle four ■ Worst four

Source: UNICEF calculation from MEC 2008.

Figure 4.13: Pupil-teacher ratio, 2004–2009



Source: Ministry of Education and Culture, *Contribuição do Sector Para a Reunião de Planificação do QAD*, Government of Mozambique, Maputo, 2009.

3.8. Pre-service and in-service teacher training

In 2009, 68 per cent of EP1 teachers and 79 per cent of EP2 teachers were trained and had qualified to teach. However, nearly 32 per cent of the primary school teacher training force in Mozambique has not received pre-service training.³⁹

There are two major types of primary education teaching training institution in Mozambique: the *Institutos de Formação dos Professores* (IFPs), administered by MINED, and the *Escolas de Professores do Futuro* (EPFs), run by the international non-governmental organization ADPP (Ajuda de Desenvolvimento de Povo para Povo).

In Zambezia province, only 58 per cent of EP1 teachers were qualified in 2009.⁴⁰ MINED is training increasing number of teachers per year, reaching 10,000 teachers in 2009.⁴¹ The decrease in the proportion of qualified teachers is particularly challenging at the secondary level, where 30 per cent of all teachers in the first cycle of secondary education were untrained in 2009, compared to only eight per cent in 1992.^{42, 43} The sector has effectively eliminated the hiring of untrained teachers since 2008.⁴⁴

The numbers of both types of educational institution have been gradually increasing,

and there is at least one of each type in every province in the country. In order to accelerate the recruitment of trained teachers for primary schools, the Government, in 2007, reduced the duration of the pre-service teacher training course from two years to one year. Both types of colleges now run the one-year pre-service training courses. The IFPs also conduct in-service programmes.

The requirement for admission to the IFPs/EPFs is a grade 10 completion certificate. Due to the poor quality of secondary education in the country, many of the teacher trainees have poor reading and writing abilities. A study by the Matola training institute in Maputo province showed that nearly 40 per cent of trainees had acquired their grade 10 qualification more than six years before enrolling in the programme and consequently had lost most of their basic academic competencies and found it difficult to cope with the heavy, knowledge-oriented and highly theoretical course content.

The change to a one-year programme has given rise to issues of quality and management of the courses. The IFP course is run in a top-down manner, with only a week's time stipulated for teaching practice. As a result, IFP graduates do not acquire the necessary teaching experience and

classroom management skills. Due to the lack of transportation, trainees must utilise schools close to the training colleges for their teaching practice. This leads to large numbers of trainees attempting to practice their skills in a small number of schools, further curtailing the time available for acquiring teaching experience. EPF colleges, which were compelled to shorten their two-year course structure to one year in order to conform to national guidelines, are comparatively better managed, devoting 50 per cent of the one-year course to teaching practice. Trainees learn through a computer-aided, self-learning system with tutors on hand to solve problems. Students are assigned responsibility in the management of certain college functions, thus providing them with practical experience in institutional management.

Few of the IFP teaching faculty have a professional background as teacher trainers; they are usually recruited from the administrative stream of MINED. There is also a shortage of trainers in the IFP system. The course content of the IFPs has been constantly changed over the last three years to accommodate new areas. These changes have resulted in a very heavy pre-service course. Often there is insufficient time to cover subjects adequately. The MINED is currently planning a revision of the course structure and content of the IFPs.

In order to orient IFP trainers to the ever-evolving course structure, technical staff members from the MINED Department of Human Resources are deployed to train the trainers, despite the fact that many of them are not necessarily professionally qualified teacher trainers or equipped with teacher training methodologies. In addition, allocation of resources to IFPs remains highly uneven amongst different provinces, and the criteria used in allocation are unclear. All these factors contribute to a critical situation in the country's teacher training system.

A two-year course in Basic Education run by the Universidade Pedagógica is designed

principally to prepare teacher trainers. The course, however, remains theoretical and lacking in practical knowledge and training skills.

The main body mandated to provide pedagogic monitoring and teacher support for in-service training is the *Zona de Influência Pedagógica* (ZIP). Schools have also been mandated to provide in-service support to teachers at the cluster level. There is no structured system or policy on in-service teachers training in Mozambique. In-service training is usually run on an ad hoc basis in the IFPs, driven mainly by central requirements rather than based on local needs assessment. As a result, there are several short-term in-service teacher training interventions being supported by partners that run parallel to each other. These interventions remain uncoordinated and unsustainable and have little institutional impact or sustainable impact on teachers' professional development.

The ZIP is a sub-district lead school mandated to provide pedagogic supervision to teachers and school directors. The district educational authority also conducts one or two supervision visits per year to a limited number of schools. Several elements limit the effective functioning of the ZIP coordinator, who is also the director of the lead school with teaching and administrative responsibilities, which restrict the time available to visit the other schools in the ZIP cluster. There may be as many as 20 schools in a cluster, and they can be located 25 km or more from the lead school. The excessive non-academic demands placed on ZIP coordinators have prevented the development of a more structured system of teacher support at the ZIP level. Experiences from other countries show a successful use of ZIPs as a channel for holding regular teacher development sessions for mutual learning, joint planning of lessons and problem solving.

The current work conditions of teachers (low salaries, lack of housing in rural areas,

lack of transportation) will need to be simultaneously addressed for achieving a functional system of supervision and teacher support at local levels.

3.9. School management

The weaknesses in the teacher training system and the resultant poor quality of teachers in the country makes schools management even more important in the achievement of results, however, this too

is an area not without problems. In the first instance, there is no School Directors' training course in Mozambique and, therefore, all of the School Directors are simply teachers that were considered able to perform that duty. Many School Directors are not even trained teachers. Further, all School Directors are required to undertake teaching duties as well, often with two shifts or extra hours (in EP2), reducing the time available to them to undertake school management and supervision.



3.10. Lack of focus on school health

School health and nutrition programmes provide cost-effective ways to retain children in school and to promote quality education. Mozambique has a school health programme that forms part of the national integrated programme in the health sector, which commenced in the early 1980s. The Ministry of Health and MINED have jointly implemented the school health programme under a memorandum of understanding that defines the roles and responsibilities of both sectors and establishes the mechanism for coordination. However, there is a wide gap between the policy and its implementation.

Chronic health issues remain a major challenge which could erode the gains made in increased access to education. Poor health, particularly malaria, malnutrition and cholera, are underlying factors for absenteeism, poor classroom performance and high school dropout. See Chapter 3 for more information on the health challenges faced by Mozambican children.

3.11. Impact of language on educational outcomes

The language of instruction throughout the country is Portuguese, the official language of Mozambique. However, Mozambique has 19 local languages. A majority of communities speak in their local language

or a mixture of Portuguese and a local language at home. A child's first contact with Portuguese often occurs when the child first attends school. This can negatively affect the learning achievement of children.⁴⁵ Some teachers never become fully skilled at teaching in Portuguese, because Portuguese is their second language. The use of Portuguese as the predominant medium of instruction can delay the entry into school of children who come from cultural sub-groups and speak different languages, and can lead to lower educational outcomes, such as low literacy levels in Portuguese.

With education reform, bilingual education has been incorporated into the new curriculum and two alternative approaches are currently being piloted in a small number of schools. In the first, Portuguese is the main teaching language, and the local language is used as an additional teaching and learning resource; in the second, the local language is used as the teaching language until the second grade, while Portuguese is studied as a separate, formal subject. This initiative is still in the pilot phase and is being implemented in only a few schools throughout the country. Indications are that, while extremely limited, it is beginning to show positive results. Therefore, the Ministry intends to expand it gradually to the rest of the country from 2011 onwards. Production of school materials to accommodate all the local languages is a challenge.

4. Further issues in the education sector

4.1. Life skills strategy to combat AIDS

Since 2002, MINED has been implementing educational programmes to combat HIV.

These programmes are aligned to the national HIV and AIDS strategic plan and are guided by the sector's strategy on HIV,⁴⁶ which aims to reduce the impact of HIV and AIDS on staff through workplace policies and on students by developing life skills programming in schools, integrating HIV and sexual and reproductive health into the school curriculum, and providing HIV and AIDS information kits. With the help of several partners, the programme Geração Biz, supported by the UNFPA and now support by MINED as a national programme, promotes life skills education through its basic package for the 15–18 age group. UNICEF promotes a life skills programme that combines knowledge with communications strategies for the *Window of Hope* age group (10-14 year-olds). The programme, which has been implemented in 86 districts in all provinces of Mozambique, helps children hone their life skills and acquire knowledge and information to protect themselves from risky behaviours. The programme also includes the creation of a community support system through radio programmes.

The main challenge of these approaches is sustainability in developing partnerships with non-governmental organizations, building the capacity of teachers to impart life skills-based education and allocating resources, as these programmes continue to be funded with external aid.

MINED has adopted a workplace policy to reduce the impact of HIV and AIDS on staff. In 2009, the Ministry commenced implementation of a programme to monitor and gradually decrease the prevalence of sexually-transmitted infections among staff. The programme also includes periodic health checks of employees.

4.2. Children's participation

The education system remains teacher-centred rather than child-centred.

Children only speak in response to questions posed by teachers and are encouraged to respond in unison. Efforts are being made to encourage children's participation in school. One such initiative is children's participation in the school council system. School councils comprise student representatives, parents, teachers and other community members. Student representatives are elected by their peers. The school councils discuss and promote solutions to the problems that affect their schools. The challenge of this initiative is to ensure that the children's participation goes beyond mere tokenism and gives them an active voice in school management. In its concluding observations in Mozambique's second periodic report, the Committee on the Rights of the Child expressed concern that "the views of the child in Mozambique are sometimes not solicited or taken into account in various settings concerning children...including in matters of school administration and education...."⁴⁷

Sport and play are a child's right, as prescribed by Article 31 of the Convention on the Rights of the Child.

While sport is a vital component of children's well-being and physical education is an integral part of the primary school curriculum, schools in Mozambique, especially at the primary level, do not conduct any organised play or team activities. Most school teachers lack formal training in physical education and sports management. Recreational equipment or facilities are not always available, especially at schools in rural areas. There is, however, a strong informal sporting culture at the community level in the country, though participation of girls and children with disabilities is not very common.

4.3. Education for children with special needs

As per the education sector's national strategic plan, special education is mainstreamed into inclusive education.

Special schools managed by the Ministry of Women and Social Action are the predominant institutions of special education. In 2009, there were about 62,000 children with special needs attending normal schools. In 2008, only 3,127 teachers were trained to cater to children with special needs, and there were only 98 schools providing inclusive education.⁴⁸

4.4. Sector financing and budget allocations

\$US 593 million was allocated to the education sector in 2010. This represents a 10 per cent increase over 2009 (see Figure 4.14). Total public sector education expenditure has increased substantially between 2005 and 2009 (20–37 per cent per year).⁴⁹ Budget execution in the education sector is often higher than budget allocation, as 'top-ups' to the budget are frequently made during the year.

Over the last few years, the education sector has been allocated a steady 18–22 per cent of the budget. In terms of actual expenditure, the percentage has consistently been above the 20 per cent benchmark

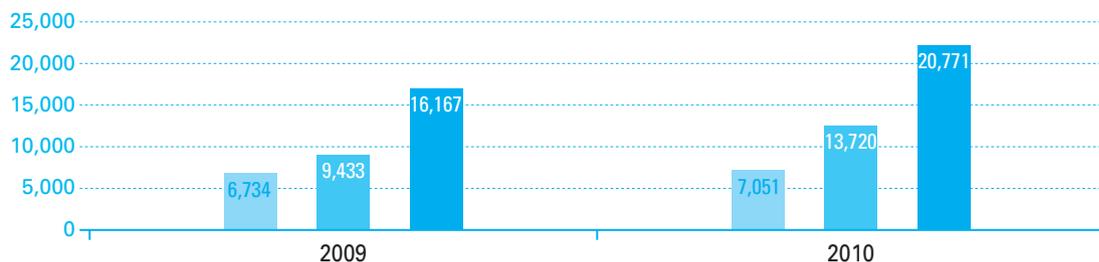
(in 2009, the education share was around 22 per cent). The PARPA II target is 19 per cent. The education sector increased its expenditures by about 68 per cent between 2004 and 2008. In general, the execution rate of the education sector has been fair (90 per cent) compared to other sectors, which could explain the higher percentage share in execution compared to the budget allocation.⁵⁰

Direct external funding to the sector has been 35–40 per cent of total expenditure (around \$US 230 million in 2009). Around 60 per cent of external funding is channelled through the education sector common fund. External funding finances most of the investment and non-salary-related recurrent costs.⁵¹

Although the current budget structure does not disaggregate per level of education, it is estimated that primary schooling (EP1 and EP2) received the major share of resources, around 48–54 per cent of total expenditure. Secondary education is estimated to receive around 20 per cent of the budget (ES1 and ES2).⁵² Salaries and remunerations accounted for approximately half of total budget in 2010.⁵³

Funds are allocated to provinces based on historical trends that are directly related to the education structure at provincial level. Some corrective measures are being taken to address inequalities between provinces, for example the allocation of new teachers

Figure 4.14: Education budget allocation in millions of MTN, 2009 and 2010



Source: FDC and UNICEF, *O Que Diz a Proposta de Orçamento do Estado 2010 Sobre a Previsão de Recursos no Sector de Educação?*, Budget Brief, UNICEF Mozambique, Maputo, 2010.

based on pupil/teacher ratio. Nevertheless, funds allocated per student in Nampula are just over a quarter of those allocated per student in Niassa province and a third of funds allocated per capita in Maputo City.⁵⁴

In spite of the gains in efficiency resulting from the existence of a national sector strategic plan, increased investment in the post-primary school system (i.e. secondary and technical schools) is needed to keep up with the increasing demand for places.

Investment in secondary and higher education is also necessary to produce sufficient numbers of qualified teachers to staff the growing numbers of primary and secondary schools.

4.5. External financing

The global financial crisis and the EU Code of Conduct on Division of Labour are likely to have a negative effect on external funding for the educational sector in coming years.

For 2010, external commitments were 22 per cent less than in 2009. Although the overall education budget for 2010 increased by approximately 10 per cent, due to increased internal financing of 36 per cent, the loss of external funding has directly affected financing for sector programme activities, since the increase in internal funding is primarily geared towards financing new teacher contracts and salary reform. Mozambique has, however, applied

for additional funds under the Fast Track Initiative Catalytic Funds (see Box 4.1) after the expiry of phase I in 2010, and has successfully been awarded \$US 90 million for the period 2011 to 2013.⁵⁵

Internal sector resources have been prioritised to: (i) maintain the existing support system; (ii) improve the quality of primary education; and (iii) strengthen implementation capacity at district levels.⁵⁶ The consequence of declining external funds for 2010 primarily affects the expansion of post-primary education.

4.6. Direct Support to Schools Programme

Direct Support to Schools (or *Apoio Directo à Escola* [ADE]) transfers funds directly to schools according to the number of pupils enrolled to overcome cost barriers through a process of decentralization. The ADE increased its financial assistance to schools five-fold between 2003 and 2009.^{57, 58} According to an evaluation study conducted in 2007/08, the general sentiment among education stakeholders was that ADE contributes to the reduction of problems in schools (via provision of needed materials and improving functioning of schools), improves the teaching and learning process and thus the quality of education, and supports children in need.⁵⁹ However, even though some school materials are provided

Box 4.1: Education for All – Fast Track Initiative

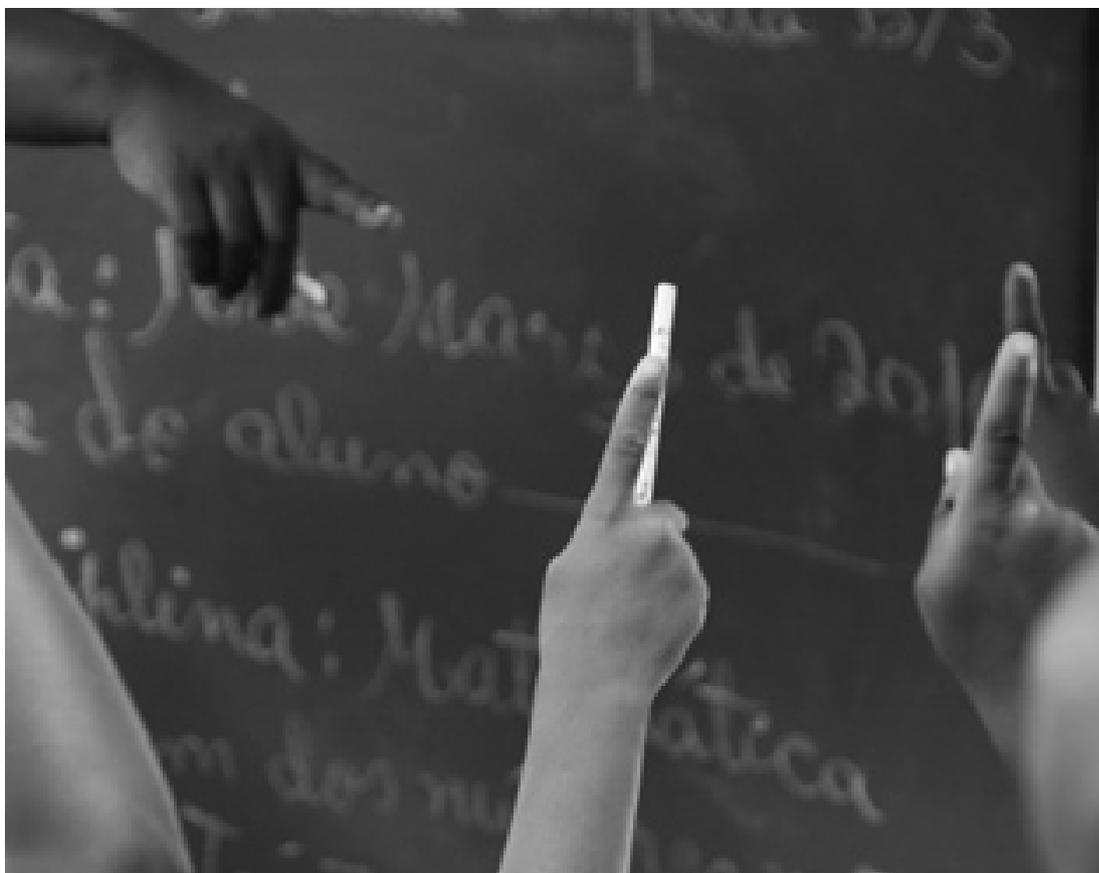
The Education for All – Fast Track Initiative (EFA-FTI) was launched in 2002 as a global partnership between donor and developing countries to ensure accelerated progress towards the Millennium Development Goal of universal primary education by 2015. All low-income countries that demonstrate serious commitment to achieving universal primary completion can receive support from FTI.

FTI is built on mutual commitments. Partner countries have put primary education at the forefront of their domestic efforts and developed sound national education plans. Donors provide coordinated and increased financial and technical support in a transparent and predictable manner. The Fast Track Initiative manages two trust funds that can provide financial support for education goals in low-income countries: the Catalytic Fund for Education, with a total of \$US 1.5 billion in commitments (2003–2009), and the Education Program Development Fund, with \$US 92 million in commitments (2005–2009).

through ADE, they are often insufficient in quantity, resulting in parents having to purchase additional consumables.

In March 2006, a pilot programme – *Apoio Directo à Escola - Crianças Orfãs e Vulneráveis* (ADE-COV) – was created to support school enrolment and retention of orphaned and vulnerable children in four districts, increasing to 12.^{vi} It doubled the ADE funds available per child for the

provision of materials and reduced the main barriers to school enrolment and retention associated with opportunity costs. In two districts, the pilot was also complemented by measures to reduce other barriers both inside and outside of school.^{vii} Available data^{viii} indicate that the number of orphans and vulnerable children enrolled increased in the target districts of ADE-COV by 56 per cent, compared to the national average increase of 21 per cent.



^{vi} The four districts were: Angónia district, Tete province; Búzi district, Sofala province; Chokwé district, Gaza province; and Mocímboa da Praia district, Cabo Delgado province. They were chosen based on HIV prevalence rates, net school enrolment rates, population density, livelihoods and vulnerability, and their governing and administrative context.

^{vii} Namely, provision for birth registration, an outreach programme to identify out-of-school orphans and vulnerable children and monitor their attendance, and provision of psychosocial support to orphans and vulnerable children as required. The Ministry of Women and Social Action and the National Directorate for Registry and Notary conducted them in collaboration with school councils.

^{viii} Sofala province, which included Buzi district, did not have official data on orphans and vulnerable children for 2007.

5. Conclusions

Significant progress has been achieved in expanding participation in primary education in recent years. However, primary school completion rates and secondary school attendance rates remain low. Although gaps remain, long-standing discrepancies in children's school attendance between urban and rural areas and between the poorest and richest households have also been reduced. Disparities between girls and boys net attendance rates at have been eliminated.

The quality of education is a key challenge for the sector with recent SACMEQ data indicate that the quality of education has deteriorated in recent years. A comprehensive approach is needed to improve quality of education through the (i) development of school quality standards, (ii) establishing national framework on assessment of learning achievement, and (iii) integrating various teacher training, motivation and supervision efforts, especially for in-service pedagogic supervision and teacher support. The implementation of the new textbook policy should have a positive impact on educational quality. A national policy on the expansion of bilingual education should also contribute to improving quality.

In the context of reduced external-funding, strategic allocation of funds are needed to avoid losing gains made to date such as support for the Direct Support to orphans and vulnerable children initiative (ADE-OVC). In order to ensure equity, the usage of ADE for different levels of education needs to be reviewed.

Significant and sustained investment is required to strengthen the institutional capacity of Government at the national and sub-national levels. Innovative arrangements should be piloted that are designed to provide incentives in order to address certain key constraints (including relating to being posted in remote locations) and also

strengthen accountability mechanisms. It is also necessary to conduct and implement a comprehensive salary review and reform process that prioritises providing adequate support to "front-line" workers.

If improvements in educational quality are to be realised it will be necessary to professionalise the teacher education programme, both the in- and pre-service components, at all levels. An area that calls for serious attention is the development of training and teaching methodologies that move away from authoritarian, lecture-driven to student-centred and independent learning practices that promote faculties of critical thinking and creativity. Streamlining the process of selection of pre-service trainees will guarantee the quality of human resources in the teaching profession.

There is a need for the decentralisation of in-service training programmes that are designed on the basis of needs assessment of teachers. This will promote the development of teacher professionalism, confidence and motivation. Development of a structured and non-threatening system of teacher support and supervision with ZIPs as the local resource centres will ensure the necessary and continuous support that is crucial for teacher development.

A system for the identification of core learner competencies and the tracking of children's progress through continuous assessment is required. Monitoring the level and acquisition of competencies by children is an integral component of the semi-automatic promotion system. This will require developing teacher training programmes, both pre- and in-service, that focus on teaching methodologies around core competencies and assessment of those competencies through non-threatening methods. The development of a national assessment system (which is being pursued by INDE currently) will need to be built

through a stakeholder consultative process to ensure ownership and accountability.

Gender units at national and decentralised levels should be strengthened to sensitise all school authorities and school council members on the prevention and reporting of sexual abuse; that the Ministry in cooperation with the Ministry of Women and Social Action, revise its Despacho 39/GM/2003 to ensure that punitive action is taken against those who commit acts of abuse and violence.

Civil society will continue to play a critical role both in creating demand, promoting

behaviour change and also supporting the expansion in access and quality of basic services. Recognising that many civil society organisations are based at the community level, they are also often well placed to ensure that the most vulnerable populations are reached by development programmes and to advocate for the realisation of human's rights. Civil society organisation capacities at all levels should be further strengthened, and coordination mechanisms be put in place to promote coherence and information-sharing in approaches under the leadership and overall direction of national and sub-national government counterparts.

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CHAPTER

5

CHILD PROTECTION

CHILD PROTECTION

1. Introduction

The Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, and other international and regional level instruments, are comprehensive in their consideration of the need for child protection. Such legal frameworks recognise that children are vulnerable to violations of their basic human rights and are thus accorded the fundamental right to legal and social protection before and after birth. The duty of protecting children falls on both public and private actors, who have the responsibility to safeguard both boys and girls from violence, abuse, exploitation and neglect, including unnecessary separation from their family environment, and from the effects of emergencies. Through appropriate legislative, social and administrative systems and services, including social protection programmes, known risks to violations of children's rights can be addressed, and children's vulnerability can accordingly be minimised and their resilience strengthened.

The many forms of harm and abuse that threaten children include sexual abuse and exploitation; trafficking; hazardous labour; violence; living or working on the streets; disabilities; AIDS; and harmful practices such as child marriage, lack of access to

child-friendly justice, child separation and unnecessary institutionalisation, among others. Effective child protection mitigates the risks and vulnerabilities that underlie these abuses. A protective environment for children supported by a robust child protection system and infrastructure is a rights-based approach to boosting human and economic development progress and improves the health, education and well-being of children and their evolving capacities to be parents, citizens and productive members of society. A diffused and fragmented child protection system, on the other hand, exacerbates poverty, social exclusion and susceptibility to HIV infection, and increases the likelihood that successive generations will face similar risks.

The key Government ministries in Mozambique responsible for building, strengthening and sustaining a child protection system are the Ministry of Women and Social Action, Ministry of Justice, Ministry of Interior and the judicial courts. All branches of government, civil society and international organisations, alongside informal systems such as families and communities, have a responsibility to cooperate, coordinate and collaborate to nurture and sustain efforts to protect the rights of children.

While there has been important progress in protecting children's rights in Mozambique, much remains to be achieved: increasing children's access to protective and other key social services, harmonising monitoring tools to improve the collection and analysis of data to effectively track and plan for the well-being of children over time, and strengthening the capacities of relevant line ministries to develop a robust and systemic approach to child protection, in order to reinforce accountability and improve coordination among these ministries at the

various administrative levels to effectively protect children. Efforts also need to focus on increasing awareness at all levels of society, including children, families and communities, of children's rights and the obligation of all stakeholders to promote child protection.

This chapter describes the situation of child protection in Mozambique, examines progress and provides an analysis of the gaps and issues in the protective environment for children.



2. Legislative and policy reform

The comprehensive package of legislation passed in 2008 demonstrates the commitment of the Government of Mozambique to protect the rights of children and improve the situation of children and women who are victims of violence, abuse and exploitation. In addition, four specialised courts for children have been established to reduce the backlog of pending adjudication and improve the capacities of the judicial system to effectively handle cases of children in conflict with the law and improve the protection of children's rights.

The Ministry of Interior has also been creating and streamlining standard procedures and applying more systematic approaches within the police services to protect the rights of children and women. Also, a multi-sectoral working group on prevention of violence against children was established by the Ministry of Women and Social Action in 2009 as a follow-up to the United Nations Violence Study and the World Congress III Against Sexual Exploitation of Children and Adolescents, where the Government acknowledged the urgent need for a multi-sectoral approach to prevent and respond to violence against children and to create a functioning referral system for assistance to victims.¹

Effective national child protection systems begin with laws, policies and regulations designed to uphold a child's rights in all circumstances. The absence of an adequate policy framework exacerbates a child's vulnerability and increases the likelihood that he or she will be denied a range of rights extending beyond those strictly associated with protection. The responsibility for respecting, protecting and fulfilling rights is shared among many actors. However, the State is the primary guarantor of rights under both international law and the Mozambican constitution; it must ensure to the fullest extent possible that protection exists in the law, establish and strengthen

effective institutions to enforce the law, and work with civil society and the private sector to promote positive values and practices to enhance the effectiveness of legal protection.

An effective national Child Protection System has been promoted through the approval of three instruments – the Children's Act, Juvenile Justice Act and Domestic Violence Act. The Children's Act, adopted in 2008, effectively translates the Convention on the Rights of the Child's articles into national child rights legislation and outlines the responsibilities of all stakeholders in realising these rights. The development of the Child Protection framework is on-going. Additional measures that have been adopted by the Government include: creation of the National Council of Children's and Human Rights Commission and the Child Parliament, and raising awareness of children's rights issues in the media. Minor courts have been created in five provinces to strengthen protection for children in conflict with and in contact with the law.

Mozambique has ratified several key international and regional human rights instruments on the protection of children, signifying the Government's commitment to harmonise national legislation with international standards. The 2004 constitution clearly states that all actions concerning children, whether by public bodies or private institutions, must consider the best interest of the child, in accordance with the Convention on the Rights of the Child. The constitution sets the stage for the legal and policy framework for children, as described below. See Box 5.1 for recent developments in the legal framework for child protection.

Social protection policies and programmes have proven effective at responding to the needs of vulnerable families and children, as social protection plays a key role in reducing poverty, overcoming social exclusion and

building human capital in order to mitigate the risks faced by vulnerable groups, particularly children and their families. Several forms of social protection policy have existed in Mozambique since 1975, with the purported role of the State varying over the years from ambitious provider of all services (following independence) to marginal provider of extremely limited pension schemes, emergency response aid and food subsidies for the elderly (following structural adjustment programmes). In recent years, however, increased attention has been focused on strengthening social protection across the country, with protection of vulnerable children starting to be recognised as important in the national policy dialogue. In addition, the Health and Education sectors have specific programs for children with specific needs (free health services for children under five and children suffering from malnutrition, and education material support for vulnerable children).

The Social Protection Act, passed in 2007, calls for the provision of basic social security for poor people and children in difficult situations. The Act defines social protection as “a set of measures which seek to mitigate, in step with the economic conditions of the country, the absolute poverty of the population, guaranteeing the subsistence of workers in situations of deprivation or diminished capacity to work, as well as of the surviving family members in cases where the aforementioned worker has passed away, and to ensure conditions for their survival.”² The law further divides social protection into three pillars: obligatory social protection (social insurance under the Ministries of Labour and Finance for those in the formal labour market); complementary social protection (additional initiatives via the private and voluntary sectors); and basic social protection, which has the greatest potential to reach vulnerable children. Basic social protection covers citizens who are

unable to work or do not have the means to satisfy their basic needs, namely:

- People living in absolute poverty;
- Children living in difficult circumstances;
- Elderly people living in poverty;
- Disabled people living in absolute poverty;
- People with chronic or degenerative illnesses.

The Basic Social Security Regulations approved in 2009 further divides basic social security into direct social action, health related social action, education related social action and productive safety nets.

The multi-sectoral Basic Social Security Strategy was approved by the Council of Ministers in 2010. This strategy identifies four programmes as part of the basic social security package: two cash transfer programs (the current Programa Subsídio de Alimentos [PSA] and a new child grant programme for families taking care of orphans and vulnerable children); the current in-kind social transfer program (PASD); and a new productive safety net programme. There are plans to scale up the PSA programme to include a greater focus on orphans and vulnerable children as indirect beneficiaries. The operationalisation of the proposed child grants programme depends on the findings of the on-going PSA impact evaluation and other feasibility studies. PASD’s currently limited reach still includes a relatively high percentage of child beneficiaries. It is anticipated that a mechanism will be put in place to guarantee that vulnerable households have access to a range of basic and protective services, possibly building on the experience of the current poverty card. An operational plan to complement the strategy will be finalised soon and will be an important tool in advocating for increased government funds to implement these programmes.

Box 5.1: Recently approved social protection legislation and policies

2010	The Basic Social Protection Strategy includes child grants as an integral part of the strategy.
2009	The Domestic Violence Act aims to increase protection of both women and children from sexual abuse and exploitation at home and in communities. It makes domestic violence a crime in Mozambique for the first time, calls for increased penalties for offenders, and places an obligation on the State to assist victims by providing services such as police investigation and medical treatment.
2008	The Children's Act and Juvenile Justice Act , both approved in 2008, translate the Convention on the Rights of the Child into national child rights legislation. This is a major step towards creation of a comprehensive legal and policy framework for children. The Trafficking of Persons, especially Women and Children, Act defines trafficking of persons in line with international legal instruments (namely the Palermo Protocol, ratified in 2006) and criminalises trafficking, particularly of children and women. Regulations for this act need to be drafted and approved.
2007	The Labour Law explicitly prohibits the worst forms of child labour for children under 18. It establishes that children between 15 and 18 can only work up to 38 hours per week or 7 hours per day. In recognition of the economic realities of the country, it does allow children 12–15 to work, provided that they do so with the permission of a parent or other legal guardian. The Social Protection Act calls for the provision of basic social security for poor people and children in difficult situations. The law defines social protection as “a set of measures which seek to mitigate...absolute poverty of the population, guaranteeing the subsistence of workers in situations of deprivation or diminished capacity to work, as well as of the surviving family members in cases where the aforementioned worker has passed away, and to ensure conditions for their survival.”
2006	The National Plan for Orphaned and Vulnerable Children identifies six key services to address children's most fundamental needs: health, education, nutritional and food support, financial support, legal help and psychosocial support. The Government of Mozambique has committed itself to ensuring that children have access to at least three out of these six services, focusing particularly on children who live below the absolute poverty line, including orphans and children living with or affected by AIDS. Implementation of the plan is coordinated by the Ministry of Women and Social Action with the support of a multisectoral technical working group and the Orphans and Vulnerable Children Technical Working Group.
2005	2006–2010 National Action Plan for Children aims to protect the civil and human rights and security of all children by developing and coordinating the activities of key stakeholders. The Family Law articulates new legal standards for parental responsibilities, guardianship, adoption and inheritance, and raises the age of marriage from 16 to 18 for both boys and girls.
2004	The Code of Civil Registration expands the period of free birth registration from 30 to 120 days after a child is born.

3. Violence, abuse and exploitation

Violence against children is a profound violation of human rights and has devastating short- and long-term mental and physical health consequences. Child victims of violence include children who have been sexually abused or subjected to violence as punishment; forced to work in intolerable conditions or trafficked into exploitative conditions of work; or forced into early marriage. This violence spans geographical boundaries and cuts across culture, race, class and religion. It can be expressed as physical or sexual assault or abuse, psychological or emotional abuse, or deprivation or neglect. The risk of violence is exacerbated by poverty, which often goes hand-in-hand with a lack of adequate protection by caregivers and limited access to essential services. Ministry of the Interior statistics reveal that more than 3,500 cases of child violence were reported to the police in 2009.³ The number of children who suffer from violence, abuse and exploitation is likely to be much higher than the number of reported cases.

The United Nations Violence Study notes that violence against children is significant in its scale, scope and under-reporting, all of which are exacerbated by societal acceptance of the phenomenon.⁴ Some forms of violence are rooted in discriminatory and unequal gender dynamics and harmful practices, and Mozambique is no exception. Available studies and data provide a basis for arguing that the existing patriarchal culture and male-dominated social order is exceptionally strong in Mozambique.⁵ Victims' low level of knowledge of their rights and a culture of silence and acceptance of violence are the key barriers to addressing the problem.

Although recent quantitative data are limited, previous surveys reported a high incidence of sexual exploitation and abuse of children and women at home, in the workplace and at school. Sexual abuse of children and women remains a major

concern in Mozambique. The 2001 National Survey of reproductive health and sexual behaviour of young people indicated that 30 per cent of women and 37 per cent of men had directly witnessed violence between their parents as a child or teenager, and that 15 per cent of women and 20 per cent of men had suffered physical abuse from a relative in their youth.⁶ A study conducted by the Ministry of Women and Social Action in 2004 indicated that as many as 54 per cent of women surveyed reported having been beaten, and 23 per cent of respondents reported having been subjected to some form of sexual abuse.⁷ Most violators are known to the victims and are often close family members and friends.

Laws to protect children and adolescents from sexual abuse leave considerable discretion to the judicial system to interpret whether a child was a victim of sexual abuse. For example, only with children under 12 are sexual relations prohibited under any circumstances (including if consent has been established) and criminal sentences can be anywhere from two to eight years. For children over twelve, the judge is given latitude to determine whether sexual abuse has occurred, even in the case of adolescent victims of abuse by adults.

3.1. Violence and sexual abuse in schools

Sexual abuse in schools is an area of particular concern, as noted by the Committee on the Rights of the Child.⁸ A 2008 Ministry of Education (MINED) survey revealed that 70 per cent of girl respondents reported that some teachers use sexual intercourse as a condition for promotion between grades, and 50 per cent of girls stated that not only teachers abuse them sexually, but also boys in their peer group. Furthermore, 80 per cent of girls recognised that sexual abuse and harassment occur

not only in schools but also in communities. Many girls did not know whether these acts were prohibited by law or where to report them when they occur.⁹

The institutional response to sexual abuse in schools is limited. The study also examined the level of awareness of MINED officials on the issue. Seventy per cent of provincial gender unit staff and 65 per cent of district gender coordinators acknowledged that sexual abuse against girls and early pregnancy were major concerns and important constraints on providing a safe learning environment for girls. School council members were also concerned about sexual abuse and harassment in school and sought strict disciplinary measures against teachers who abuse girls in school.

The MINED has a ‘zero-tolerance’ policy on sexual abuse in schools, but enforcement of this policy remains weak. In 2003, MINED issued a decree (Despacho 39/GM/2003) prohibiting teachers from having sexual relations with female students and declared ‘zero tolerance’ of sexual abuse in schools. The 2008 Mozambican Children’s Act reaffirms the duty of school management to report to the relevant authorities any cases of mistreatment of learners. However, follow-up on acts of violence in schools and implementation of the decree remain weak. Revision of the gender strategy and of decree 39/GM/2003 to emphasise reporting violence and sexual abuse is integrated into the 2010 MINED work plan. Integrating sexual abuse issues into the 2010 planning guidelines is a significant step forward and is leading to developing defined actions to strengthen the capacity of provincial gender focal points in monitoring and reporting cases of sexual abuse in schools.

Corporal punishment remains lawful at home and school and is often considered the only way to discipline children. The Committee on the Rights of the Child expressed concern that “the Child Rights Protection Law (of Mozambique) does not explicitly prohibit corporal punishment at home and in schools...that in spite of

internal regulations of the MINED prohibiting corporal punishment, it continues to be inflicted on children by teachers and parents.”

The UN Study on Violence against Children considers raising awareness essential to influencing social norms, not only for communities, including schools, but also for professionals in contact with children. Appropriate media attention also raises awareness, promotes open discussion and encourages communities to respond to cases of abuse and exploitation. Making support and rehabilitation services available are another key dimensions. Such responses are made significantly more effective by the existence of an effective coordination mechanism. In 2009, the Ministry of Women and Social Action established a multi-sectoral working group on the prevention of violence against children as a follow-up to the United Nations Violence Study and the World Congress III against Sexual Exploitation of Children and Adolescents. While the legal reform process has progressed, translation of the new legislation into effective regulations and programmes remains a challenge due to lack of funds.

The Plan of Action for the Prevention of Violence Against Children is being finalised at present. The plan outlines activities relating to protect of children from violence, neglect and sexual exploitation are in place.¹⁰ The promulgation of the 2009 Domestic Violence Act may provide momentum for strengthening mechanisms to protect women and children from sexual abuse. Civil society partners have offered awareness-raising activities at the community level, including Action Aid’s campaign against sexual abuse of girls in school.

3.2. Domestic violence

Fifty-four per cent of women who participated in a 2004 Ministry of Women and Social Action study reported having been beaten. Cultural acceptance of violence is a major cause of domestic violence.¹¹ The perpetrator of violence was most frequently

the woman's husband or a close relative or acquaintance. Ten per cent of respondents reported having been subjected to some form of sexual abuse. Higher levels of violence against women were reported in rural areas than in urban areas.ⁱ

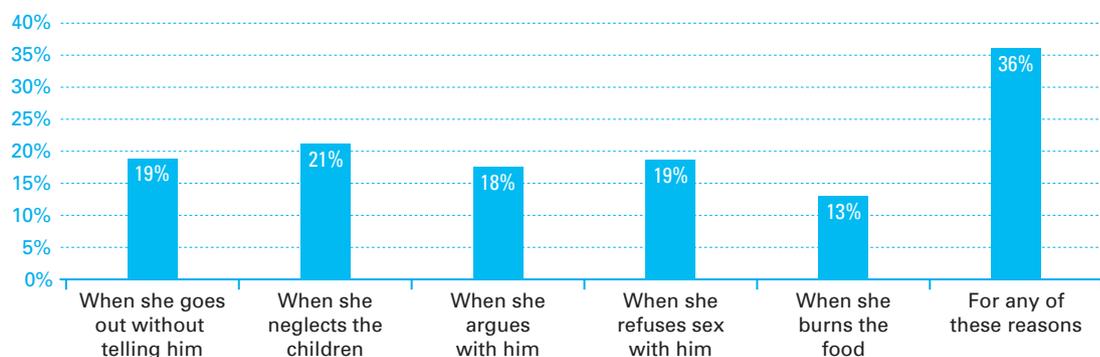
The proportion of women who feel that men have the right to beat them under certain circumstances has dropped from 54 per cent in 2003 to 36 per cent in 2008.^{ii, iii} While the reduction is positive, the acceptance of violence by women remains very high. The reason most commonly cited in the 2008 MICS as justification for wife-beating is the perception by the husband that the wife is neglecting the children. This reason was cited by 21 per cent of respondents (see Figure 5.1).

Regional disparities in attitudes toward domestic violence exist. Education of men and women is the key factor in reducing violence against children and women. The

percentage of women who believe that wife-beating is justified in certain circumstances varies from 10 percent in Maputo City to almost 70 per cent in Niassa province (see Figure 5.2).¹² The 2008 MICS also notes that 24 per cent of women who attended secondary school and higher accept violence, compared to 38 per cent of women who have never attended school. The 2004 Ministry of Women and Social Action study concluded that these differences are strongly related to socio-cultural norms and practices as well as lack of education and knowledge of the rights of women and children in society.¹³

A multivariate probabilistic regression analysis was conducted to examine the factors correlated with women's acceptance of domestic violence (see Figure 5.3). The dependent variable is whether a woman (15 to 49 years old) accepts being beaten by her husband. The analysis revealed that women with secondary or higher education

Figure 5.1: Percentage of women aged 15–49 who think that a husband can beat his spouse, by specific reason, 2008



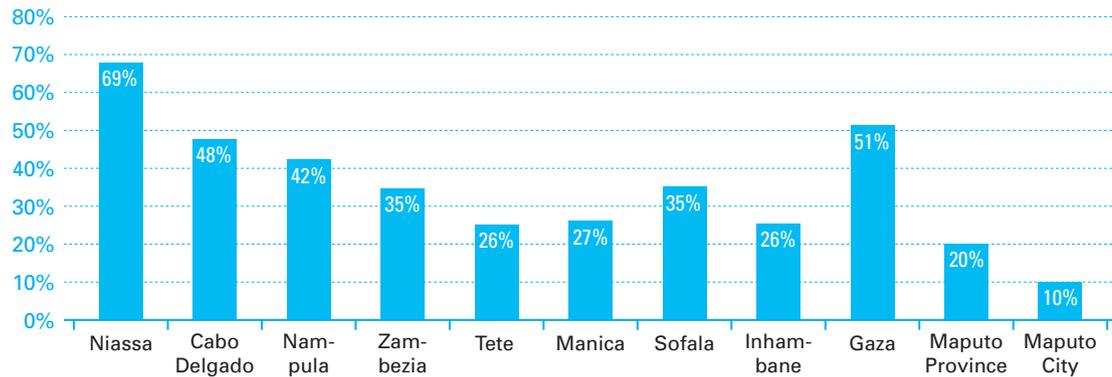
Source: MICS 2008.

ⁱ The Study, conducted in 2004 for the Ministry by the Eduardo Mondlane University, Centro de Estudos da População, included 2052 women aged 18–45 in Maputo City, Maputo province, Sofala, Manica, Zambezia and Nampula (the Universidade Eduardo Mondlane 2004).

ⁱⁱ This is significantly lower than the average in eastern and southern African countries, where 65 per cent of girls and women aged 15–49 think that a husband is justified in hitting or beating his wife under certain circumstances. Source: UNICEF, *Progress for Children - A Report Card on Child Protection, Number 8*, UNICEF, New York, September 2009.

ⁱⁱⁱ The DHS indicator is the percentage of women aged 15 and 49 who said that it would be justifiable to be beaten by their husband for one or more of the following reasons: stealing food, arguing with husband, leaving the house without informing the husband, refusing sex with husband, and/or not looking after children.

Figure 5.2: Proportion of women aged 15-49 who believe that wife-beating is justified under certain circumstances, 2008

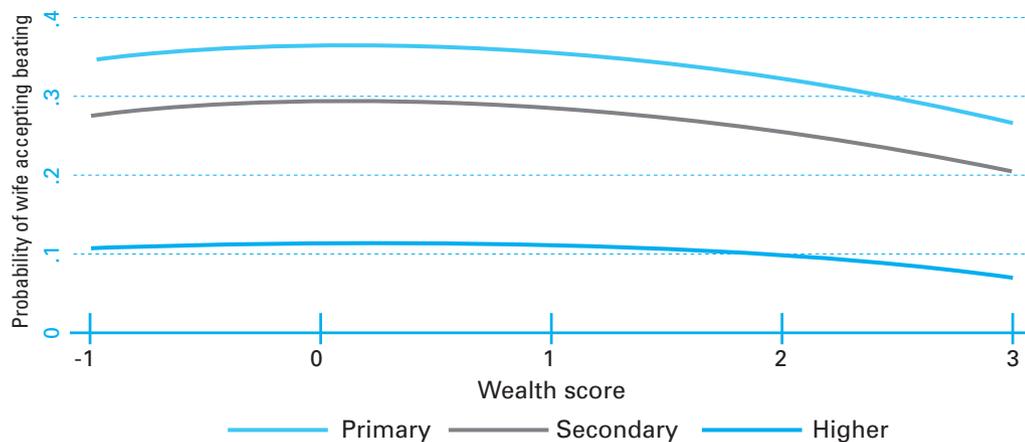


Source: MICS 2008.

are far less likely to consider wife-beating acceptable than women with no education. Having primary education, however, does not appear to influence women's attitudes. Wealth is found to be statistically related to women's protection only at very high levels (see Figure 5.3), which very few households attain. Given the enormous challenges in promoting women's wealth to this level, promoting access to education may be the more feasible policy response to adjusting women's attitudes to domestic violence.

The model shows no statistically reliable differences in attitudes to domestic violence among women in polygamous versus monogamous relationships. Neither does the age of a woman, or a difference in ages between husband and wife. In terms of geography, all women living in provinces other than Maputo City (especially in the north) show a higher likelihood of accepting violence, while there seems to be no difference in attitudes between rural and urban women.

Figure 5.3: Probability of women aged 15-49 accepting domestic violence, by socio-economic background, 2008



Source: UNICEF calculations based on MICS 2008

Breaking the culture of silence on abuse of children and women requires open dialogue, increased awareness and protective external systems to intervene when abuse is identified. This is not easy to do where gender-based violence and sexual abuse, especially of children, are condoned by some communities and individuals. Despite the progress made in strengthening the Government and developing a comprehensive legal and policy framework to protect children from violence, abuse and exploitation, the limited capacity of Government to enforce such laws and the limited knowledge of community members about the issues allow such practices to continue unabated. Furthermore, customary law often prevails in many rural areas of the country, particularly in relation to marriage and inheritance. Addressing social conventions and norms that contribute to violence, exploitation and abuse is the first step towards halting such practices in Mozambique.

3.3. Commercial sexual exploitation and abuse

Although data are extremely limited, evidence suggests that commercial sexual exploitation and abuse of children does occur in Mozambique. Children are often forced to engage in commercial sexual acts to obtain help from adults in meeting their expenses or as a coping strategy for extreme poverty. Victims of commercial sexual exploitation commonly are poor and have suffered some degree of prior violence or abuse. While commercial sexual exploitation occurs with both boys and girls, girls are considered to be more commonly the victims. One study also found peer group pressure to be an important factor in introducing girls to the child commercial sexual exploitation industry.¹⁴ This same study found that girls suffering from sexual exploitation are at further risk as they engage in sex without a condom for

greater economic benefits. Many children who are exploited in commercial sexual take drugs to cope with the situation and this also affects condom use.¹⁵ Perpetrators of commercial exploitation of children come from all walks of life: local community members, national and foreign tourists in Mozambique's resorts and transport drivers in towns and on main roads.

3.4. Child trafficking and migration

In a report published in 2002/03 by the International Organisation on Migration (IOM) it was estimated that approximately one thousand children and women are trafficked to South Africa every year for the purpose of exploitative labour and commercial sexual exploitation.¹⁶ The trafficking of children not only removes them from the protective environment of their family, but also increases their vulnerability to violence, exploitation and abuse.^{iv} It is also suggested that trafficking of persons is linked with the extraction of human organs for ritual purposes, though this is still disputed by government agencies.¹⁷

In a study published by Save the Children in 2009, children's responses suggest that internal trafficking and exploitation in Mozambique usually occur by means of 'trickery', fraud or deception, perpetrated largely by children's relatives and peers.¹⁸ Child trafficking usually occurs within a wider regional context and can only be effectively combated by strengthening regional and cross-border mechanisms for a multifaceted and coordinated response tailored to regional and national differences. For example, the Southern African Regional Police Chiefs' Cooperation is working together with the Southern African Development Community on counter-trafficking measures, including regional police training.

^{iv} Trafficking refers to the illegal transport of human beings, in particular women and children, for the purpose of selling them or exploiting their labour.

Voluntary child migration is often driven by poverty or as a result of being orphaned or abandoned. Children in Mozambique move to cities from villages or sometimes cross illegally and unaccompanied into neighbouring countries, mainly South Africa, in an attempt to improve their own lives or the lives of their families. These patterns of migration make both boys and girls vulnerable to abuse and exploitation on their journeys and at their destination. A 2008 Save the Children report¹⁹ compiles the experiences of migrant children in the sub-region, and indicates that girls in particular travel to South Africa from Mozambique in search of work, but end up being sexually abused and exploited. Those who cannot find employment and are unable or unwilling to return to Mozambique sometimes resort to sex work in the absence of alternative options.

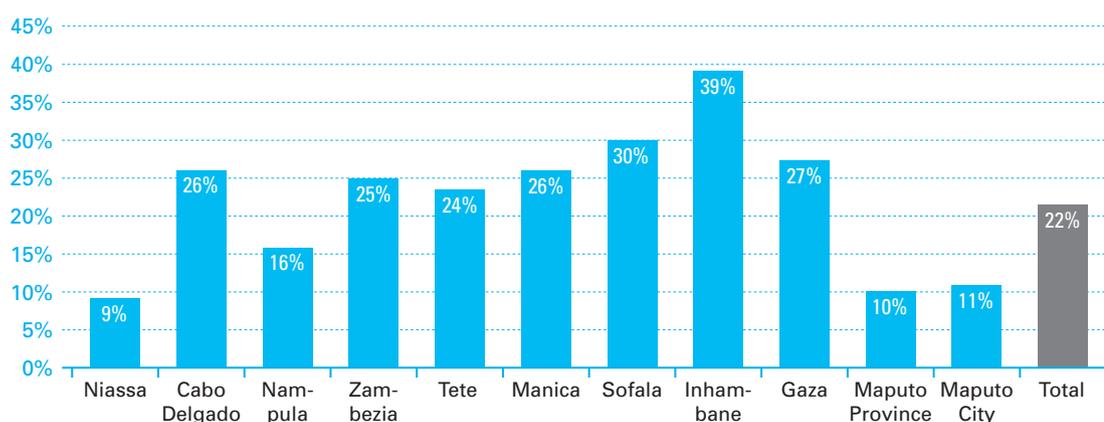
3.5. Child labour

Child labour is another serious form of abuse and exploitation in Mozambique. Data reveal that 22 per cent of children aged 5–14

are involved in child labour, with a large disparity between urban and rural areas (15 per cent and 25 per cent, respectively).^{20 v} The proportion of children involved in child labour also varies by the age of the child: one in five children aged 5–11 are engaged in child labour, rising to one in four children aged 12–14. Disparities across provinces are apparent; almost 40 per cent of children in Inhambane are involved in child labour, compared to less than 10 per cent of children in Niassa.

The prevalence of child labour is linked with the mother's level of education. Twenty-four per cent of children whose mothers have no schooling are involved in child labour, compared to 10 per cent of children whose mothers were educated to at least secondary level. The prevalence of child labour is slightly higher among girls (24 per cent) than boys (21 per cent). Also, girls work more than boys in support of domestic tasks (8 per cent against 5 per cent, respectively). The percentage of children who work to support household businesses is the same for both sexes (16 per cent). There is not a strong

Figure 5.4: Percentage of children aged 5–14 who are involved in child labour by province and gender, 2008



Source: MICS 2008.

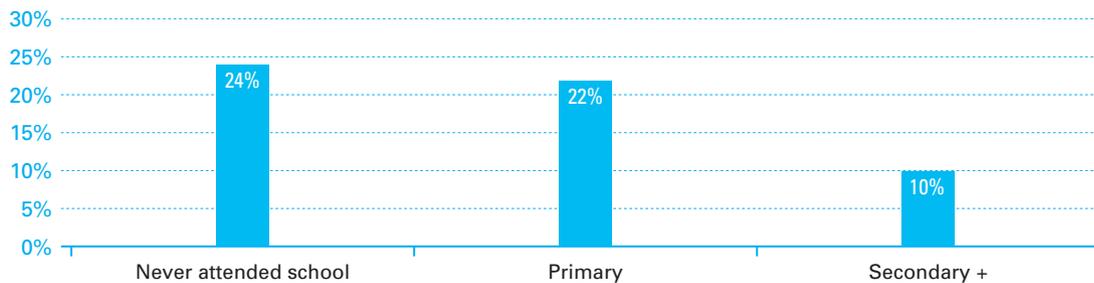
^v A child is considered involved in child labour if, during the week prior to the survey, he/she was involved in: (i) at least one hour of economic work or 28 hours of domestic work per week, if the child is 5–11 years old, (ii) at least 14 hours of economic work or 28 hours of domestic work per week, if the child is 12–14 years old.

correlation between wealth and child labour. Prevalence of child labour is relatively stable for the bottom four quintiles, and only reduces for the best-off families. A 2009 study indicates that child workers are further exploited by poor working conditions, including verbal and sexual abuse, and wages paid late or not at all.²¹

MICS 2008 reveals that 86 per cent of children who work in urban areas also attend school, compared with 76 per cent in rural areas. Almost 30 per cent of students in rural areas are involved in some type of child labour before or after school.

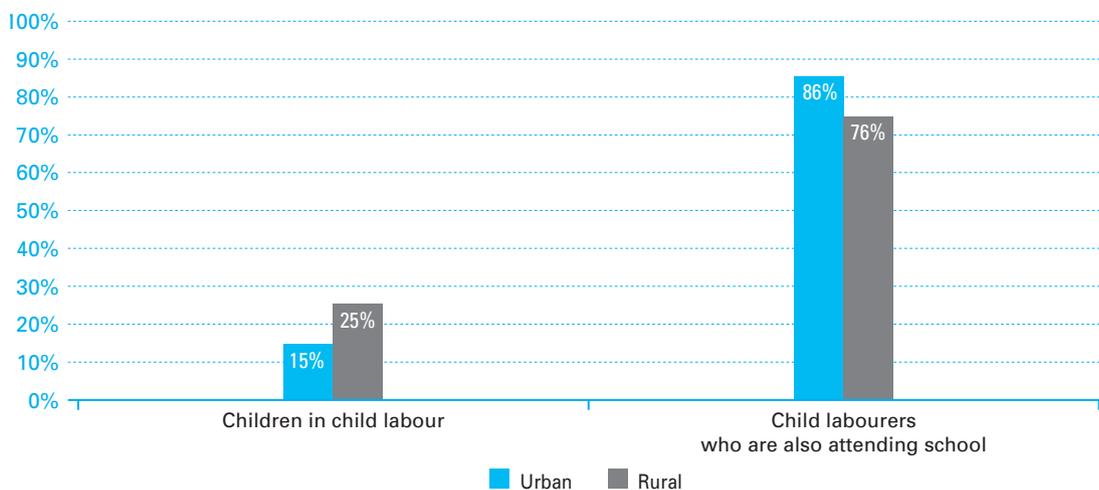
In Mozambique, the Ministry of Labour is responsible for guiding and coordinating actions related to child labour. National responses to child labour focus on four areas: developing national legislation that reflects the international standards that Mozambique has ratified; developing effective enforcement mechanisms for existing and complementary legislation, including legislation on compulsory education; enhancing the capacity of government institutions and other actors to identify and act upon the issue of child labour; and finally, raising awareness of the issue among the general public. The

Figure 5.5: Prevalence of child labour by level of mother's education, 2008



Source: MICS 2008.

Figure 5.6: Child labour and school attendance by geographic area, 2008



Source: MICS 2008.

effectiveness of initiatives will be enhanced by a greater commitment to collecting data on the nature (including the gender dimension) and dynamics of child labour in Mozambique.

The 2008 Children’s Act prohibits child labour and any form of work for children under 15 and provides for punitive measures to be taken against the employer. The Children’s Act also defines prohibited forms of work, including commercial sexual exploitation and work that could be harmful to the health and well-being of the child. However, effective enforcement requires dissemination of the act to all stakeholders, as well as considerable capacity strengthening of all authorities charged with implementing its provisions. Finally, economic and social pressures that compel parents to force their children into exploitative child labour must be addressed through more effective social protection.

Reducing the burden of work on children depends on ensuring that children and their families, particularly the poorest and most vulnerable, benefit from poverty reduction programmes. As long as child work remains an economic necessity for certain households, the Government should focus on ensuring that any economic activity

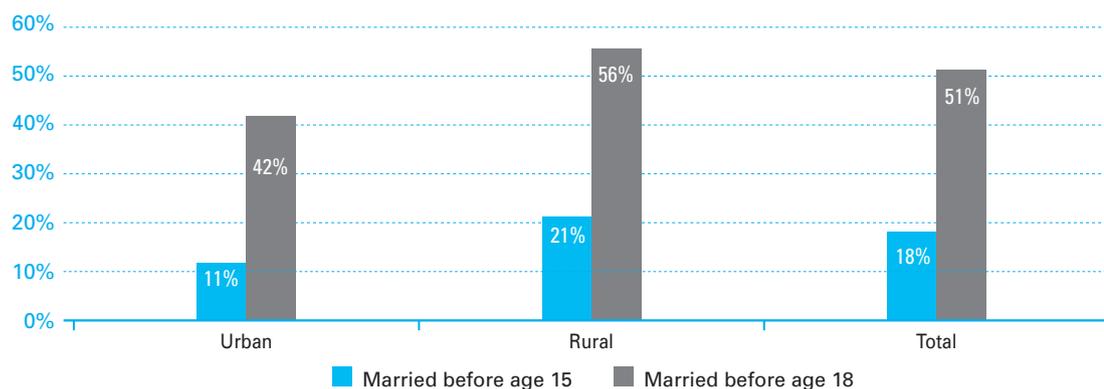
undertaken is appropriate for the age and capacity of the child and that it in no way compromises his or her survival, health, education, development or overall well-being.

3.6. Child marriage

In Mozambique, marriage before the age of 16 is illegal. Under the Family Law of 2004, the Government of Mozambique raised the legal age of marriage without parental consent from 16 to 18. The minimum age at which marriage can occur with parental consent was raised from 14 to 16. Nevertheless, capacity to implement the law is limited, and traditional marriages under customary law continue to present a challenge to establishing 18 as the minimum age of marriage. In many communities, girls are considered to be ready for marriage on reaching puberty.²²

Recent data revealed that 18 per cent of girls aged 20–24 were married before they turned 15, with 51 per cent of them married before they turned 18.²³ The proportion of girls entering into child marriages has dropped slightly since 2003. There are significant differences in the rates of child marriage among the southern, central and northern regions of Mozambique: the southern

Figure 5.7: Women aged 20–24 who were married before ages 15 and 18, by geographic location, 2008



Source: DHS 2003 & MICS 2008.

provinces of Gaza, Inhambane, Maputo and Maputo City all have a child marriage rate of below 10 per cent; the central provinces have an average rate of 20 per cent; while Niassa and Cabo Delgado in the north have rates of 24 and 30 per cent, respectively.

Child marriage is not only a serious contravention of a child's rights in and of itself, but also seriously compromises the realisation of a range of other rights. For example, marriage during adolescence may have serious health implications for a girl. Adolescent pregnancy and childbirth are associated with poor health and nutritional outcomes for both the mother and her children. This is particularly true for very young, first-time mothers.²⁴ Married adolescents often receive less information on reproductive health than their unmarried peers.²⁵ Married girls are much less likely than their unmarried peers to attend school, and girls are often removed from school in order to marry or as a result of being pregnant, which can sometimes be related to sexual abuse.²⁶

Child marriage is influenced by traditional gender relations and the values assigned to women and girls in society. Marriage may reflect the value placed on a girl's virginity and be regarded by parents as a means to prevent premarital sexual relations and pregnancy. In communities, many girl victims do not report cases of sexual abuse to the authorities partly because of the stigma and myth that surround the issue

of sexual abuse. Even when police or other authorities want to pursue a case of sexual abuse, the parents often halt the proceedings because they consider it an issue to be solved within or between families. The lack of a rigid legal instrument to penalise cases of sexual abuse further exacerbates the problem.

In many cases, child marriage, for both boys and girls, has an economic motivation. Child marriage is a survival strategy to relieve the family of what they perceive to be a financial burden in the face of severe poverty. Although economic status is a factor in child marriage, it is not the sole motivation. Prevalence of child marriage is also linked to the cultural practices of specific ethnic groups.²⁷ Although campaigns to raise awareness of sexual health and pregnancy are conducted at schools, condom use is still low among children. Marriage is sometimes arranged at an early age with girls entering their husband's house at puberty. Effective mapping of child marriage within Mozambique by ethnic group would support programme efforts and enhance the effectiveness of prevention campaigns.

Polygamous relationships are also common in Mozambique, with almost a quarter of women aged 15-49 in a polygamous relationship.²⁸ Though polygamy is not legal in Mozambique, it is particularly prevalent in the central provinces, with around a third of women in Manica, Tete and Sofala in such unions.

4. Children and the justice sector

The need to improve the justice sector has been recognised as a key priority for enhancing child protection systems by both the Government and civil society in Mozambique. This includes protecting children who come into contact with the justice system as victims, witnesses or offenders towards the end of impunity for crimes against children. Important progress has been made, including the establishment of a children's section in the court in three provinces and creation of more than 200 Police Victim Support Centres (Gabinetes de Atendimento à Mulher e Criança) across all provinces. The creation of these new support structures has helped to ensure that child rights are protected and that children are treated in a child-friendly and gender-sensitive manner when they come into contact with the justice system, in line with international norms and standards.

Justice systems are not yet effective for most children. In the 2009 concluding observations of the Committee on the Rights of the Child noted in Mozambique's second periodic report, for example, perpetrators of violence and abuse are rarely brought to justice, incarceration of children who are in conflict with the law is not used as a measure of last resort and pre-trial detention is frequent.²⁹

The Ministry of Justice and the Ministry of the Interior have insufficient financial and human resources to improve the effectiveness of the system for children. State budget allocations in 2008 to the Ministry of Justice and the Ministry of the Interior, which includes the police, were two and three per cent respectively, with limited resources targeting children and youth justice programmes.

Mozambique has made great strides in the area of legislative reform, bringing national legislation further in line with the Convention on the Rights of the Child.

Certain internal inconsistencies remain to be addressed, and initiatives and preventive measures, particularly in relation to children in conflict with the law, need to be strengthened, including the application of alternative corrective measures that are in line with international standards. Children in conflict with the law in Mozambique often do not benefit from protection as stipulated in international instruments, including Articles 37 and 40 of the Convention on the Rights of the Child, the Beijing Rules for the Administration of Juvenile Justice (1985), and the Riyadh Directives for the Prevention of Juvenile Delinquency (1998).

Children in conflict with the law are often placed in adult prisons, though the law stipulates that they should be placed in separate quarters. The police have the authority to detain minors who have allegedly committed an offence for a maximum of 30 days, following which the child must be presented in Minor Court or Civil Sections. Ideally, a transition centre or intermediate facility should be used and special considerations should be given to ensure that such cases are brought to the courts in a timely manner. However, this is not common practice in Mozambique.

Prison policies requiring that prisoners be separated by gender and age and ideally housed in separate facilities are frequently not adhered to, and safe and sanitary conditions in prisons are a problem.³⁰ The National Prison Service reports that no centres for children in conflict with the law are currently operational; one has been rehabilitated (Centro de Reabilitação Chiango) but is not functioning due to resource constraints. Three juvenile detention centres for minors aged 16–18 (as well as youths up to 21, and exceptionally up to 25) are planned or operational. These facilities are located in Nampula, Matutuine in Maputo province (still under construction), and Beira (planned).

Thirty-five per cent of the total prison population in Mozambique is 16–21 years old. Data issued by the National Prison Services on minors aged 16–18 in conflict with the law reveal that 898 males and 8 females are currently in prisons nationwide. There is only one prison for women, located at Ndlavela in Maputo, with a capacity to house about 300 prisoners; however, there are female sections in all provincial prisons. In 2008, there were 297 female prisoners out of a total prison population of 14,309. The Access to Justice Study conducted as part of the PARPA II evaluation (2009) reports that the Government is making efforts to afford special treatment to women and minors; however, these efforts are not yet being translated into practice according to the objectives of the prison policy and the minimum rules and standards of international instruments.³¹

To protect vulnerable women and children and promote access to justice, the Government has decided to improve the capacity of the justice sector by prioritising the constitutional right to representation. To that effect, allocation of funds to the Legal Aid Institute (Instituto do Patrocínio e Assistência Jurídica [IPAJ]) has increased and it was included in the state budget for the first time in 2008. Recruitment of professional staff during 2007 and 2008 brought the number of employees receiving a state salary up from 10 in 2002³² to 138 by the first semester of 2008.³³ During the same period, the total number of IPAJ staff members increased from 360 to 700. The coverage of services provided by IPAJ has increased from 41 branches in 2005 to 57 by the first semester of 2008. The number of persons benefiting from these services increased from 7,327 in 2007 to 9,615 in the first half of 2008.^{34, 35}

4.1. Children's access to property and inheritance

Women and children's rights to property and inheritance are threatened by the AIDS pandemic, as an increasing number of widows and orphans are faced with property grabbing. In Mozambique, the succession

laws established in the Succession Book of the 1966 Civil Code grant equal rights to female and male heirs. Under customary law, however, men are better protected and widows are vulnerable to property grabbing.

A study in four provinces of Mozambique revealed that widows and orphans tend to suffer some kind of material loss after the death of their husband or father.³⁶ Because inheritance is seen as a private, family matter, other members of the community usually choose not to interfere in such cases. A 2009 follow-up study reported that most of the research addressing the issue of property grabbing focuses on legal aspects of succession and noted that there is a lack of quantitative data on the status of children and women's property rights.³⁷ The study highlights the need for: (i) an assessment of the extent of property grabbing from children and widows in Mozambique, (ii) prevention of property grabbing, (iii) ensuring that widows and their children receive justice, either through local conflict resolution mechanisms or within the formal legal system. To address these needs, advocacy to promote changes in legislation and government policies and to improve community monitoring and support and promote behaviour change at the community level are required.

4.2. Birth registration

Birth registration gives a child legal existence and authority to claim citizenship and the rights, benefits and obligations that accrue from citizenship. As such, birth registration is recognised as a right by the Convention on the Rights of the Child (Article 7) and by the African Charter on the Rights and Welfare of the Child (Article 6). Mozambique's obligation to register children immediately after birth is legally recognised in the Civil Registry Code. Lack of birth registration violates children's inalienable human right to an identity and puts their development and protection at risk.

Birth registration is especially important in the context of the AIDS pandemic that is leaving an increasing number of

children without parental care. Lack of a birth certificate can result in problems in determining family connections, legal relationships and inheritance rights and can lead to difficulties in accessing basic social services, including school enrolment and social assistance. Although the use of a birth registration for children is currently only at a rudimentary stage in Mozambique, the modernisation process and the introduction of the district as the centre of development is rendering a legal identification document more and more important for legal protection and for preventing socio-economic exclusion, especially of the most vulnerable in society.

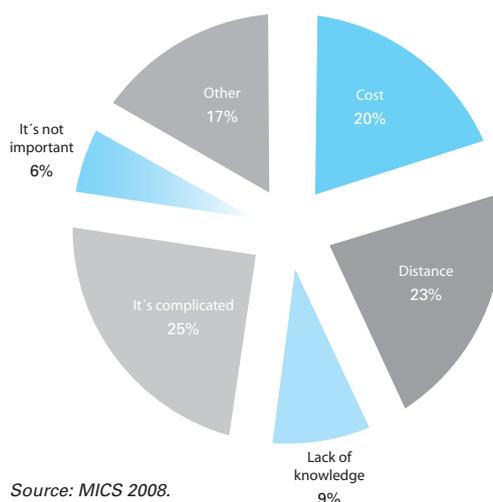
Mozambique has significantly increased access to birth registration services across the country. A national plan of action on birth registration was developed in 2004, and birth registration is an integral part of the 2006–2010 national plan of action for children. A long-term birth registration campaign was launched in 2006 by the National Directorate of Registry and Notaries at the Ministry of Justice. The campaign's objectives are to clear the extensive backlog of unregistered children, increase awareness of the

importance of (early) registration and improve public access to birth registration services by bringing them closer to the population.

Since the adoption of the national plan of action on birth registration and the launch of the campaign, about 4.2 million children under 18 have been registered.

This represents 40 per cent of all children in Mozambique. The proportion of children under five who have had their birth registered from 8 per cent in 2003³⁸ to 31 per cent in 2008.^{vi} There are significant geographical disparities in registration: 39 per cent of children under five had their births registered in urban areas compared to 28 per cent in rural areas; and while 47 per cent of children under five are registered in Maputo City, only 11 per cent are registered in Tete province. The survey also found that respondents cited the main barriers to registration as the complicated procedures involved (25 per cent), distance to registration services (23 per cent) and expense (20 per cent), with only a relatively small proportion citing lack of knowledge of the service (9 per cent) or failure to see the importance of birth registration (6 per cent). (See Figure 5.8).

Figure 5.8: Reasons for not registering births, 2008



^{vi} Not all districts surveyed had undertaken birth registration activities at the time of the survey, and as a result the data potentially underestimate the national average.

In a country with low literacy rates (with illiteracy rates highest and registration rates lowest in rural areas), community-based radio has played a key role in mobilising families to register their children.

Spots produced and broadcast in local languages provide strong communication channels for local activists, who work not only to disseminate the basic facts on birth registration, but also to help families overcome some of the socio-cultural barriers to timely registration of newborns. In some communities, for instance, traditional naming practices can extend well beyond the 120-day period during which births can be registered free of charge. The cultural impediment to mothers registering a child without the presence of the father is another challenge, especially in cases where the father is absent from home for long periods of time, e.g., due to migration work.

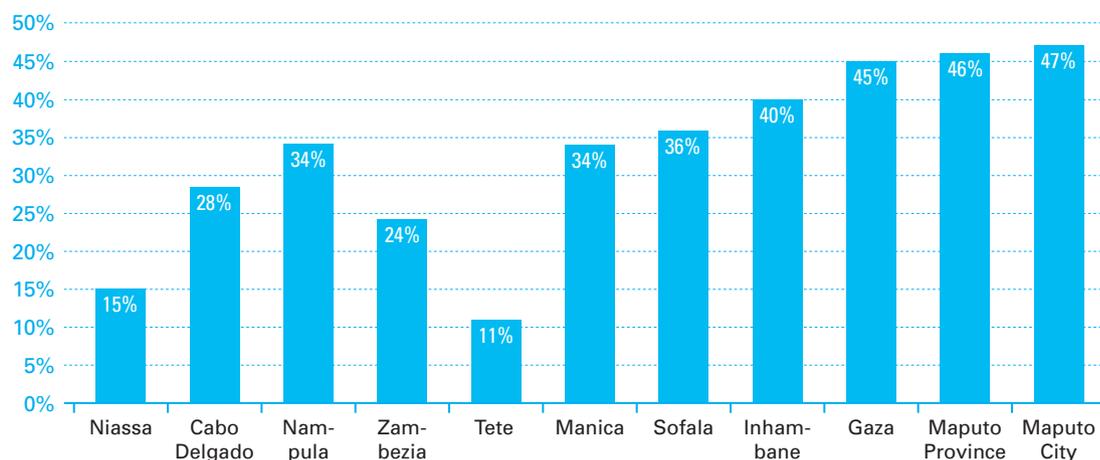
The birth registration campaign activities lend critical momentum to the introduction of routine birth registration services that bring registration services closer to the community and prevent a future registration backlog by establishing a culture of (early) child registration. Long-term, sustainable, routine solutions are being developed with

the involvement of the Ministries of Health, Education, State Administration and Women and Social Action. Close cooperation with these state agents will be important in establishing an effective, efficient and sustainable system with a specific focus on registration at birth. For the short to medium term, until the above-mentioned Ministries have the institutional capacity to lead the registration process, alternative registration services are being offered by local registration agents that link communities and Government and facilitate establishment of a culture of early child registration.

4.3. Children with disabilities

Mozambique is not a signatory to the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol. The national policy for persons with disabilities makes the Ministry of Women and Social Action responsible for promoting the effective integration of children with disabilities into preschool activities, and guaranteeing the social protection of persons with disabilities and their families by means of measures to encourage their autonomy and integration into the community.

Figure 5.9: Percentage of children under five whose birth was registered by province, 2008



Source: MICS 2008.

The state food subsidy programme (a small monthly cash payment to especially vulnerable people) is only available to citizens over 18, and therefore excludes disabled children.³⁹ The national education policy foresees the possibility of children with mild disabilities attending regular schools and children with more serious disabilities attending special schools. According to “Education and Child development,” children with disabilities are 40 per cent less likely to attend primary school than non-disabled children. Data indicate that 13 per cent of children aged 2–9 are living with at least one disability (see Figure 5.10).⁴⁰ The most common disability reported was delay in sitting, standing or walking (6 per cent of children).

4.4. Alternative care mechanisms

In practice, Mozambique has two types of alternative care systems: formal and informal. The Government of Mozambique encourages strengthening of the protective role of families as the first step towards realising children’s rights. However, specific actions are needed to address alternative care mechanisms for children who are not under parental or familial care.

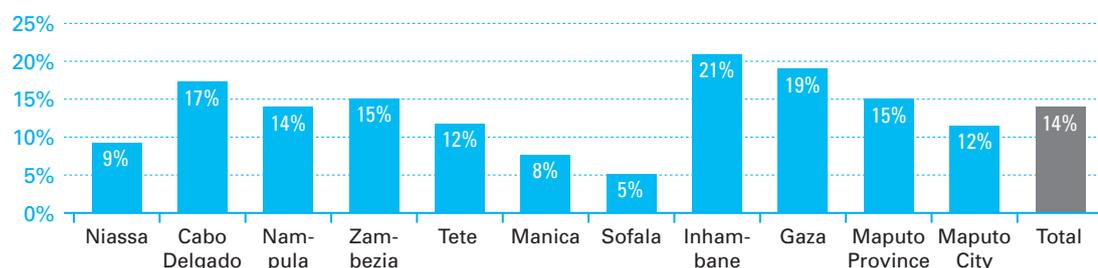
The traditional alternative care systems are increasingly pressured due to societal changes arising from economic development, migration and urbanisation

and the AIDS pandemic. Extended families and communities have historically been the first line of response to the situation of orphans and vulnerable children in Mozambique.

Formal care falls under civil jurisdiction in the form of guardianship (tutor), foster care (família de acolhimento) and adoption. Under Mozambican law, decisions regarding formal care are taken through a judicial authority and in accordance with the principle of the best interest of the child, and placement in foster care or institutions is used only as a last resort. Residential care is also considered a means of formal care; however, the decision to place a child in an institution is mainly taken through administrative procedures under the responsibility of the Ministry of Women and Social Action. Recently, draft residential care regulations (Regulamento dos Centros de Acolhimento da Criança) have been developed to ensure quality of childcare services and the application of minimum standards, and these are pending final approval by Ministry of Women and Social Action. This regulatory framework also specifies how inspections are to be undertaken and how children’s well-being is to be monitored in these institutions.

The concept of the foster family for children without parental care was introduced by the Family Law. However, implementation procedures and regulations need to be developed in order to take the initiative

Figure 5.10: Percentage of children aged 2–9 with at least one reported disability, 2008



Source: Calculations based on MICS 2008.

forward. There is also a need to: (i) improve the network of child institutions and boarding-type child institutions, transferring state child institutions into family-based support centres; (ii) create a system of alternative care services (community and family-based services, guardianship, trusteeship, fostering, adoption); and (iii) implement mechanisms to expand and stimulate the integration of children into family care (both biological or alternative).

Current legislation makes no distinction between inter-country adoption and domestic adoption. Adoption procedures need to be harmonised across institutions and Ministries to ensure adequate placement procedures and supervision during the period of integration. As for inter-country adoption, Mozambique has not signed the Hague Convention No. 33 on the Protection of Children and Co-operation in Respect of Inter-country Adoption 1993 or any other bilateral agreements on adoption, and this represents a gap in the legal framework. Ratification of the Hague Convention on Adoption will create the necessary legal framework to ensure due process for adoption cases and also that the best interest of the child remains paramount. Signing of the Hague Convention was recommended by the Committee on the Rights of the Child in 2009.⁴¹

There is a need to provide comprehensive information about adoption to the general public, to develop specific regulations for domestic and inter-country adoptions, and to harmonise adoption procedures with the Convention on the Rights of the Child and other relevant global agreements so as to ensure supervision of the adoption process by Social Welfare Services and appropriate judicial bodies. For instance, while the Children's Act adopts the Convention on the Rights of the Child definition of a child as any person up to age 18, the Civil Code sets the age of adults at 21. Attempts to bring other aspects of national legislation in line with human rights standards are on-going.

While in Mozambique quantitative data about the placement of vulnerable children in different types of care are limited, there is evidence that residential care centres are proliferating. As of 2010, data recorded by the Provincial Directorates of Women and Social Action indicated a total of 12,767 children being cared for in 143 residential institutions across the country. During 2009 and 2010, the Ministry of Women and Social Action assessed 113 of these institutions to determine the quality of care and services received by children. It was found that most centres were not legally registered and most lacked sustainability and depended on external aid or donations. Furthermore, most centres do not provide occupational activities and do not have an exit program for children up to age 18. Employees lack sufficient knowledge and skills on childcare and child development. Actions are under way in every province to address issues encountered in the monitoring visits. While much remains to be done, there has been some progress: a national data base to track the situation of each centre has been developed, and a series of training workshops have been carried out with centre staff to address human resource shortcomings.

4.5. Orphaned, vulnerable and other marginalised children

Children's vulnerability is not limited to their orphan or non-orphan status, nor is it solely linked to being affected by HIV or AIDS.

Children who have lost parents to AIDS are part of a much larger group of children who face severe and urgent needs. It is the interlinked triple threat of AIDS, poverty and food insecurity that renders a wide range of children vulnerable. Indeed, analysis shows that in settings of widespread destitution differences between orphans and non-orphans do not emerge, or are very small compared to the deprivation and suffering that all vulnerable children confront.⁴²

Consequently, some experts recommend re-defining the target group for a social protection intervention from 'orphans' to

a broader group of vulnerable children, though such a step would have challenges of its own, such as reaching consensus on where to set limits or potentially significantly increasing the number of beneficiaries of existing programmes.

At present, the number of children orphaned by AIDS has been adopted as a marker to gauge the severity of the impact of the epidemic on children, families, communities, and on the country in general. Providing support to children who have lost parents was, and continues to be seen as an imperative. In the context of HIV and AIDS, children are considered Orphaned or Vulnerable Children (OVC) if one or both of their natural parents is dead, if there was an adult death in their household during the previous 12 months after a prolonged illness, if they live in households headed by chronically ill adults, or if they live in households headed by other children, youths, women or elderly persons.

There are an estimated 1.8 million orphans in Mozambique, 510,000 of whom have been orphaned due to AIDS.⁴³ The number of orphans is expected to rise, with AIDS-related illnesses increasingly becoming the primary cause of orphanhood. The number of orphans does not take into account additional children who may be vulnerable due to living with HIV or living in households that include people living with HIV. There are 100,000 children aged 0–14 living with HIV.⁴⁴ MICS further states that 17 per cent of Mozambican children are orphaned or made vulnerable due to AIDS.

The legislative framework for guiding the national response to OVCs comprises two main action plans: the National Action Plan for Children 2006-2010, and the Action Plan for Orphaned and Vulnerable Children (PACOV). The PACOV also applies to children made vulnerable due to factors other than HIV and AIDS. It includes those living on the street, living in institutions (orphanages, prisons, mental health institutions), in conflict with the law, living with disabilities, victims of violence, victims of abuse and

sexual exploitation, victims of trafficking, victims of the worst forms of child labour, married before the legal age, and refugee or internally displaced children.

The PACOV has identified six key services to address children's most fundamental needs: health, education, nutritional and food support, financial support, legal help and psychosocial support. The Government of Mozambique has committed itself to ensuring that children have access to at least three out of these six services, focusing particularly on children who live below the absolute poverty line, including orphans and children living with or affected by HIV and AIDS. In addition to the PACOV, the 2005–2009 poverty reduction strategy (PARPA II) also included specific targets for OVC, including the need to develop and consolidate social safety nets for orphaned children and ensuring that the ratios of school attendance and malnutrition among orphaned children are the same as among non-orphaned children.

Some of the child protection threats facing orphaned children include: an increase in sibling or child-headed households, lower school enrolment and performance, and increased risk of sexual abuse and HIV infection, hazardous child labour, early sexual activity and marriage, severe psychosocial problems and poor health and nutrition.⁴⁵ Furthermore, stigma and discrimination against people affected by AIDS remains a challenging issue. Children and young people with sick or dying relatives are particularly exposed to stigma. They may be ostracised by their communities and receive minimal support from their families due to the shame and stigma that are currently associated with an AIDS-related death. In schools, discrimination against children is expressed through teasing and bullying. In some cases, children avoid their HIV-positive peers due to fear that they may become infected.

MICS found that twelve per cent of Mozambican children are orphans (of whom 11 per cent were single orphans and 1 per cent were double orphans), while another 6 per cent were considered 'vulnerable'.⁴⁶

Geographic differences were also observed, with more OVC living in urban than rural areas (20 and 16 per cent, respectively), and in the southern provinces than the central and northern regions of the country (see Figure 5.11). Only 68 per cent of children were living with both parents in 2008.

There is no evidence of a higher rate of severe education deprivation for OVC than for non-orphans. However, there is a difference in the school attendance rates of double orphans and non-orphans, with male double orphans and female double orphans having a school attendance ratio to

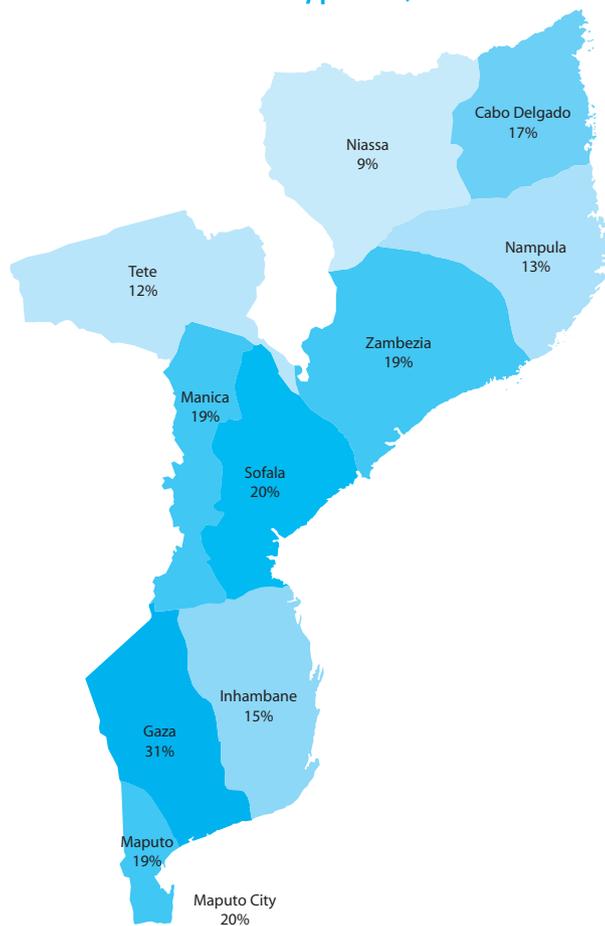
their non-orphaned peers of 0.90 and 0.92 for boys and girls respectively.

The MICS further shows that only 22 per cent of households with OVC receive any external support; most of this goes for education, with two per cent of households receiving material or financial support and less than one per cent receiving medical support. Only 20 per cent of children from the poorest quintile receive free external support, as compared to 27 per cent in the second poorest quintile.

Orphaned and vulnerable children are likely to live in poor households headed by elderly people. The MICS found that 10 per cent of households are headed by an elderly person, over half of whom have at least one child dependant. A study conducted in 2006 found that meeting the costs associated with childcare was an impossible burden for the elderly: caring for an orphaned or vulnerable child cost an average of US\$ 21 per month and caring for someone living with HIV cost \$US 30, while elderly people had an average monthly income of \$US 12.5.⁴⁷

Some households are also headed by a child, or have a child who must act as the main provider due to the illness or disability of the adult family members (approximately one and two per cent, respectively, according to the MICS). In such situations, children typically have very limited means of generating income and thus often have to resort to risky coping strategies, such as early marriage, transactional sex and hazardous child labour. They also have limited access to basic services such as health, education, food, or legal, financial and psychosocial services. In addition to these challenges, children orphaned as a result of AIDS are often living with social stigma and discrimination, and potentially face exclusion from their communities. For example, a study by the Ministry of Planning and Development conducted in 2005 established that within poor households, discrimination exists in the allocation of resources to children who are not biological descendants of the household head. The study found that children with no direct biological relationship to the household

Figure 5.11: Percentage of orphans and vulnerable children due to AIDS by province, 2008



Source: MICS, 2008.

head were discriminated against in terms of their access to education, in both rural and urban areas.⁴⁸

The 2003 Demographic and Health Survey found that female orphans aged 15–17 are more likely than non-orphans to have experienced sexual debut and that female maternal orphans are more likely than non-orphans to have been married.⁴⁹

The implication is that adolescents, and particularly girls, are especially vulnerable. One study found that orphans were more likely to be bullied and depressed, and were less likely to have a trusted adult or friends. Caregivers of orphans also reported similar depression and isolation.⁵⁰

4.6. Basic social protection

At present, the National Institute for Social Action oversees five social protection programmes: two assistance programmes (a cash transfer programme and an in-kind social transfer programme) and three promotion and development programmes (Social Benefit for Work, Income Generation, and Community Development).

Of these, the Food Subsidy Programme (PSA) has by far the largest outreach. This unconditional cash transfer programme was introduced in 1990 and was designed to target the elderly, disabled and chronically sick and their dependants within the poorest section of society. Currently, its main direct beneficiaries are the elderly (93 per cent), people living with disabilities (6 per cent) and the chronically ill (1 per

cent). It therefore has the characteristics of a non-contributory (old age) pension. Mozambique is one of the few low-income African countries with such a longstanding cash transfer programme that is supported by state funds and national legislation. In 2007 the PSA reached 128,000 households with monthly cash transfers, increasing to 143,455 households in 2008 and 166,824 households in 2009. In total, the programme reached 166,824 direct beneficiaries and 140,643 indirect beneficiaries (dependents) in 2009. A significant proportion of the indirect beneficiaries are children, including biological children of the direct beneficiary and orphans and vulnerable children who live within the household.

In 2008, the PSA went through two important reforms: an incremental increase of the subsidy scale, and an increased focus on inclusion of eligible dependants as indirect beneficiaries in the payment scheme. A significant part of these indirect beneficiaries are children, which hitherto has been problematic due to the fact that they frequently do not meet the eligibility criteria. In the case of children, this is often due to the lack of a birth registration document or orphanhood status. According to the programme procedures, non-orphans living with the elderly, even if they receive no financial support from their parents, are not eligible beneficiaries of PSA. Consequently, a significant number of extremely vulnerable children are excluded from the programme. A planned inventory and update of the registry forms of direct and indirect beneficiaries in 2010 will shed more light on

Table 5.1: Projected cash transfers to households headed by elderly people, people living with deficiencies and the chronically ill, 2010-2014

	2010	2011	2012	2013	2014
Number of extended families	242,296	312,592	382,888	453,183	523,479
Allocated amount (Millions of Mts)	668.74	862.75	1,056.77	1,250.79	1,444.80
Per cent of state funds	0.24%	0.29%	0.34%	0.38%	0.42%
Number of elderly as direct and indirect beneficiaries	300,447	387,614	474,781	561,947	649,114

Source: Government of Mozambique, "Estratégia Nacional de Segurança Social Básica," Maputo, March 2010.

the number of potentially eligible children in beneficiary households who are not currently receiving an entitlement. This information will feed into the new programme management system that will become operational in 2011 and will ensure improved coverage of eligible dependants. A revision of the programme manual is foreseen as part of the operational plan of the Basic Social Security Strategy. It will include discussions of the criteria that determine the inclusion of dependent children. The current birth registration campaign should address the issue of a lack of a birth registration document, thereby facilitating the inclusion of vulnerable children as entitlement holders.

An impact assessment of the PSA is on-going, in which a treatment (1016 households) and control group (1650 households) participate in a survey to establish the impact of the monthly cash transfer on consumption, health and education (including access to services), employment, housing, and intra-household demographic changes. The baseline survey was conducted in 2008 with follow-up surveys scheduled for 2009 (completed), 2011 and 2013. Its objective is to analyse the impact of the PSA on individual beneficiaries and families so as to inform the technical and political dialogue with Government and partners on the future direction of the programme. It is anticipated that the empirical evidence generated through this evaluation will influence key programmatic decisions such as the amounts and range of the benefit scale, number of beneficiaries, constitution of target group, etc. The results of the assessment are also expected to inform the political and technical dialogue

regarding the introduction of a child grant, as proposed in the Basic Social Security Strategy.

The Strategy projects to scale the PSA programme up to 452,000 households by 2014. These households are expected to consist of 1,356,000 direct and indirect beneficiaries, of which 795,520 indirect beneficiaries will likely be children.

In addition to the PSA, the in-kind transfer programme identifies orphans and vulnerable children as direct beneficiaries. Material support is provided to individuals and families who need immediate assistance in the form of nutritional products, school supplies, domestic utensils and building material. In 2008 this support reached 24 per cent of households. The largest group of beneficiaries is children, including 26 per cent orphaned children, 23 per cent malnourished children; 12 per cent twins; 10 per cent abandoned children; 6 per cent babies that cannot breastfeed; 6 per cent child heads of households; 2 per cent adolescents and 0.24 per cent triplets. Although this support is a valuable contribution to alleviating the deprivation of families in dire need, it is given on a supply basis, and coverage is limited and insufficient to meet the current demand.

The proposed child grant programme will target families who care for orphans and vulnerable children. The grant is expected to be introduced in a phased approach (see Table 5.2). However, state funds for the introduction of this grant have not been secured yet, and launch of the programme in 2010 was not feasible.

Table 5.2: Cash transfers to families with orphans and vulnerable children, 2010-2014

	2010	2011	2012	2013	2014
Number of extended families	66,780	133,559	200,339	267,119	333,899
Allocated amount (Millions of Mts)	186.51	373.03	559.54	746.06	932.57
Percentage of state funds	0.20%	0.39%	0.55%	0.71%	0.85%
Number of child beneficiaries	203,531	407,062	610,594	814,125	1,017,656

Source: Government of Mozambique, "Estratégia Nacional de Segurança Social Básica," Maputo, March 2010.

4.7. Poverty certificates

The Government has created a system whereby poverty certificates are issued to vulnerable households to ensure free access of children to education, health and civil registration services. The beneficiary families are defined as those who have no resources to survive without help from the state. The process of obtaining poverty certificates requires interaction with the local registry (to confirm the place of residence), then with the social action services at district level (to verify the applicant's social status information) and finally with the district administration (for issuance of the certificate). Reports from non-governmental organisations supporting the access of families to this programme have revealed that lengthy procedures and lack of clarity on which services the certificates apply to (even among the service providers and administration agents), as well as lack of means from the service providers to take on beneficiaries for free, represent major constraints.

4.8. Capacity analysis

The 2009 Access to Justice Study, commissioned by the Ministry of Planning and Development as part of the PARPA II evaluation process, concluded that during the period 2005–2009 access to justice in Mozambique did not improve (although it did not decline either).⁵¹ Weaknesses persist in ensuring that the benefits of public services offered by the justice sector (i.e., courts, Attorney General's Office, Ministry of Justice, and Legal Aid Institute actually reach the majority of citizens, especially those most vulnerable.

The PARPA II impact evaluation revealed that of 36 planned actions in the areas of justice reform, legality, order and public security, only six actions were fully completed, and ten registered no progress at all. Important actions that were not completed include the new Legal Aid Institute law, the digitisation of judicial court data, approval of the

National Human Rights Policy, and reform of the Criminal Investigation Police Unit.

The entire justice sector, and particularly the police force, needs to play a more active role in ensuring that families, communities and schools provide safe and protective environments for children by enforcing existing criminal laws and scaling up initiatives such as the Police Victim Support Centres (Gabinetes de Atendimento).

More than 200 centres have been set up nationwide since the establishment of the first Police Victim Support Centre in Beira in 2002.⁵² These centres were established to create a safe space for victims to report incidents of violence to the police and to be referred to necessary services by the Ministry of Women and Social Action, the Ministry of Health and related government ministries, including health workers and social workers. Between January and September 2009, more than 14,000 victims of violence, abuse and exploitation, of which 2,721 were children (1,219 boys and 1,502 girls), were supported through these centres nationwide. However, significant gaps remain before these centres can be considered fully operational. The available human and logistical resources are insufficient to enable most centres to operate on a 24-hour basis. Only seven of the 200 Police Victim Support Centres have their own vehicles, which represents a serious constraint on mobility to investigate cases of violence against children and women and to provide care and support for the victims. Further support must be mobilised to strengthen the capacity of the centres to facilitate prompt referral of cases to essential service providers and to ensure quality services for children and women victims of violence.

The collection of reliable data on issues related to child protection in the justice sector is key to improving child protection but is extremely difficult in Mozambique, particularly at the provincial and district levels. This is due in part to a tradition of dealing with cases within families and households, rather than through formal legal

channels, and in part to a lack of technical and material capacity in the Government and the justice system. Violence, exploitation and abuse thrive in conditions of illegality and lack of transparency, making it difficult for the Ministry of Justice and the Ministry of Interior's statistics to reflect the true scale and extent of the problems.⁵³

The reality for most Mozambicans is that the judicial courts are inaccessible, blocked by a range of obstacles including high costs relative to income, distance and poor transport networks. Mozambique faces significant challenges in providing access to justice for the majority of its citizens and in meeting constitutional and international standards of justice.⁵⁴ The principal centres of the justice system are found in urban areas, mainly in Maputo, leaving rural areas unserved. The Justice Sector and Rule of Law Report published by the Open Society Foundation (Sociedade Aberta) cited constraints in access to justice, including insufficient numbers of court staff and the lack of qualified existing staff, such as magistrates, attorney generals and court clerks. Further obstacles noted were the backlog of cases in the various sections, lack of equipment and infrastructure (only provincial capitals and slightly more than half of district headquarters were covered at this time) and a lack of lawyers available to represent children charged with a crime, especially outside of Maputo City. These critical impediments in the justice system prevent the courts from meeting the growing demands for guardianship and other juvenile justice issues and contribute to an ever-larger backlog of pending cases.

Although the capacity of justice systems to prevent and respond to different forms of violence, abuse and exploitation has been strengthened, the overall response continues to be fragmented, reactive, weak and underfunded. Improvement of the capacity of the Ministries of Justice and Interior is urgently required to provide adequate attention and protection to victims of violence, abuse and exploitation. The capacity of social welfare, police and

judicial sectors to prevent and respond to cases of violence against children at both national and provincial levels also requires strengthening via improved data collection, monitoring and reporting mechanisms at all levels.

A related capacity gap concerns the lack of a national database on violence and sexual abuse. Development of an effective national system would greatly enhance the Government's ability to record, monitor, assess and respond to patterns of abuse and violence. This would be especially useful for key ministries such as the Ministry of Interior (for reporting criminal cases), the Ministry of Women and Social Action (to allow social workers to provide information on gender-based cases), and the Ministry of Education (for reporting incidents in schools) as well as to reinforce community capacity to prevent and respond to violence in households or on the street. The concluding observations of the Committee on the Rights of the Child on Mozambique's second periodic report recognise that strengthening the evidence base on child protection in the justice sector is vital, not least to ensure that data are used to improve laws, policies and practices.⁵⁵

Another major challenge for the justice sector is the need to coordinate, streamline and maximise the impact of capacity building and sensitisation efforts by a wide variety of stakeholders. Donors, non-governmental organisations and UN agencies are targeting judges, court personnel, prison officers and police officers at both the national and community levels. However, the Government has not established standards for training materials and sensitisation messages, and there is no systematic, coordinated approach to training and raising awareness. To better institutionalise capacity building efforts, both the Ministry of Justice and the Ministry of Interior have been integrating training modules that describe in detail how to protect children's rights as victims, witnesses and offenders in the criminal

justice system into the training manuals used by the national Legal and Judiciary Training Institute and the national police academy, thereby mainstreaming attention to child protection issues.

In spite of the constraints mentioned above, improvements have been made, particularly within the courts and the prosecution service.

According to the Second Strategic Integrated Plan of the Justice sector (Plano Estratégico Integrado II) a total of 1,173 persons have graduated from the various law faculties in the country since 2000. Since the Legal and Judicial Training Centre began its activities in 2001, approximately 136 judges and prosecutors, 343 court officials, 51 legal assistants and 45 public notaries have graduated from the Centre and an estimated 90 per cent of the graduates subsequently entered one of the sector institutions. Since 2004 the Police Academy has awarded the equivalent of Bachelor's and Master's Degrees in police science to approximately 85 candidates per year, and 1,200 police officers graduate each year from the basic police school.

The Ministry of Women and Social Action has received technical and financial support to implement the PACOV from a range of partners. However, an assessment found that the Ministry operates with limited resources and competences at the district level, weakening their capacity to comprehensively respond to children's existing needs.⁵⁶ Accordingly, a study is currently being commissioned to generate further evidence of where capacity gaps or weaknesses lie at the district level, and consequently, how these gaps can be transformed into strengths.

In order to assess the impact of implementing the PACOV, the Ministry of Women and Social Action has commissioned an evaluation. Its results will inform PACOV's relevance and efficiency in providing care and support for children, in particular for those living in a situation of vulnerability. The elaboration of Minimum Standards of Care of Orphaned and

Vulnerable Children with a specific focus on the six basic services defined by the PACOV, now in progress, will be an important guide for implementing activities for children in the country.

As stipulated in the Children's Act, the Council of Ministers approved the National Council of Children's Rights in 2009. This will be an important forum for different government institutions and civil society organisations to establish the main strategies for children's rights and effectively coordinate actions in the future.

4.9. Civil society partnerships

Civil society is also actively engaged in advocacy, policy dialogue, capacity building and community sensitisation on child protection issues in the justice system. Civil society partners have taken an active role in disseminating several Acts, including the child-friendly version of the Children's Act.

Civil society organisations in Mozambique also play a vital role in providing basic services, especially in support of households and vulnerable children coping with HIV and AIDS. Although specific data on support to orphans and vulnerable children by civil society organisations are not available, it should be noted that the US President's Emergency Plan for AIDS Relief alone supported 16 non-governmental organisations to reach 242,800 OVC in 2008.⁵⁷ Civil society organisations spent approximately 38 per cent of all funds spent on HIV from 2004 to 2006.⁵⁸

Improving coordination of civil society organisation activities is needed to avoid duplication, to scale up what is often localised support and to ensure sustainability, given that up to 70 per cent of civil society organization support comes from external sources.⁵⁹ A meta-analysis⁶⁰ of community-based groups that work on child protection and well-being underscored the need for longer-term funding to enable the development of community-owned child protection groups.

4.10. Sector financing and budget allocations

The Ministry of Women and Social Action receives low levels of financial support by the Government of Mozambique: in 2010, it was allocated only 1.1 per cent of GDP, a 0.3 per cent decrease from 2009.⁶¹ In addition, the ability of the Provincial Directorates of Women and Social Action to effectively perform their roles and responsibilities has been limited by the lack of human resources and adequate training (in terms of both social work and programme management).

Since 2003, budget allocations to the justice sector have been reasonably stable, representing between six and seven per cent

of the state budget.⁶² The Ministry of Interior absorbs about 70 per cent of allocated resources.^{vii} In nominal terms, the allocations have grown from 22 per cent to 25 per cent each year, with the exception of 2006 (an increase of 5 per cent). Budget allocations per institution for investment expenditures have been irregular, and no clear trend can be observed.

Budget allocations to the provincial level are increasing, but only proportionally to the total budget increases. Allocations to the provincial level account for approximately 25 per cent of total allocations to the justice sector in 2008. There is little evidence of effective decentralisation of resources or their administration to provincial level.



^{vii} The budget of the Ministry of Interior is not disaggregated and therefore does not permit an identification of the share allocated to the police forces.

5. Conclusions

Children face a wide range of protection issues in Mozambique. Physical and sexual violence, early marriage, child labour and child trafficking continue to be prevalent; although data are scarce in these areas, available information indicates that trends have not improved significantly in recent years. The number of orphans and vulnerable children continues to increase, principally as a result of HIV and AIDS. While extended families and communities in Mozambique have historically represented the first line of response, this traditional support system is increasingly under pressure as the number of children in need of care mounts. Also, significant progress has been registered in the area of birth registration services across the country, with close to 7 million children registered since 2005; the challenge in this area will be to ensure that current initiatives are sustained to achieve universal coverage.

Significant progress has been achieved within the legal and policy framework with regard to child protection in recent years, notably the approval of the Domestic Violence Act, Children's Act and Juvenile Justice Act, amongst others. Despite these improvements, the overall response continues to be fragmented, reactive, weak and underfunded, and this new legislation needs to be translated into effective regulations and programmes. The Basic Social Security Strategy recently approved by the Council of Ministers and currently in the process of operationalisation presents a promising scenario to address child and household vulnerability, particularly because it incorporates a child grant component. The progress achieved in the PSA social transfer programme, where the number of households rose from 90,000 in 2005 to approximately 170,000 in 2009, provides an encouraging example of how children could benefit from social protection initiatives.

Social protection policies and programmes are effective means of responding to the needs of vulnerable families and children, as social protection plays a key role in reducing poverty, overcoming social exclusion and building human capital in order to reduce the risks and vulnerability faced by vulnerable groups, particularly children and their caregivers. Specifically, three critical challenges have to be addressed to meet the needs of and deliver effective and beneficial outcomes for vulnerable children and their families:

- Government-led support and services must reach *all* children who need them in poor communities affected by HIV and AIDS. This includes children who have lost parents, but also many others, including victims of violence, abuse and exploitation;
- Policies and programmes for vulnerable children must strengthen the capacity of extended families and communities to care for them at the grassroots level;
- Family poverty and gender inequality must be tackled to improve outcomes for children.

While there has been important progress in the area of protecting children's rights in Mozambique, there is much more to be done to develop a *holistic child protection system* that seeks synergy between the social welfare and justice sectors to increase children's access to protective and other key social services. This would principally involve improving data and monitoring mechanisms; developing a more systemic and coordinated approach within and between the key line ministries; and strengthening the capacities of relevant line ministries to develop a robust and systemic approach to child protection. Furthermore,

since cultural and social norms play such an important role in the context of child protection, there is a continued need to effectively disseminate information on key issues and increase awareness among society as a whole of children's rights and the obligation of all to protect them. However, without additional resources,

the capacity of the Ministry of Women and Social Action at national and sub-national levels to deliver on its mandate will remain constrained. Adequate financing and implementation of the Government's policy response to the threats posed to orphans and vulnerable children will be crucial to protecting the rights of these children.

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A black and white photograph of a woman and a child walking across a dry, cracked landscape. The woman is on the left, wearing a light-colored dress and carrying a bag. The child is on the right, wearing a dark shirt and pants. The ground is parched and cracked, with a large, deep crack in the foreground. The background shows a clear sky and some sparse vegetation on the right.

CHAPTER

6

CROSS-CUTTING ISSUES

CROSS-CUTTING ISSUES

1. Introduction

Improving the situation for the most vulnerable members of society requires an understanding of who they are, where they live and what specific challenges and hazards they face. Mozambique is not a homogeneous country, and children living in different areas or even under the same roof do not always face the same levels of vulnerability. Certain children, households and entire communities are threatened by the presence of physical, environmental or social hazards that others do not have to worry about. In addition, there are a number of factors that affect the capacity of certain subsets of the population to cope with the presence of threats to their well-

being. Issues related to gender, geographical disparities, HIV and AIDS, lack of information and environmental conditions complicate and challenge each of the sectors discussed in the previous three chapters: child survival, education and protection. A thorough analysis of these cross-cutting issues and the institutional and social systems in place to address them is essential for effective interventions to be designed and implemented to decrease overall vulnerability.

This chapter is focused on five cross-cutting issues: gender, regional disparities, HIV and AIDS, environment and communication for development.

2. Gender

Equal enjoyment of human rights by women and men is a principle enshrined in the Universal Declaration of Human Rights.¹

In 1979, the United Nations approved the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which further defined the legal and human rights of women.² The principle of equal enjoyment of rights was subsequently reaffirmed by the Vienna declaration, adopted by 171 states at the World Conference on Human Rights in June 1993.³

UNICEF is committed to promoting “the equal rights of women and girls and to support their full participation in the political, social and economic development of their communities.” Only by ensuring equal opportunities for women and men, girls and boys, can societies expect to create the conditions for ending poverty and enable every person to develop to his or her full potential.

Gender and gender development are not solely concerned with the rights of women and girls; rather, they address all forms of discrimination or bias encountered in the realisation of human rights or achievement of development that are based on the gender of an individual. In many cases, women and girls are most often the victims of gender discrimination, although it can also be the case that boys or men are discriminated against, and these cases should be given equal consideration.

Mozambique ratified the United Nations Convention on the Elimination of all Forms of Discrimination against Women in 1993, and it entered into force in 1997. Mozambique has also ratified the Optional Protocol to the Convention. Mozambique is

also a signatory to the 2005 African Charter on Human Rights and Peoples’ Rights and the Rights of Women.

The Ministry of Women and Social Action was created in 2005.ⁱ Its mandate is to implement and coordinate initiatives concerning the rights of women and children. The National Council for the Advancement of Women is a multi-sectoral coordination platform through which the Ministry of Women and Social Action monitors the implementation of the National Plan for the Advancement of Women.

In spite of progress in the legal framework, discrimination on the basis of gender, and especially discrimination against women, does occur in Mozambique. This discrimination is reflected in aspects of the social, cultural, political and economic life of women, including the following:⁴

- In the family, women are discriminated against by their direct relatives and do not receive the same treatment afforded to men. For example, boys are often favoured in decisions over which members of a family are to receive formal education, although gender inequality in education has narrowed in recent years. Decisions are often made based on customary practice, which have defines boys and men as the breadwinners and girls and women as the home-makers. The higher levels of illiteracy among women and a lack of knowledge regarding their rights means that cases of discrimination against women are rarely brought before a court of law;
- In the labour sector, few opportunities exist for women in the formal sector, especially in senior positions;

ⁱ In 2000 the Ministry for Coordination of Social Action was established. In 2005, the Ministry was re-structured and became known as the Ministry for Women and Social Action, the name the reflecting the elevation of gender equality issues in Mozambique.

- Both men and women are reluctant to resolve their conflicts in formal courts of law. In rural areas the courts may be far away. Victims of domestic violence may be reluctant to bring their partner to court. Domestic violence is not yet seen as a crime but rather as a normal part of relationships between men and women.

The Government's Five-Year Plan 2010–2014 sets the objective of promoting equal economic, social and cultural opportunities for men and women.⁵

2.1. Gender aspects of poverty in Mozambique

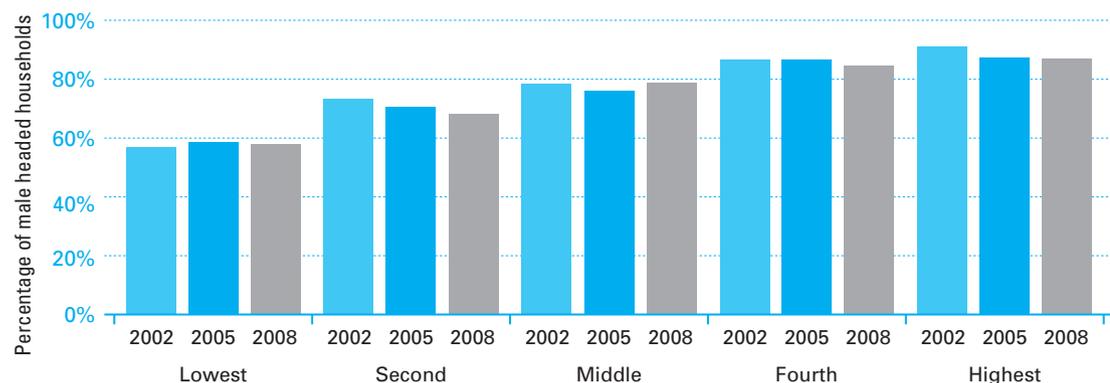
As discussed in Chapter 1, poverty reduction in Mozambique between 1996/97 and 2002/03 did not equally benefit all segments of the population. Poverty was reduced much more significantly among male-headed households than female-headed households. While poverty was reduced by 26 per cent in male-headed households (from about 70 per cent in 1996/97 to 52 per cent in 2002/03), it was only reduced by 6 per cent in female-headed households (from about 67 per cent to 63 per cent between 1996/97 and 2002/03). This may have implications for orphaned children, as they are more often found in female-

headed households. The 2004/05 Labour Force Survey (IFTRAB) indicated that 54 per cent of all orphaned children were living in households headed by women, compared to 46 per cent in households headed by men.⁶

Recent studies indicate that the trend of feminisation of poverty is at least partly due to women being more heavily involved in the agricultural sector than men (89 per cent compared with 68 per cent).⁷ At the same time, women have less access to education, fewer opportunities for formal employment, lower incomes and fewer opportunities to diversify their income sources. Studies have also shown that female-headed households, besides being poorer than male-headed households in monetary terms, have reduced 'social access' as a consequence of the predominantly patriarchal societal structures in Mozambique.⁸

Further evidence of the feminisation of poverty comes from an analysis of three National Agricultural Surveys (2002, 2005 and 2008), which revealed that female-headed households were over-represented among the poorest households in all three survey years.⁹ In contrast, the proportion of male-headed households tends to increase with increasing income quintile (see Figure 6.1).

Figure 6.1: Proportion of male-headed households by wealth quintile, 2002, 2005 and 2008



Source: Cunguara, Benedito and Brendan Kelly, 'Trends in agriculture producers' income in rural Mozambique', study as input to Impact Evaluation Report of PARPA II, MPD, 2009.

The trend towards a feminisation of poverty is supported by the perceptions of change held by male- and female-headed households respectively. A higher proportion of female- than male-headed households believe that their situation has worsened over the last five years. At the same time, the perception of deteriorating conditions is more pronounced among rural than among urban female-headed households, which may indicate better opportunities for female-headed household heads in urban areas.

Overall levels of participation in the workforce are slightly higher among women of active age (15–59), at 82 per cent, than among men of a similar age (79 per cent). Women's participation in the labour force is primarily concentrated in subsistence agriculture in rural areas, where women make up 62 per cent of the working population, while men predominate in all the other major sectors of the economy, where earning potential is higher. Women in the labour force have lower educational levels than men, with 15 per cent of men in the workforce having attained upper primary education or better, compared with only five per cent of participating women.¹⁰

Although women make up the majority of the economically active population, they are predominantly engaged in the agricultural sector, where they are mostly involved in household production with limited surplus. Where income generating opportunities exist, men tend to be more likely to access these opportunities and derive benefits from them. In urban areas, women are more likely to depend on the informal sector due to low entry requirements and the fact that access to formal jobs is largely controlled by social capital (social contacts) that favour men since they are still seen as the breadwinner.

2.2. Gender development and gender empowerment

In the 2009 Human Development Report, Mozambique is ranked 145th of 155 countries and is assigned a Gender Development Index of 0.395 for 2007. In 1995, Mozambique achieved a Gender Development Index (GDI)

of 0.229, placing it 123rd of 130 countries for which the index was calculated. This reflects that while Mozambique improved in gender equality in absolute terms, it did not improve as much as other countries. The GDI was lower in central and northern provinces than in the south.

The GDI used was based on three indicators assigned equal weight:

- Life expectancy at birth;
- A combination of the adult literacy rate and the combined net enrolment rate across primary, secondary and tertiary education levels;
- Per capita Gross Domestic Product expressed as US dollars purchasing power parity.

A study to update the United Nations Development Programme GDI for Mozambique was commissioned as part of the 2009 PARPA II impact evaluation.¹¹

The GDI was calculated according to four different scenarios: three using different methods of determining the salary gap between men and women, and one using a life expectancy adjusted for the impact of AIDS:

- Scenario A: non-agricultural salary gap calculated based on different levels of qualification of men and women;
- Scenario B: global salary gap (agricultural and non-agricultural) based on different levels of qualification of men and women;
- Scenario C: non-agricultural salary gap based on the United Nations Development Programme assumption that on average women earn 75 per cent of the salary of their male peers;
- Scenario D: using life expectancy estimates adjusted for AIDS. Scenario D provides an illustration of the impact of HIV on the Gender Development Index in the absence of interventions for the prevention and treatment of AIDS.

Under scenarios A and C, the PARPA II target for the GDI was reached in 2008, and the report ascribed this result to the high levels of gender equity achieved in primary school enrolment.

Mozambique fared much better under the Gender Empowerment Measure (GEM), which was calculated at 0.350, placing Mozambique 61st of 116 countries. The higher GEM was a reflection of the relatively high proportion of parliamentary seats held by women in Mozambique (15 per cent in 1994) and the proportional earned income share of women (40 per cent in 1994), which was higher than for several other countries in the rankings. No GEM is provided for Mozambique in the 2009 Human Development Report. There is a high degree of regional disparity in the GEM. The four provinces with the lowest (worst) indices are all in the north of the country.

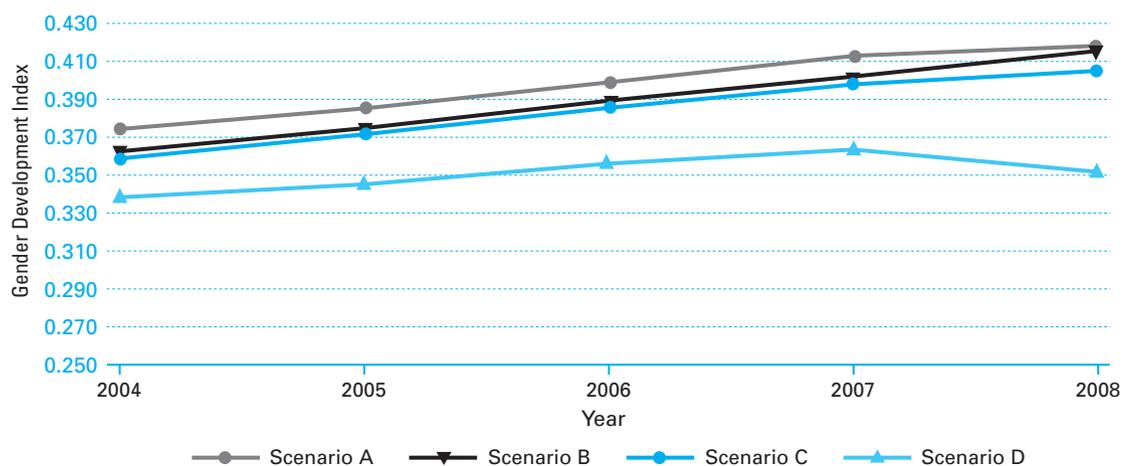
Arguably, the area in which most progress has been made in terms of gender equality in Mozambique is political participation of women. Mozambique has a high proportion

of women in decision-making bodies such as the parliament, where following the 2004 election, 36 per cent of seats were held by women.¹² Until the new Government was announced in 2010, the position of prime minister was held by a woman. Although there has been a reduction in the proportion of women in Government following the 2009 elections, female political participation in Mozambique is high by regional standards. Currently, 18 per cent of ministers (full and junior) and 27 per cent of provincial governors are women.

2.3. Gender disparities

A study conducted by the Ministry of Planning and Development as part of the 2009 PARPA II Impact Evaluation revealed no difference in the proportion of girls and boys experiencing absolute poverty, as measured by the deprivations-based approach (see Chapter 1, Child poverty in Mozambique, for a more detailed discussion of deprivations-based poverty). A higher proportion of boys suffer from severe nutritional deprivation than girls (23 per cent versus 17 per cent).

Figure 6.2: GDI based on different methods of determining salary gap, 2009



Source: Ministry of Planning and Development, Ministry of Women and Social Action and Gender Coordination Group (GCG), 'Calculando o GenderDevelopmentIndex no Contexto da Avaliação do PARPA II (2006–2009)', Maputo, 2009.

There are numerous hypotheses on the reasons for this difference, including differences in nutrition requirements, food habits, access to food and childcare practices, but there is insufficient evidence to confirm or refute any of these possible explanations.

Girls are more likely to experience severe education deprivation than boys (13 and 10 per cent, respectively). Education deprivation was reduced significantly for both girls and boys, however, between 2003 and 2008. Completion (especially at secondary level) and literacy rates for girls are also lower than for boys.

2.4. Gender issues in education

PARPA II discusses the relationship between education, poverty reduction and economic growth, with a particular emphasis on the role of girls' education. The PARPA II objectives for primary, secondary and tertiary levels of the education system explicitly refer to inclusion on the basis of gender, vulnerability and special needs. Strategies to increase girls' education are also presented, including dealing with the sensitive but critical issue of reducing the incidence of sexual abuse in schools. The Government's Five-Year Plan 2010–14 also prioritises gender parity in primary school.

Low levels of literacy, especially among women, have been a consistent feature of Mozambican society for many years. For example, the 2003 Demographic and Health Survey recorded a 62 per cent illiteracy rate among women, compared to 33 per cent among men. The 2008 MICS reports that 41 per cent of female Mozambicans aged 20–24 are literate, and this figure rises to 53 per cent among young females aged 15–19.¹³

In the period 1992–2009, the number of learners in primary and secondary schools rose dramatically for both boys and girls. A gender gap remains at all levels of education, however. The absolute gender gap in gross enrolment in the first stage of

primary school has decreased since 1999, but remains high at 14 per cent.¹⁴

Gender disparity in enrolment shows considerable geographical variation, with fewer girls enrolled in the central and northern regions, whereas in some southern provinces, such as Maputo and Inhambane, slightly more girls are enrolled than boys. In 2007, the completion rate for the first stage of primary education was 65 per cent for girls and 80 per cent for boys. This gender gap persists in the second stage of primary education, with completion rates of 39 per cent for girls and 53 per cent for boys.¹⁵

Gender is a major factor influencing the education sector; its effect is particularly strong among poorer households, in rural areas and in central and northern provinces. Gender disparity is also undermining some apparent gains, with substantially lower completion rates for girls than for boys. Although the gender gap has narrowed in recent years, there remain marked disparities that need to be examined in the context of poverty, place of residence, and cultural practices and traditions.

To promote girls' education, the Ministry of Education is focusing on improving safety in schools, including defining key steps to respond to sexual abuse in schools. There have also been efforts to strengthen the capacity of the Ministry's unit in charge of gender in order to better mainstream gender and AIDS in the planning, implementation and monitoring processes initiated and to work with communities to promote girls' education, prevent sexual abuse and premature pregnancy. Further, capacity of gender units needs to be strengthened in the monitoring and reporting of sexual abuse and violence. Focusing on girls' education is both a means of addressing gender disparity and a strategy for leveraging gains in dealing with other disparities.

2.5. Violence, abuse and exploitation

Some forms of violence against women and children are rooted in discriminatory and unequal societal gender dynamics.¹⁶

Available studies and data suggest that the traditional patriarchal culture and male-dominated social order is strong in Mozambique.¹⁷ Child marriage, for example, continues in spite of the provisions of the 1997 Family Law and appears to be related to traditional gender relations persistence of the gender roles assigned to women and girls as mothers and care-givers in society.

Many girl victims do not report cases of rape or sexual abuse to the authorities partly because of the stigma that surrounds the issue of sexual abuse.

In its combined first and second reports to the United Nations Committee on the Elimination of Discrimination against Women (CEDAW), Mozambique reported that most families prefer to resolve cases of sexual abuse out of court through indemnity or marriages. The report also recognises lack of knowledge about the legal system and unreasonable delays in the court system as further obstacles to a legal solution to such cases.¹⁸ Weak access to the justice system, insufficient knowledge of women's rights, and the lack of a system for enforcing legal penalties further exacerbate the problem.

Domestic violence against women is also a serious issue in Mozambique. Although quantitative data are scarce, data from 2004 indicate that 54 per cent of women surveyed reported having been abused, as discussed in Chapter 5. Data also reveal a widespread acceptance of the use of violence. In 2008, the proportion of women who stated that men had the right to beat them under certain circumstances, such as leaving the house without informing the husband or refusing sex, was 36 per cent, a reduction from 54 per cent in 2003. Educated women are less likely to accept domestic violence, as are women living in urban areas (see Chapter 5). Despite the apparent cultural acceptance of domestic violence, other studies¹⁹ have shown that

extreme violence resulting in actual bodily harm is unacceptable to communities as well as to individual men and women.

The prevalence of child labour is slightly higher among girls (24 per cent) than among boys (21 per cent). A higher proportion of girls than boys work in domestic tasks (eight per cent against five per cent, respectively). The percentage of children who work to support household businesses is the same for both sexes (16 per cent).²⁰

It is women and girls who traditionally collect water for the household. The MICS found that an adult woman collects water in 86 per cent of households, and a girl (under 15) collects water in 7 per cent of households. Water sources are usually far from the household, an average of nearly 50 minutes' walk from the family home (excluding those households with water on their premises – 9 per cent of households). Typically, multiple trips are made each day to the water source.²¹

2.6. Lineage systems

In Mozambique, both patrilineal and matrilineal lineage systems exist. Under the patrilineal system, the wife and children 'belong' to the husband and his family, and it is the husband who grants his female spouse access to land. In the matrilineal system, the woman and her children continue to be regarded as members of the woman's matrilineal family. Under the matrilineal system, it is the woman's uncle who grants access to land, while the children belong to the mother's blood relatives.²² In both patrilineal and matrilineal systems, women's positions are based on submission to the male members of the family – i.e., her husband/father or brothers, respectively.²³

Land rights are somewhat problematic in Mozambique due to the existence of two contradictory systems. Officially, and in accordance with the constitution and the Land Act, land is an inalienable property of the State. However, under customary law and tradition, land belongs to the community

living in its surrounding area and that community's ancestors. Access to land is managed by a complex network of social traditions that is built around marriage, as a basis of alliances among families. As a result, hereditary rights to land depend on age, sex and social status, including kinship or other ties to the families that were first to have populated the area. Formal land titles do not seem to be relevant for inheritance purposes. In patrilineal societies, problems arise in case of divorce or death of a husband, where a woman runs the risk of losing her land and all her belongings in favour of other members of her late husband's family, even where she has the responsibility to look after her offspring and other relatives.²⁴

2.7. HIV and gender

The 2001 Declaration of Commitment on HIV/AIDS acknowledges that women are disproportionately affected by AIDS in the global context and must be given priority in national and global responses.²⁵ The gender dimension of HIV and AIDS has both a biological and a social component. Biologically, women are more vulnerable to infection with HIV than men, and young girls are more vulnerable still. However, it is the social component that is most important in determining the differential in transmission and impact on women. Women in Mozambique are taught that sex is a survival strategy and thus they often submit men's

decisions and are less able to negotiate for safe sex, fidelity or abstinence. Coerced or forced sex and sexual violence exacerbate women's biological and social vulnerabilities to infection. Girls tend to begin regular sexual relations earlier than boys, increasing the risk of transmission.²⁶

As a result of these two groups of factors, prevalence of infection among women aged 15–49 (13.1 per cent) is more than a third higher than among men of the same age (9.2 per cent).

Among women in the 15–24 age group, HIV prevalence is 3 times higher than among males of the same age.^{27,28} AIDS Accountability International has prepared a Scorecard on Women that rates Government responses to the AIDS epidemic from a gender perspective. The six key elements included in the scorecard are: data collection, gender mainstreaming, policy and legal environment, national programmes, knowledge and behaviour, and impact. Countries are assigned a rank from A (very good) to E (very poor) for each element. See Table 6.1 below for Mozambique's score.²⁹

2.8. Conclusions

Women are more likely to experience poverty than men in Mozambique. The poverty headcount for female-headed households is higher than for male-headed households. Women have less access to formal employment than men, and tend to work in lower-paid industries. There is evidence, however, that the inequality

Table 6.1: Scorecard for Government of Mozambique's gender response to AIDS

	Score
Data collection	A – Very Good
Gender mainstreaming	C – Medium
Policy and legal environment	C – Medium
National programmes	B – Good
Knowledge and behaviour	A – Very Good
Impact	C – Medium

Source: AIDS Accountability International, 'The AIDS Accountability Scorecard on Women 2009', Joint United Nations Programme on HIV/AIDS, Geneva, 2009.

between men and women has decreased in Mozambique in recent years.

There is an unambiguous relationship between the well-being of women and the well-being of their children. Educated mothers are far more likely to have better educated, healthier, less vulnerable children. Targeting girls in education, health and protection programmes is likely to not only improve the well-being of those targeted, but also generate significant positive spin-off effects on the future children of these girls.

Gender parity in education, in terms of attendance rates, has been improving.

Considerable disparities remain, however in terms of literacy and completion rates.

Improving safety in schools is crucial in promoting female access to education. To this end, the capacity of gender units to monitor and report sexual abuse and violence needs to be strengthened.

Violence against women is common and is considered acceptable by a large proportion of women, as well as by society at large.

Sensitisation initiatives to change minds and improved information dissemination are necessary to reduce the incidence of gender-related violence.



3. Geographical disparities

Mozambique is a large country with a relatively low population density. The country covers a surface area of approximately 802,000 km² and has a coastline that stretches almost 2,500 km from South Africa in the south to Tanzania in the north. The average population density is approximately 26 inhabitants per km². Linked to the country's wide geographic expanse is its linguistic, cultural and ethnic diversity. Traditions and customs vary from one region to another. More than a dozen local languages, some with their own dialects, are spoken in Mozambique. Portuguese is the official language and the language of Government, but less than ten per cent of the population speak Portuguese as their mother tongue and only an estimated 40 per cent of the population have learned to speak Portuguese.³⁰

Data reveal the existence of clear disparities in poverty headcount among provinces.

For example, the poverty headcount in the 2008/09 survey varies from 71 per cent in Zambezia to 31 per cent in Niassa. A significant urban/rural divide remains in terms of poverty rates: 57 per cent of rural dwellers are living in absolute poverty compared to 50 per cent of the urban population.³¹

Access to basic social services is generally higher in the south of the country. Provincial disparities in the Human Development Index (HDI) and the related GDI of the United Nations Development Programme have observed that provinces in the north of the country generally exhibit lower levels of human development than those in the centre or south.³² All provinces of the country demonstrated improvements in their GDI between 2001 and 2006.³³ Other key indicators, including per capita GDP, also show considerable variation among provinces.³⁴ There is some evidence that the inequalities in consumption that exist in Mozambique are often more pronounced

within regions and provinces than between them.³⁵

In its first Poverty Reduction Strategy Paper (PARPA I), the Government of Mozambique acknowledged the economic and social inequalities between the Maputo-Matola conurbation area and the rest of the country as being the "most noticeable characteristic" of the country. This inequality is ascribed to various factors, including the civil war. The Government's second Poverty Reduction Strategy Paper (PARPA II) also noted that both consumption-based and non-income-based poverty measures vary considerably among the provinces. Dealing with regional disparities was a priority objective of both PARPA I and PARPA II. The 2009 impact evaluation of PARPA II concluded that there had been a modest reduction in disparities, although disparities in relation to agriculture had increased, while those in the health and education sectors continue to persist at high levels.³⁶

Provincial disparities are also seen in relation to non-income-based measures of poverty. A study on severe deprivation among children conducted as part of the PARPA II evaluation (see Chapter 1) revealed that in both 2003 and 2008, the highest proportion of children experiencing severe deprivation lived in Zambezia province, 80 per cent in 2003 and 64 per cent in 2008 (see Table 6.2).³⁷ Maputo City has by far the lowest levels of child poverty, as measured using this method, with only around 4 per cent of children experiencing two or more severe deprivations.

A comparison of the levels of poverty in 2008, measured using the consumption-based approach and the severe deprivations-based approach, reveals some interesting findings. For most provinces in the northern and central regions of the country, the levels of poverty measured using the two methods are quite similar. However, in the

Table 6.2: Proportion of children experiencing two or more severe deprivations, 2003 and 2008

	2003	2008
Overall	59%	48%
Urban	30%	22%
Rural	73%	60%
Province		
Niassa	58%	35%
Cabo Delgado	62%	45%
Nampula	66%	59%
Zambezia	80%	64%
Tete	65%	60%
Manica	58%	52%
Sofala	68%	53%
Inhambane	48%	37%
Gaza	53%	39%
Maputo province	24%	18%
Maputo City	11%	4%
Wealth quintile		
Lowest	95%	91%
Second	87%	65%
Middle	60%	41%
Fourth	36%	33%
Highest	13%	5%

Source: UNICEF, *Trends in Child Poverty in Mozambique: A deprivations-based approach*, Ministry of Planning and Development, Maputo, 2009.

south of the country, the poverty headcount index is much higher than the proportion of children suffering from two or more severe deprivations. This difference is because the deprivations-based approach incorporates a measure of access to basic social services, including health, education, water and sanitation, whereas the poverty headcount does not directly capture these aspects.

An examination of the proportions of children experiencing individual deprivations also reveals a pattern of wide disparity among provinces. These findings are presented in more detail in the relevant sectoral chapters of this report, but to summarise:

- Levels of severe nutritional deprivation are highest in the northern provinces, followed by the central provinces and lowest in the southern provinces;³⁸
- Besides urban/rural disparities in access to sanitation services, there are also large disparities between provinces. In Zambezia, 73 per cent of children are experiencing severe sanitation deprivation compared to less than one per cent in Maputo City;³⁹
- Provincial disparities in relation to health deprivation also occur. Five per cent of children in Maputo City experience severe health deprivation, compared to 19 per cent in Zambezia and Nampula;⁴⁰
- Disparities in HIV prevalence and access to prevention and treatment services are marked among provinces and regions of the country, with both prevalence and treatment higher in the south. HIV prevalence varies from 25 per cent in Gaza in the south to 4 per cent in Niassa in the north;⁴¹

- Only three per cent of children in Gaza experienced severe educational deprivation in 2008, compared with 22 per cent in Tete, 15 per cent in Niassa and 12 per cent in Zambezia.⁴²

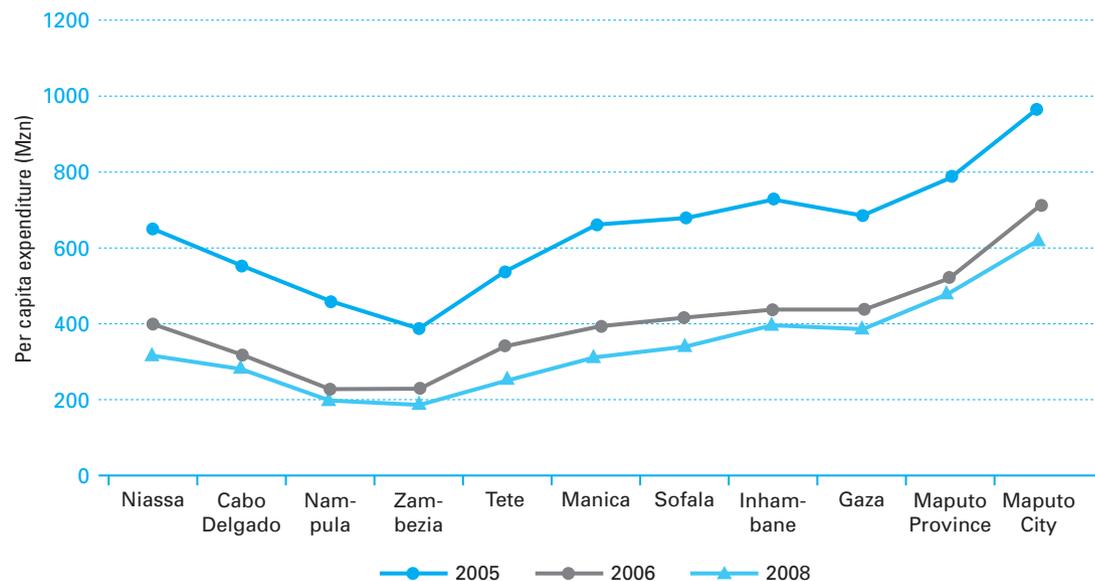
3.1. Disparities in budgetary allocations

In its 2006 *Childhood Poverty in Mozambique: A Situation and Trends Analysis*, UNICEF made the following recommendation: "...it is particularly striking that state budget allocations for key sectors often do not correspond to the pattern of child development indicators.... There is therefore a clear need to review, based on evidence, the criteria used to allocate state budget resources and to attain a more equitable allocation." A recent study further investigated this issue of the least-

developed provinces receiving a lower allocation from the state budget than other more developed provinces.⁴³ The study confirms the perception of inequality and reports that the observed provincial patterns of funding allocation are strongly indicative of an unequal geographical distribution of resources, with the most populous provinces of Nampula and Zambezia consistently receiving less than they should, based on the size of their populations. For example, in 2008, per capita expenditure in Zambezia was 69 per cent of the national average for health and 73 per cent in education 2008.⁴⁴

Provincial disparities in budget allocations have not been reduced in recent years. As can be seen from Figure 6.3 below, per capita expenditure increased from 2005 to 2008. Relative provincial allocations remained reasonably constant, however. Per capita

Figure 6.3: Combined per capita expenditure for health, education and justice, 2005, 2006 and 2008



Source: Sal e Caldeira and Ximango Consultores. "Análise do Impacto da Estrutura das Despesas sobre o Desenvolvimento Económico e as Condições de Vida em Moçambique," 2009.

allocation is higher in the southern provinces than in the centre and north of the country. It should be noted that the cost of providing services is not equal in different provinces. In rural areas, per capita costs are generally higher.

Sectors and Ministries tend to plan their activities and consequently allocate their funding according to key themes, programmes and projects that span several provinces, rather than planning interventions by province. As a result, centrally-administered funds are not explicitly allocated and accounted for on a provincial basis, complicating the quantification of total funding received at the level of the province. Recurrent expenditures, which include salaries, generally show close agreement between central financial accounts and provincial or sectoral financial reports. Much more variation is observed with respect to investment expenditures.

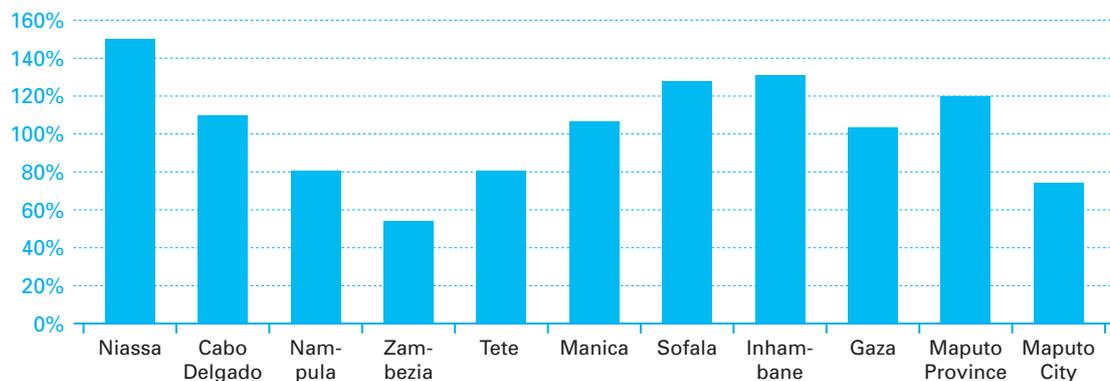
3.2. Disparities in health

There are severe disparities in per capita health expenditure by province. Zambezia receives the lowest per capita allocation, 60 per cent of the national average, compared to 156 per cent in Niassa. Zambezia has the lowest performance with regards to many child health outcome indicators.

Child mortality

There are significant disparities in provincial under-five mortality rates. The highest rates are recorded in Zambezia (206 deaths per 1,000 live births) and Cabo Delgado (181 deaths per 1,000 live births). Tete has the third highest under-five mortality rate, at 175 per 1,000 live births. Maputo province and Maputo City report the lowest under-five mortality rates (103 and 109, respectively).⁴⁵ A comparison of the child survival rate and health expenditures per provinces reveals

Figure 6.4: Health expenditure per capita, percentage of national average, 2008



Source: Sal e Caldeira and Ximango Consultores, 'Análise do Impacto da Estrutura das Despesas sobre o Desenvolvimento Económico e as Condições de Vida em Moçambique,' Swiss Agency for Development and Cooperation, 2009.

a significant correlation. Provinces with low health expenditures also tend to have low child survival rates (see Figure 6.5).

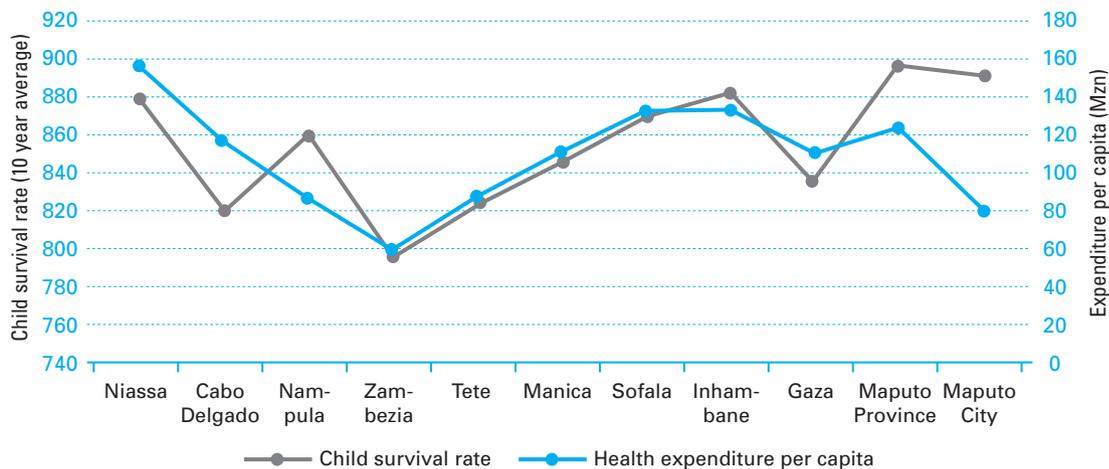
Antenatal care coverage varies among provinces, with a range of between 81 per cent in Zambezia to universal coverage in Gaza and Maputo City. The proportion of births attended by skilled personnel also varies across provinces. The provinces with the lowest proportion of births attended by skilled personnel were Manica (33 per cent) and Zambezia (38 per cent).⁴⁶

HIV and AIDS

HIV prevalence also demonstrates marked geographic disparities, with the highest rates recorded in the southern provinces of Gaza and Maputo (25.1 and 19.8 per cent, respectively) and the lowest rates recorded in the northern provinces of Niassa, Nampula and Cabo Delgado (3.7, 4.6 and 9.4 per cent, respectively) (see Figure 6.6).

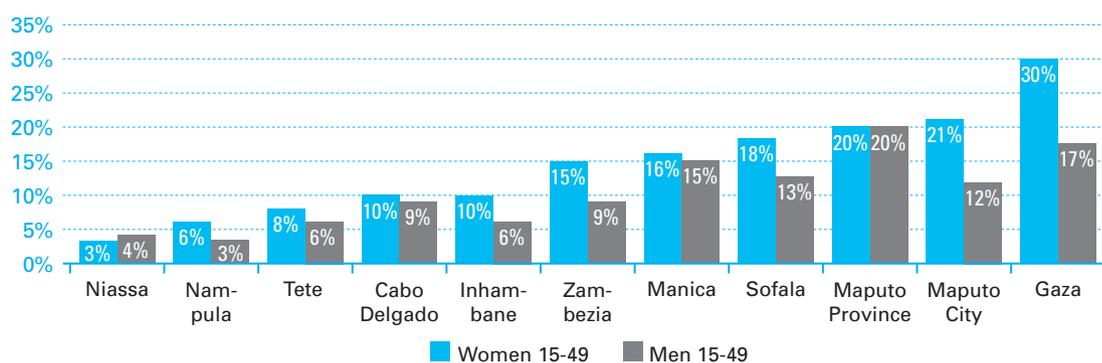
Geographic disparities in the proportion of women who received HIV counselling as

Figure 6.5: Per capita expenditure for health (2008) and child survival (1998-2008)



Source: Sal e Caldeira and Ximango Consultores, 'Análise do Impacto da Estrutura das Despesas sobre o Desenvolvimento Económico e as Condições de Vida em Moçambique,' Swiss Agency for Development and Cooperation' 2009 and MICS 2008.

Figure 6.6: HIV prevalence by province, 2009



Source: National Institute of Statistics, Ministry of Health, 'Inquerito Nacional de Prevalência. Riscos Comportamentais e Informação sobre o HIV e SIDA em Moçambique (INSIDA), Relatório Preliminar sobre a Prevalência da Infecção por HIV, 2009.

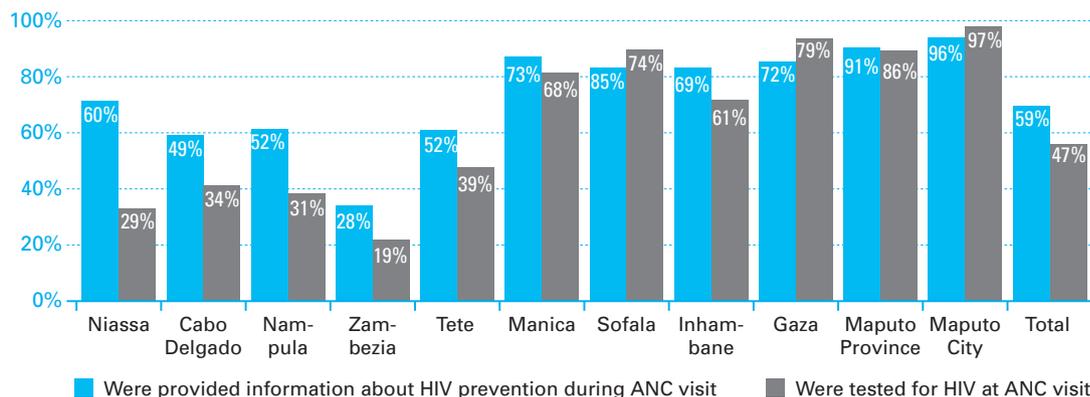
part of their antenatal consultation are large, varying from only 28 per cent in Zambezia to 94 per cent in Maputo City. The proportion of women tested for HIV in 2008 also varies considerably among provinces, with only 19 per cent of pregnant women being tested in Zambezia, compared with 95 per cent in Maputo City. Forty-three per cent of women received their test results.⁴⁷

In 2006, 68 per cent of all children receiving treatment for AIDS were living in the four

southern provinces of the country, and 55 per cent were living in Maputo City. In 2008, the southern provinces accounted for 56 per cent of all children receiving antiretroviral drugs, and Maputo City accounted for 33 per cent. The geographic distribution of children accessing treatment is still highly inequitable: in the southern region of the country, approximately half of children in need of antiretroviral treatment are able to access it, while the percentage of unmet needs is much higher in the central and northern regions.

Box 6.1. Zambezia: The forgotten province?

- Lowest per capita budget allocation (health, education and justice)
- Highest deprivation-based child poverty rate (64 per cent)
- Highest consumption-based poverty rate (71 per cent)
- Highest child mortality rate (206/ 1,000, 10 year average 1998-2008)
- Highest proportion of children to have received no vaccinations (20 per cent)
- Lowest access to safe water (26 per cent)
- 3rd lowest access to safe sanitation (8 per cent)
- 2nd lowest net completion rate for primary school (6 per cent)
- Lowest net attendance rate for secondary school (8 per cent)
- 2nd lowest women's literacy rate (27 per cent)
- Lowest access to antenatal care from skilled person (74 per cent)
- 3rd lowest proportion of registered births
- 3rd highest child marriage (22 per cent of girls under 15)
- 2nd highest in lack of knowledge on HIV transmission (34 per cent not aware of any of the three main methods of transmission)
- Lowest proportion of women receiving HIV information during antenatal care (28 per cent)
- Lowest possession of carta de saúde (64 per cent)

Figure 6.7: Proportion of women receiving HIV information and testing during antenatal consultation visit, 2008

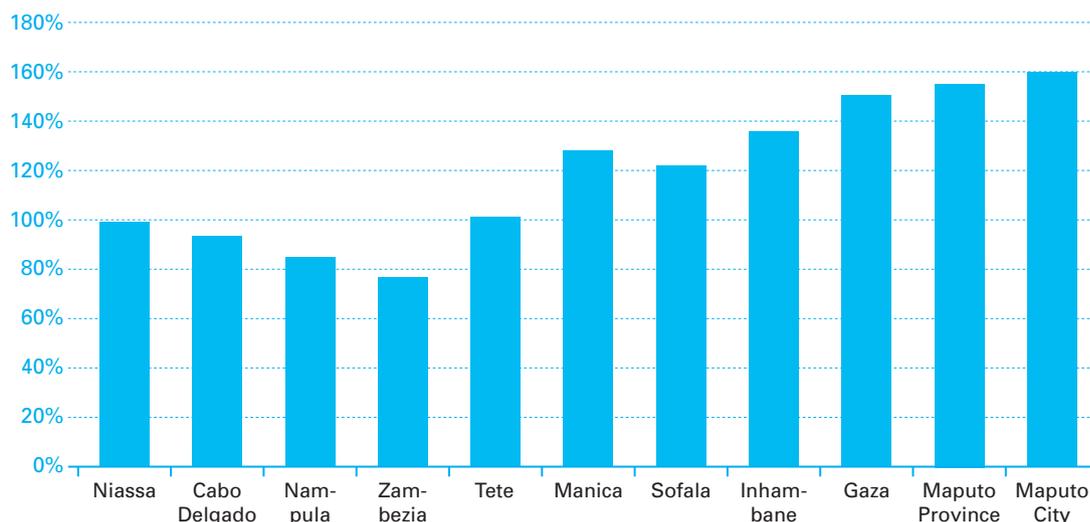
Source: National Institute of Statistics. 'Inquérito de Indicadores Múltiplos 2008. Sumário', Maputo, Mozambique, 2008.

3.3. Disparities in access to education

An analysis of education expenditure per capita reveals a situation similar to that for health expenditure. Zambezia and Nampula provinces receive the lowest allocation of funds (see Figure 6.8). Again, the central

and northern provinces are receiving a substantially lower allocation than the southern provinces.⁴⁸

Central and northern provinces receive a lower budget allocation and have lower education outcomes than southern provinces. Educational outcomes in terms of

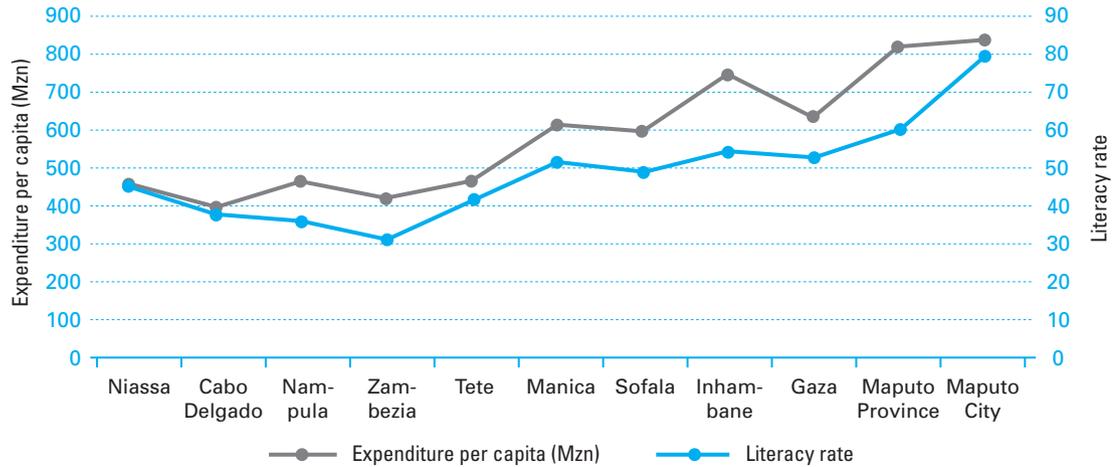
Figure 6.8: Expenditure per capita on education by province, percentage of national average, 2008

Source: Sal e Caldeira and Ximango Consoltores, 'Análise do Impacto da Estrutura das Despesas sobre o Desenvolvimento Económico e as Condições de Vida em Moçambique', Swiss Agency for Development and Cooperation, 2009 and MICS 2008.

literacy are closely correlated with per capita education expenditure (see Figure 6.9). Women’s literacy rates vary substantially by province. Literacy rates vary from 84 per cent

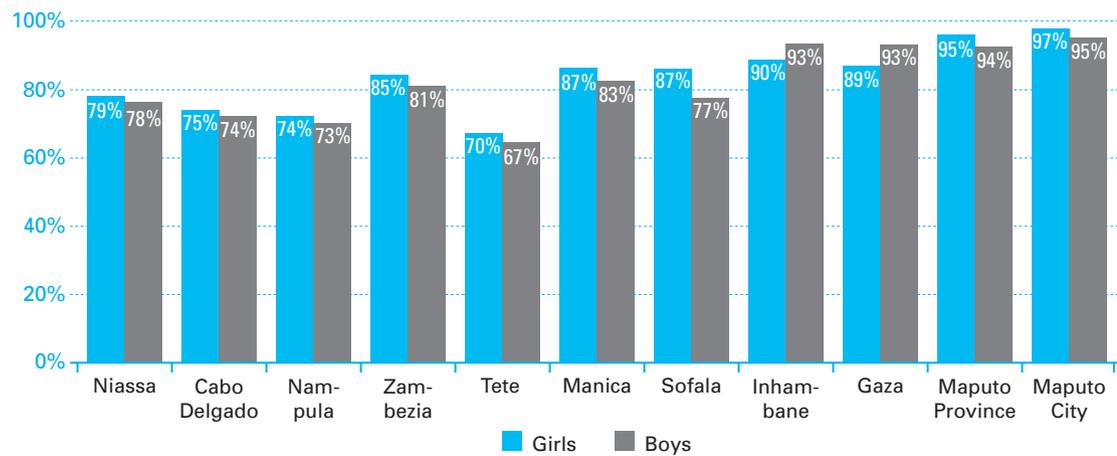
in Maputo City to below 50 per cent in Cabo Delgado, Zambezia and Nampula. The latter three provinces also receive the lowest levels of education expenditure.

Figure 6.9: Education expenditure per capita and literacy rates, 2008



Source: Sal e Caldeira and Ximango Consultores, ‘Análise do Impacto da Estrutura das Despesas sobre o Desenvolvimento Económico e as Condições de Vida em Moçambique’, Swiss Agency for Development and Cooperation, 2009 and MICS 2008.

Figure 6.10: Net enrolment ratio primary (EP1 and EP2) by province, 2008



Source: MICS 2008.

Although the 2008 gross enrolment ratioⁱⁱ for the first phase of primary education (EP1) exceeded 100 per cent regardless of region, province or gender, the gross enrolment ratio for the second phase of primary education (EP2) reveals marked geographical disparities. In Maputo City and Maputo province, which recorded the highest levels of enrolment, the gross enrolment ratio of girls in EP2 exceeds that of boys. Other provinces recorded gross enrolment ratios of less than 100 per cent for EP2, with lower enrolment ratios for girls than boys in most provinces. Regionally, the provinces with the lowest EP2 gross enrolment ratios and the greatest gender gaps are those in the central and northern parts of the country.

Similar regional disparities are observed in the net enrolment ratios. Although the net enrolment ratio for EP1 is over 80 per cent in every province, significant provincial differences appear at the EP2 level. Maputo City is the best performing area, with 43 per cent net EP2 enrolment for boys and 57 per cent for girls. Cabo Delgado, Nampula, Niassa and Zambezia are among the worst performing provinces, each with a net enrolment ratio of less than 15 per cent.

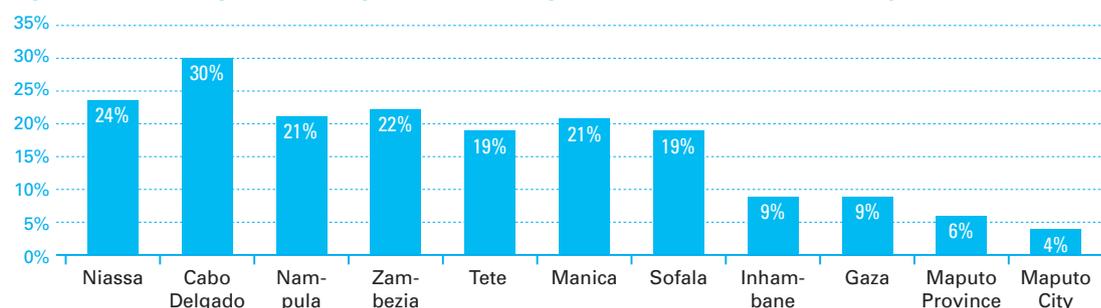
3.4. Disparities in relation to child protection

There are significant geographical disparities in birth registration. Again, central and northern provinces are far worse than the south. Thirty-nine per cent of children under five had their births registered in urban areas, compared to 28 per cent in rural areas. Forty-seven per cent of children under five are registered in Maputo City, while only 11 per cent are registered in Tete.⁴⁹

Regional disparities in attitudes toward domestic violence also exist. For example, the percentage of women who believe that wife-beating is justified in certain circumstances varies from 10 per cent in Maputo City to almost 70 per cent in Niassa.⁵⁰ A 2004 Ministry of Women and Social Action study concluded that these differences are strongly related to socio-cultural norms and practices as well as lack of education and knowledge about the rights of women and children in society.⁵¹ Education is a key factor in reducing violence against children and women.

Data from the 2008 MICS show that there is a significant difference in rates of child

Figure 6.11: Percentage of women aged 15-49 in marriage or union before their 15th birthday, 2008



Source: MICS 2008.

ⁱⁱ The gross enrolment ratio is the proportion of children of any age attending the last grade of school for the given level of education. A ratio higher than 100 per cent indicates over-age children in school.

marriage between the south, centre and north of Mozambique. The southern provinces of Maputo City, Maputo province, Gaza and Inhambane all have a child marriage rate of below 10 per cent. The central provinces have an average rate of 20 per cent, while the two most northern provinces, Niassa and Cabo Delgado, have rates of 24 and 30 per cent, respectively.

3.5. Conclusions

Provincial disparities are evident and persistent across almost all indicators of access to and performance of basic social services. The overall pattern is for the central and northern provinces to have lower budget allocations, reduced access to services and lower outcomes, compared to the southern provinces. Zambezia province is frequently the worst off in resource allocation and development outcomes. This general pattern is reversed in relation to

HIV prevalence, with the southern provinces reporting higher levels of HIV infection. But these provinces also benefit from greater access to prevention and treatment services.

These observed geographical disparities in Mozambique originate in patterns of early human settlement and colonisation that resulted in cultural, religious and linguistic differences among provinces; the centralised and deliberately discriminatory nature of the Portuguese administration during the colonial years; and the lack of a system for the allocation of State resources to provinces based on criteria related to human development status. In addition, the lack of road and rail infrastructure, including the absence of a bridge (until recently) across the Zambezi River, and poor access to markets from rural areas in many parts of central and northern Mozambique have further contributed to provincial differences in socio-economic development.



4. HIV and AIDS

The vulnerability of a country to the effects of infectious disease, including HIV and AIDS, depends to a large extent on the level of human development attained by that country. Individuals and society as a whole are better able to protect themselves against the impact of illness and disease in developed countries. This is the result of constrained financial resources at the national and household level in developing countries, as well as reduced human capital, which arises from a lack of educational opportunities and poor access to other basic social services. In developing countries, endemic diseases adversely impact development and obstruct the fulfilment of human rights, as reflected in key indicators such as life expectancy at birth, child mortality, school attendance, literacy and household income, among others.⁵²

It is at the level of the family and community that the fullest impacts of the AIDS pandemic will be felt. Illness and death among the main breadwinners in a household will have a negative impact on the whole household and will ultimately raise the level of dependence across the whole population, as other households, including those headed by elderly persons who are themselves dependent, take on responsibility for caring for the increasing number of orphans and vulnerable children. Through its effects on the numbers of trained teachers, health workers and other providers, AIDS also affects the mechanisms for generating future human capital. The structural implications of HIV-related mortality on public services are projected to be severe. Staff mortality and long periods of illness will reduce productivity, increase absenteeism and require the relevant authorities to replace lost staff or operate with fewer staff.

The Commission on HIV/AIDS and Governance in Africa recognises three generalisations about the impact of AIDS on families and households:⁵³

- The presence of AIDS in a household quickly results in depletion of household income-earning capacity and of household savings and assets. Many households quickly move into conditions of poverty: very little income or wealth, debt, reduced access to services, and even fewer options for attaining socio-economic security. Women and girls are likely to be most affected;
- AIDS exacerbates and is exacerbated by prevailing economic conditions. It is not a stand-alone condition, but exists within a wider socio-economic context that deepens the vulnerability of households, communities and nations;
- The economic costs of AIDS, the stigma surrounding the disease that leads to discrimination and withdrawal, and the inability to access social services all combine to expand socio-economic inequalities in society. AIDS is not only killing people, it is further dividing national societies.

4.1. Profile of the HIV epidemic in Mozambique

According to estimates and projections based on the 2007 Sentinel Surveillance results, more than 1.7 million Mozambicans were estimated to be living with HIV in 2010. Fifty-five per cent of people living with HIV were estimated to be women, 9 per cent (almost 150,000) were children under 15 and five per cent were children under five.⁵⁴ The Government of Mozambique is expected to release updated population estimates, based on prevalence data from the National Survey on Prevalence, Behavioral Risks and Information about HIV and AIDS in Mozambique (INSIDA) carried out in 2009, in early 2011.

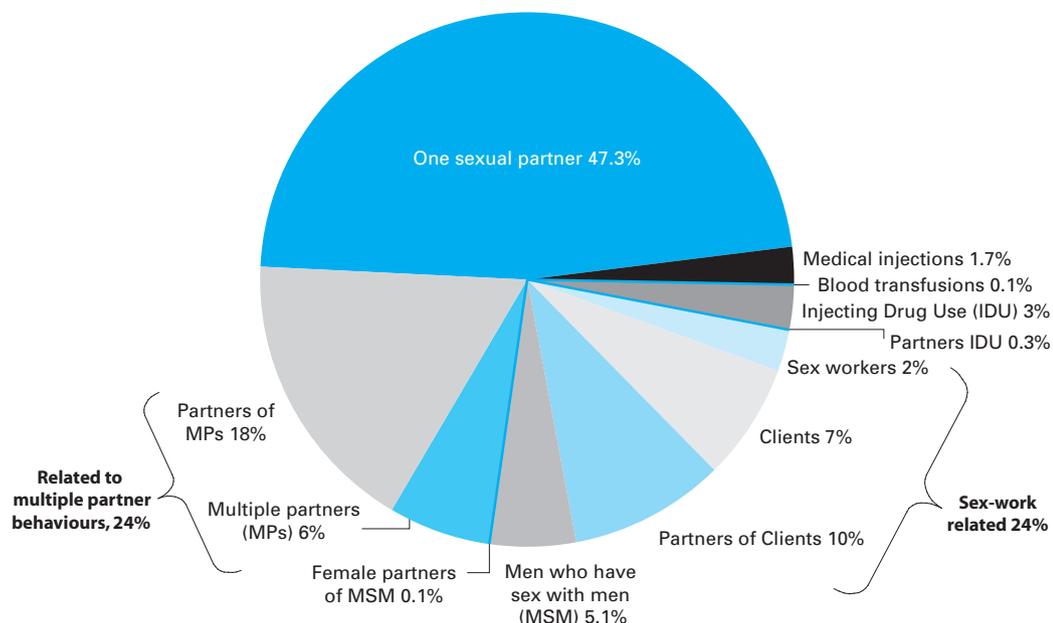
The evolution of the epidemic in Mozambique has been shaped by several

factors. In its incipient phase, prevalence in Mozambique was assumed to be lower than in its neighbouring countries (although there was a paucity of data at the time) due to the on-going civil conflict from 1975 to 1992, which kept Mozambique somewhat isolated from its neighbours. The cessation of violence and the signing of a Peace Accord in 1992 were followed by mass population movements, as people returned from other parts of the country or from neighbouring countries to their original homes, increasing people's vulnerability to infection and opportunities for transmission of the virus. Due to its geographic location, Mozambique is an important transport hub for goods arriving at the ports of Maputo, Beira and Nacala and moving inland to Mozambique's landlocked neighbours.

Poor coverage of basic social services, especially health and education, contributed to the spread of the epidemic during the

period immediately following the cessation of hostilities. Poverty, discrimination, oppression, illiteracy, mobility or migration of people, the status of women, levels of urbanisation, levels of violence, access to health care, and the distribution of wealth, among others, all might have contributed to the spread of the epidemic in Mozambique. A number of studies have found no clear link between HIV infection and wealth. Poverty may actually reduce the spread of the epidemic, for example, if people have less money to spend on transactional relationships. The INSIDA 2009 showed that HIV prevalence in Mozambique is higher among the population, in particular among women, of the highest quintile. Women, particularly those living in rural areas, are especially vulnerable because they are legally, culturally and socially disadvantaged in comparison to men. Many women have been exposed to the risk of sexual assault or rape or other forms of violence.⁵⁵

Figure 6.12: Distribution of new infections by mode of exposure in Mozambique, 2008



Source: Joint United Nations Programme on HIV and AIDS, Mozambique Modes of HIV Transmission and HIV Prevention Study, UNAIDS, Geneva, 2009.

Heterosexual relations remain the most common form of transmitting HIV in the country. About 90 per cent of HIV infections are estimated to occur via this route. Sex between different generations, casual unprotected sexual activity, lack of male circumcision, multiple concurrent sexual partners and low use of condoms are all hypothesised to be involved in the spread of the epidemic.⁵⁶ A substantial percentage (47 per cent) of new infections are, however, estimated to occur in individuals who report being in a mutually monogamous relationship.⁵⁷

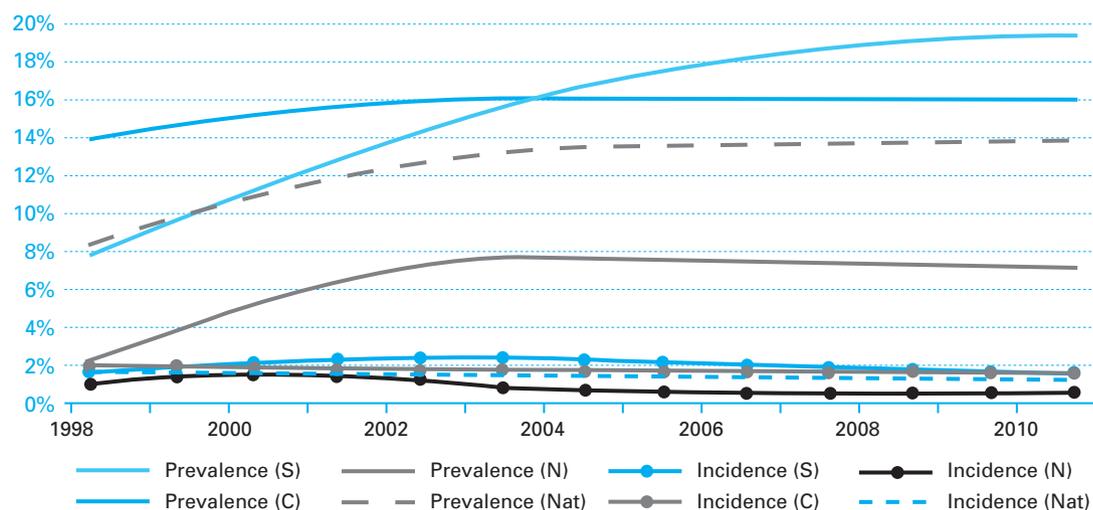
The total number of deaths from AIDS in Mozambique in 2009 was estimated at 96,000. AIDS is fast becoming a major cause of mortality among children, with 18,000 children under five and 21,000 children under 15 estimated to have died from AIDS in 2009.⁵⁸ The 2009 National Child Mortality Study data indicate that AIDS was among the top four conditions contributing to the mortality of children under five in Mozambique, accounting for almost 10 per cent of all deaths among these children.⁵⁹

AIDS is a common cause of death among children under five in urban areas.⁶⁰ It is estimated that 18 per cent of child deaths in Maputo and 16 per cent of child deaths in Gaza province are due to AIDS. These figures could be an underestimate, given that AIDS could in many instances be the underlying cause of death in cases where other opportunistic infections were recorded as the direct cause of death.

The 2009 INSIDA showed a national HIV prevalence among 15–49 year olds of 11.5 per cent. The prevalence disaggregated by region confirmed the situation emerging in previous sentinel surveillance, with the highest prevalence in the south (17.8 per cent), followed by the centre (12.5 per cent). The northern region shows a much lower prevalence (5.6 per cent). Urban HIV prevalence, at 15.9 per cent, is significantly higher than the prevalence in rural areas (9.2 per cent), across all regions.⁶¹

INSIDA also reveals that HIV prevalence in both male and female populations increases with age until it peaks for women at ages

Figure 6.13: Estimated HIV incidence and prevalence by region in Mozambique, 1998–2010



Source: CNCS, UNAIDS and GAMET, 'Draft Mozambique Analysis of Modes of HIV Transmission and National Response to HIV and AIDS,' Maputo, 2009.

25–29 (16.8 per cent) and for men at ages 35–39 (14.2 per cent); furthermore, young girls have a prevalence three times higher than boys of the same age (11.1 per cent among girls aged 15–25, versus 3.7 per cent in boys of the same age). These results highlight the increased vulnerability of adolescent and young girls to HIV in Mozambique.

Analysis of trends can at present only be done by observing the HIV prevalence obtained through epidemiological surveillance in 2004 and 2007, as the INSIDA information uses a different methodology and is hence not comparable.

HIV prevalence dropped markedly in young antenatal-care clients between the 2004 and 2007 epidemiological surveys, but this decreasing tendency was not confirmed in 2009.⁶²

In countries with generalised epidemics where the main form of HIV transmission is through heterosexual sex, like Mozambique, the trends in prevalence among young women 15–24 years old can be used to estimate trends in incidence (new infections).ⁱⁱⁱ,⁶³ HIV prevalence among antenatal-care clients aged 15–24 peaked in 2004, at 16 per cent, and showed a significant decrease in 2007 to 11 per cent. In 2009 the prevalence was estimated at 12 per cent for the same group.⁶⁴ At a national level, there was no significant reduction in the prevalence of HIV over the period 2002–2009 among females aged 15–24. The northern region had the lowest prevalence rate in the country in this age bracket. In 2009, urban areas presented higher prevalence rates in the same age group than rural areas.⁶⁵

Prevalence reflects both the incidence of a disease (i.e., the number of new cases) and the long and variable incubation of HIV. With improvements in provision of antiretroviral

therapy, people infected with HIV are living longer and staying healthier. Prevalence rates may therefore increase, even if new infection rates are falling. With only prevalence measurement, it is difficult to determine if the number of new cases is increasing, decreasing or has reached a plateau and stabilised. Analysis of HIV incidence has therefore become essential in order to answer this question, but all the methods used to determine HIV incidence have disadvantages.^{iv}

The Spectrum analysis of 2007 surveillance data estimated that the annual HIV incidence in adults has decreased from about 2.2 per cent in 2000 to about 1.6 per cent in 2008. This translates into 129,000 new HIV infections in adults in 2008. Annual estimated incidence is about 2 per cent in the central and southern regions and much lower in the north, around 0.7 per cent.

HIV incidence in children under 15 is also estimated to be decreasing, from about 38,500 new infections in 2005 to about 31,000 in 2009, equivalent to about 85 new infections every day. This decrease is mainly attributed to the roll-out of the Prevention of Mother-To-Child Transmission (PMTCT) programme (preventing infections in infants) and the antiretroviral therapy programme (reducing infectiousness of pregnant and lactating women who are on antiretrovirals). The major burden of new infections occurs in the central region, which in 2009 accounted for 60 per cent of the national total of new cases. This is due to high HIV prevalence, relatively low coverage of prevention of mother-to-child transmission services, the high population and a high fertility rate.⁶⁶

Because the HIV epidemic is mainly concentrated within the economically active portion of the population, namely those aged

ⁱⁱⁱ Since most of the young women in this age group would have just started their sexual activity, changes in the prevalence in this age group can represent changes in the number of recent infections.

^{iv} True incidence data are obtained through large-scale cohort studies. While incidence data are better than prevalence data for monitoring the HIV epidemic, these studies have disadvantages including cost, ethical considerations, participation and/or selection biases and the fact that those included in a cohort will inevitably have more exposure to HIV interventions. Other methods are also used to estimate incidence, including: indirect HIV incidence estimates, laboratory-based methods and mathematical modelling of HIV incidence.

15–49, its effects are disproportionately borne by the very age groups that play a key role in the development of the economy and of the country's social sectors. A simulation study conducted in 2002 and based on two scenarios (one with AIDS, and one without) concluded that HIV and AIDS could have a wide-ranging economic impact in Mozambique, with a visible reduction in the growth of per capita GDP.⁶⁷

According to projections over the period 2000–2010, the HIV epidemic will result in a loss of some 17 per cent of education sector staff. Across all levels, some 9,200 teachers are expected to be lost to AIDS. For each staff member lost in the education sector, nearly eighteen months of productive working time will be lost.⁶⁸ The HIV epidemic also has negative consequences for other sectors, given the need to replace and renew skilled labour.

The health system faces difficulties in responding to the growing demand for its services from the public, exacerbated by the effect the HIV epidemic has on health service workers. HIV and AIDS will likely worsen the already poor health worker-to-patient and doctor-to-patient ratios in Mozambique. The high numbers of patients in hospitals and health facilities requiring relatively expensive treatment for AIDS and related infections will also place a considerable economic toll on the health sector.

4.2. Priority actions for children in relation to HIV and AIDS

Mozambique has adopted the 2001 Declaration of Commitment from the UN Special Session on AIDS for HIV and AIDS, which includes priority actions for children and AIDS, later renamed in the “Unite for Children, Unite against AIDS” campaign as the Four Ps:⁶⁹

- P1 – Primary prevention
- P2 – Prevention of mother-to-child transmission (PMTCT)

- P3 – Paediatric AIDS
- P4 – Protection of orphans and vulnerable children (OVC)

This following section discusses each of the Four Ps.

4.3. P1 – Primary prevention

MICS 2008 data show an overall positive trend in knowledge and awareness of HIV transmission and prevention, compared to previous data from the 2003 Demographic and Health Survey. Improved knowledge, awareness and adoption of safe practices are correlated with living in an urban area, having higher education levels and belonging to a higher wealth quintile. For example, the data demonstrate an improvement in women's knowledge about AIDS and how HIV is transmitted. Eighty-one per cent of women know at least one of the three main ways of preventing HIV infection, and 13 per cent know all three of the main ways. While knowledge of all three main forms of prevention is generally low, it is higher among women living in urban areas (17 per cent) than among those living in rural areas (10 per cent). Almost 65 per cent of women aged 15–49 know that using condoms is one way to avoid infection by the virus.⁷⁰

The percentage of women aged 15–49 who do not accept the three main misconceptions concerning HIV and AIDS has grown in recent years. Almost three in every four women aged 15–49 (72 per cent) know that HIV cannot be transmitted through sharing food and that a person who looks healthy may be infected with the virus, while in 2003 the figures were 63 per cent and 45 per cent, respectively. Similarly, the percentage of women who know that HIV cannot be transmitted by a mosquito bite rose from 37 per cent in 2003 to 64 per cent in 2008.⁷¹

While general knowledge about HIV and its transmission modes has shown positive trends in the last five years, there is still much room for improvement in actual prevention.

Increased knowledge is not proof of changed attitudes and behaviours. One such example is the discrepancy between knowing where an HIV test can be obtained, 77 per cent of women interviewed, and having an HIV test, 31 per cent of the same group (see Figure 6.14). Geographical differences in knowledge of testing availability and actual testing may be linked to the availability of counselling and testing services across the country, with higher availability in the south, followed by the central and northern regions.⁷²

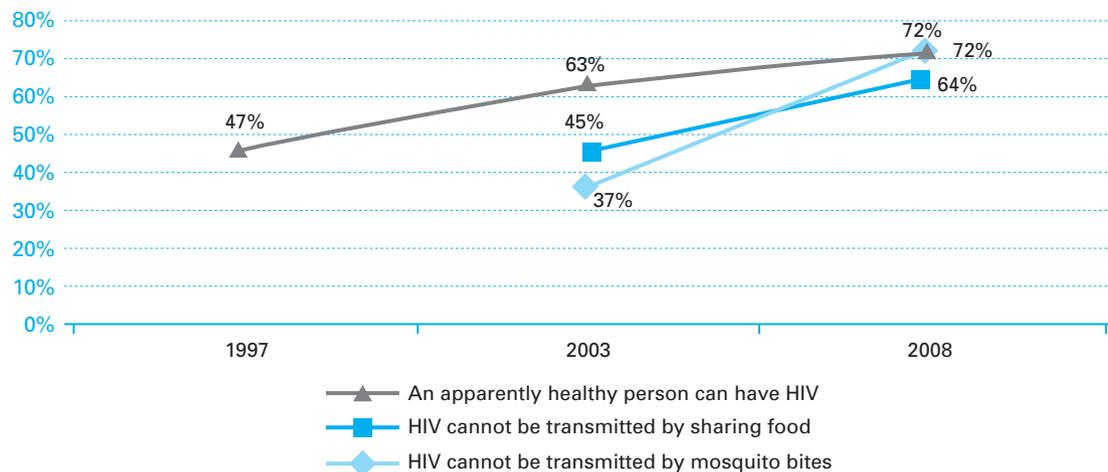
Women in Mozambique tend to enter into sexual relations at a relatively early age.

Overall, 29 per cent of females aged 15–19 first had sexual intercourse before they turned 15, and 77 per cent of females aged 20–24 first had sexual intercourse before reaching 18. The proportion of females aged 15–19 who reported entering into sexual relations before age 15 is higher in rural areas, at 32 per cent, than in urban areas (24 per cent). Around 16 per cent of sexually active females reported having had sexual relations with a man 10 years or more older than themselves during the 12 months prior to the interview. Studies in Southern Africa have consistently found that the larger the age disparity, the lower the probability of

safe sex.⁷³ Therefore, sexual relationships between older men and younger women are a possible explanation of different infection rates in male and female adolescents.

Condom use remains relatively low in Mozambique, especially in rural areas and among less educated females. Only 44 per cent of females aged 15–24 who had had sexual relations with a non-regular or non-cohabiting partner in the previous 12 months used a condom at their last sexual relation. The proportion was greater for females in the wealthiest quintile (64 per cent) than for females from the poorest households (12 per cent). A multivariate probabilistic regression analysis (using the probit model) was conducted to examine the factors correlated with women’s exposure to risky sexual behaviour. The dependent variable was whether a condom was used at a woman’s last sexual relationship with a non-cohabiting partner, as this is deemed to be a good proxy for attitudes towards risky sexual behaviour. The basic rationale is that women who have protected sexual intercourse with a non-cohabiting partner are less willing to expose themselves to HIV and other sexually transmitted diseases.

Figure 6.14: Identifying misconceptions about HIV, women 15-49 years, 2008



Source: DHS 1997 & 2003, MICS 2008.

Women with secondary or higher education are less likely to expose themselves to risk; this group shows an almost 50 per cent lower probability of risky behaviour than women with no education. Having only a primary education does not appear to be correlated with women's attitudes towards risky sexual behaviour. Surprisingly, the model shows that women with correct knowledge about HIV transmission are as likely to have unprotected sex as women who are not aware of the transmission channels of HIV. Another interesting result is that the likelihood of high-risk activity increases with age for women in monogamous relationships while decreasing for women in polygamous relationships (see Figure 6.15). In terms of household and location characteristics, wealth seems to have a positive relationship with condom use, while living in rural areas is positively associated with high-risk sexual behaviour.

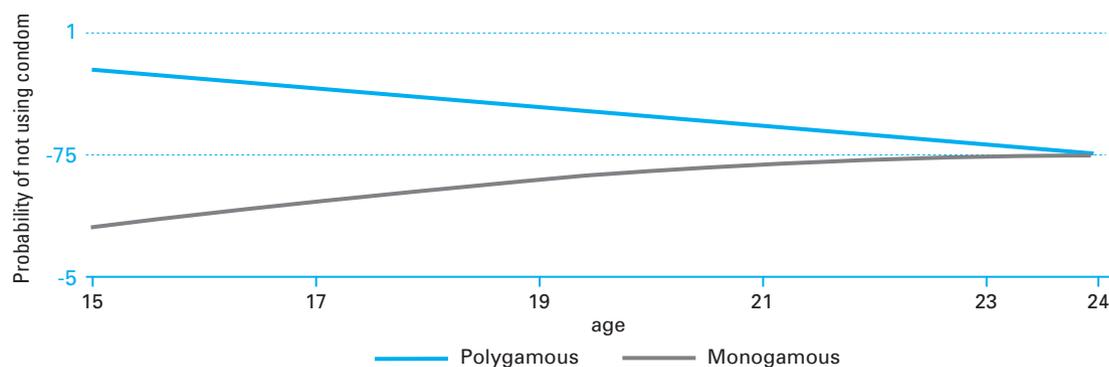
Interestingly, these behavioural indicators don't seem to correspond to the HIV-prevalence profile that recently emerged from the INSIDA preliminary results: For both men and women, HIV prevalence was higher in the highest wealth quintile, and higher among individuals with education than among those with no education. The final INSIDA report will certainly shed more light on possible correlations between behavioural and seroprevalence findings.

4.4. P2 – Prevention of mother-to-child transmission of HIV

Around the world, 700,000 children under 15 are infected with HIV each year, and more than 90 per cent of paediatric HIV infections are the result of mother-to-child transmission of the virus.⁷⁴ Up to two thirds of infections of children occur during labour, birth and pregnancy, and one third occur during breastfeeding.⁷⁵ Without preventive measures, transmission rates are between 15 and 40 per cent, but with effective antiretroviral treatment and care, this rate can be reduced to as low as two per cent, as is the case in developed countries.⁷⁶

In 2008, it was estimated that PMTCT interventions in Mozambique averted an estimated 5,820 new HIV infections in children under 15, which translates to a 15.6 per cent reduction nationally.⁷⁷ The PMTCT programme was first introduced in Mozambique in 2002. Since the establishment of the national programme, the number of health facilities offering prevention services has expanded rapidly, from eight in 2002 to more than 800 by end 2009.^v At inception, the majority of services were concentrated in and around provincial capitals, but by 2009, prevention interventions had been integrated into antenatal care services in all districts, including several peripheral health facilities.

Figure 6.15: Probability of not using condom in sexual relationship, women 15-24, 2008



Source: UNICEF calculations based on MICS 2008.

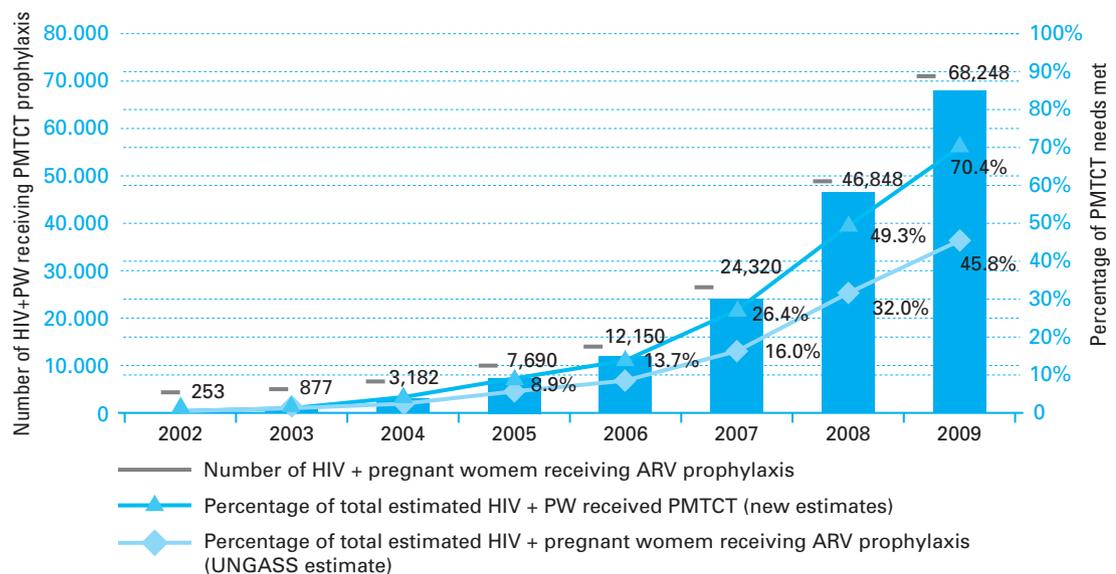
The population coverage of PMTCT and paediatric antiretroviral therapy interventions were revised in 2010 based on the more accurate population estimates from INSIDA data.⁷⁸ The revised estimates indicate that previous studies had over-estimated the population of HIV positive women. The proportion of HIV positive women estimated to be receiving PMTCT services (population coverage) has therefore increased significantly. Previous estimates⁷⁹ indicated that around 46 per cent of pregnant women were receiving the necessary prophylaxis to reduce the transmission of HIV from mother to child. Revised estimates indicate that 70 per cent of women are actually receiving treatment.⁸⁰ Figure 6.16 shows the absolute number of pregnant women receiving PMTCT treatment and the proportion of women receiving ARVs for PMTCT based on previous and the most recent population estimates. While the revised treatment estimates are encouraging, it should be noted the treatment is distributed inequitably. Pregnant women in the south of

the country have significantly higher access to treatment than their central and northern counterparts.

PMTCT policies in Mozambique

In November 2006, the Ministry of Health issued a guidance note⁸¹ introducing several key policies: provider-initiated ('opt out') testing to be offered in both antenatal care and maternity settings; blood samples for CD4 counts to be drawn in the antenatal care facility; and DNA polymerase chain reaction (PCR) testing for HIV-exposed children under 18 months. Use of combination therapy for prophylaxis (single dose nevirapine [NVP] during delivery, plus (zidovudine) [AZT] from 28 weeks) was officially introduced, and the initiation of nevirapine treatment to pregnant women was moved forward from 36 to 28 weeks. Integration of PMTCT services into maternal and child health services was strengthened in order to increase uptake of antiretroviral therapy by pregnant women. Reviving the practice of consultations for at-

Figure 6.16: Trends in PMTCT coverage between 2002 and 2009



Source: Ministry of Health, Annual Report, National Laboratory Services, Maputo, 2009.

^v Data from UNGASS Report 2010

risk children (Consulta de Criança em Risco) was recommended to strengthen follow-up of children born to HIV positive mothers.

The establishment of mother support groups by health facilities was also included in the guidance note as a necessary step towards supporting pregnant and lactating women to adhere to PMTCT interventions and the subsequent follow-up of their HIV exposed children. The guidelines on mother support groups were further developed following a nationwide mapping of this intervention in 2008. The final guidelines are awaiting approval.

Recent changes in the global guidelines for prevention of mother-to-child transmission call for a more comprehensive and 'aggressive' approach. These changes include: lifelong antiretroviral therapy for HIV-positive women in need of treatment; earlier initiation of efficacious prophylaxis regimens; and continuation of these during post-partum and breastfeeding.⁸² In early 2010, the Ministry of Health policy changed to reflect some of the revised international indications from WHO, including raising the levels at which pregnant women with low CD4 counts are considered eligible for Highly Active Antiretroviral Therapy (HAART),⁸³ early initiation of prophylaxis for women,

and continuation of Nevirapine by the infant until weaning from breastfeeding.

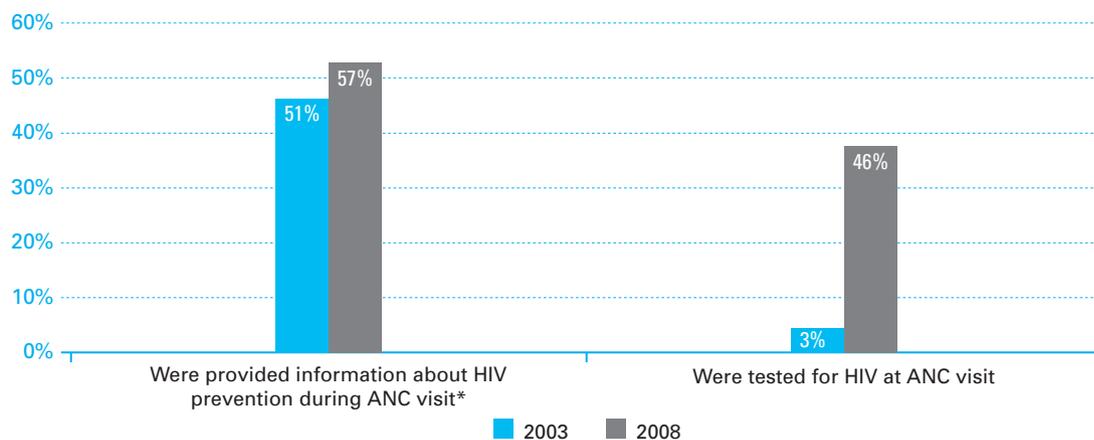
The success of a PMTCT programme depends on a complex cascade of interventions, integrated with the maternal and child health services, as described below.

Knowledge of prevention of mother-to-child transmission of HIV

The level of knowledge about mother-to-child transmission of HIV among the Mozambican population has increased.

The 2003 Demographic and Health Survey showed that only 44 per cent of women and 43 per cent of men aged 15–49 knew that HIV can be transmitted from mother to child during pregnancy, delivery and breastfeeding. Data from MICS 2008 reveal that among women of the same age group, this knowledge has increased to 78 per cent. Knowledge levels are higher in urban areas (89 per cent) than in rural areas (72 per cent). Furthermore, the data show that 70 per cent of women interviewed know that the virus can be transmitted through breastfeeding (compared to 50 per cent of women in 2003). Only slightly more than half (55 per cent) of women know all three main methods of HIV transmission (MICS 2008).

Figure 6.17: Testing and counselling during antenatal visits, 2003 and 2008



Source: DHS 2003, MICS 2008.

HIV counselling and testing as part of antenatal care

Although HIV counselling for pregnant women during antenatal care visits increased from 51 per cent in 2003 to 57 per cent in 2008, it remains low. Geographical disparities in the proportion of women who received HIV counselling as part of their antenatal consultation are large, varying from 28 per cent in Zambezia province (27 in 2003) to 94 per cent in Maputo City (81 per cent in 2003).⁸⁴

The proportion of women tested for HIV as part of their antenatal care has improved dramatically. In 2008, 46 per cent of pregnant women aged 15–49 underwent an HIV test as part of their antenatal consultation, compared with only 3 per cent in 2003. The proportion of women tested for HIV varies across provinces, with only 19 per cent of pregnant women being tested in Zambezia province in 2008, compared with 95 per cent in Maputo City.⁸⁵ Forty-three per cent of women received their test results.

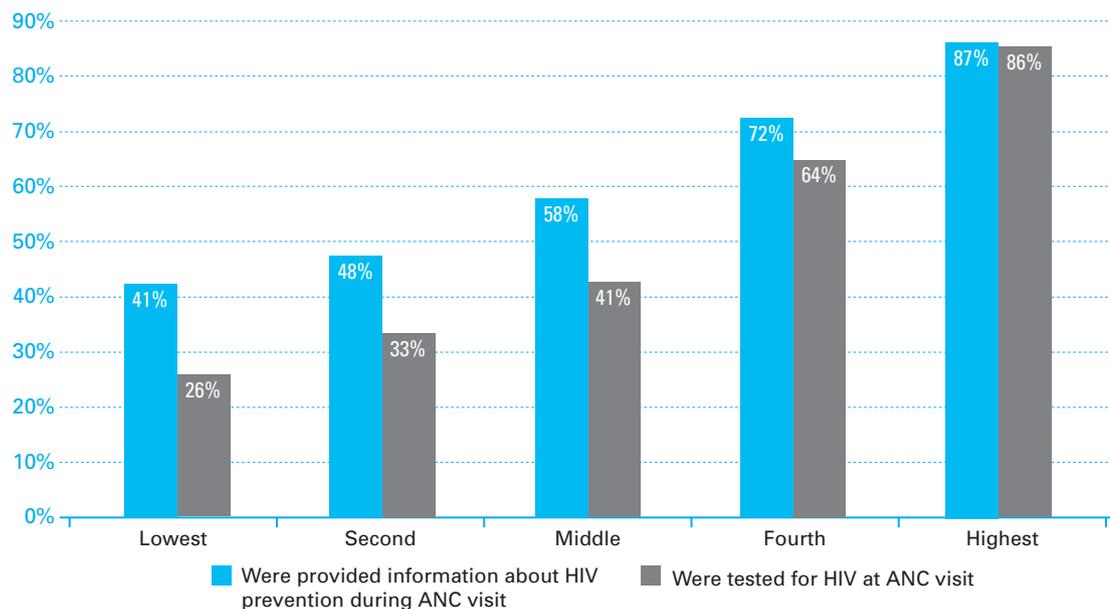
Among pregnant women who received HIV counselling, 82 per cent received an HIV test, according to MICS 2008. This is likely the consequence of provider-initiated testing and counselling at antenatal care services, as well as progressive normalization of including an HIV test as part of antenatal services.

Access to HIV information and testing during antenatal visits is highly correlated with the wealth of women. Only 26 per cent of the poorest women were tested for HIV, compared to 86 per cent of the best-off women (see Figure 6.18).

Antiretroviral prophylaxis for pregnant women

In order to reduce mother-to-child transmission of the virus, as well as for their own treatment, when eligible, HIV-positive pregnant women receive antiretroviral drugs for prophylaxis. Access to antiretroviral therapy has increased gradually since inception of the programme in 2002.

Figure 6.18: HIV test and counselling during antenatal visits, by wealth quintile, 2008



Source: MICS 2008.

Coverage of antiretroviral prophylaxis for the overall population of HIV-positive pregnant women (including both tested and non-tested women) was 0.2 per cent in 2002, increasing to 30 per cent in 2007, 32 per cent in 2008 and 46 per cent in 2009.^{86, vi} It is important to note that these coverage figures refer only to services provided during antenatal care, and exclude those women accessing antiretroviral therapy at maternity facilities. This approach was adopted by the Ministry of Health in order to avoid double-counting of women accessing both antenatal and maternity services, but it results in under-reporting. It is hoped that the new Antenatal Care Card, now being finalised, will facilitate clarity in reporting and allow collection of reliable information on coverage of PMTCT in the near future.

Prioritising access of pregnant women to HAART is critical. HAART minimizes the risk of post-natal transmission in breastfeeding mothers with low CD4 count and high viral load, who face challenges in implementing recommended infant feeding options. Women with CD4 counts of less than 200 cells/microlitre (μl) are five times more likely to transmit HIV during breastfeeding than women with CD4 counts over 500 cells/ μl .⁸⁷ HAART can reduce the risk of transmission to approximately two per cent, as compared to other interventions, e.g., single dose nevirapine, which reduces the risk to 10–15 per cent.

In 2009, out of all pregnant women who received PMTCT interventions, 48 per cent received single dose nevirapine, 40 per cent a combination of nevirapine and AZT (bithery), and 11 per cent HAART for their own health. The number of HIV-positive pregnant women who received HAART for their own health was 53 in 2003, increasing to 3,647 in 2007, 6,388 in 2008, and 7,791 in 2009 (equivalent to 5 per cent of all

estimated HIV-positive pregnant women in the country).

Although progress is being made, the number of pregnant women receiving antiretrovirals for their own health remains below expectations. HAART in 2010 is delivered in only selected health facilities, termed Antiretroviral Therapy sites. This means that pregnant women, instead of being able to access HAART as an integrated component of PMTCT services, are mainly referred to Antiretroviral Therapy sites, which may be in a different health facility. This interferes with access, including screening for eligibility.

Antiretroviral therapy prophylaxis for babies

According to international PMTCT guidelines and the revised national Antiretroviral Therapy protocol for pregnant women (option A),⁸⁸ all exposed children born to HIV-positive mothers should receive antiretroviral prophylaxis with nevirapine within 72 hours of birth, and continued nevirapine until the child is weaned from breastfeeding. Ministry of Health data reveal, however, that only an estimated 40–50 per cent of HIV-positive pregnant women give birth at health facilities in Mozambique. The fact that institutional deliveries account for only around half of all deliveries is a clear bottleneck in the provision of antiretroviral prophylaxis to newborns in the first 72 hours of life. Despite this constraint, the number of children receiving antiretroviral prophylaxis increased from 328 in 2002 to 41,266 in 2009, corresponding to 58 per cent of all children estimated to be born to HIV-positive mothers and 83 per cent of pregnant women who received any form of antiretroviral for PMTCT in the same time period. The increase may be attributable, in part, to the increasing institutional delivery rate for HIV-positive women enrolled in

^{vi} Note that population coverage of PMTCT and paediatric antiretroviral interventions will be revised during the last part of 2010, based on the more accurate population estimates in the INSIDA.

PMTCT, as well as the fact that newborns are at times brought to maternity services within 72 hours of birth to receive antiretroviral treatment.

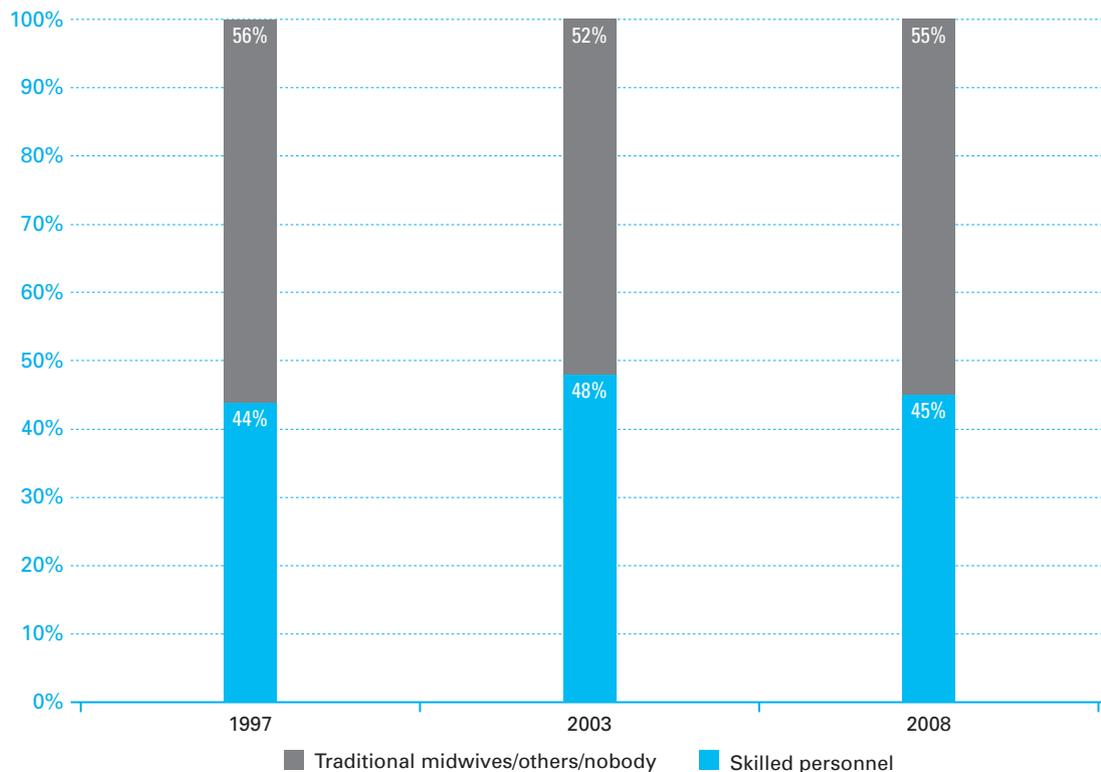
Cotrimoxazole coverage for HIV-exposed children

International guidelines recommend administration of cotrimoxazole prophylaxis to children born to HIV-positive mothers or children living with HIV.⁸⁹ This is a proven cost-effective intervention that can be widely applied even in low-resource settings. National guidelines indicate that cotrimoxazole prophylaxis should commence at four weeks for exposed

children. Anecdotal evidence from supervision visits to health facilities indicates that this intervention is widely implemented in the country, but reliable national coverage figures are not yet available.

A significant proportion of women drop out of the services at each stage in an antenatal and post-natal cascade (see Figure 6.20). Not all pregnant women attending antenatal care received counselling and testing, and even fewer received antiretroviral prophylaxis. Similarly, despite the increasing number of children exposed to HIV who are able to access antiretroviral prophylaxis, those who finally do have their HIV status confirmed through testing are relatively few.

Figure 6.19: Attended deliveries, 1997, 2003 and 2008



Source: DHS 1997 and 2003, MICS 2008.

Future plans and targets

The reduction of mother-to-child transmission of HIV has been a key

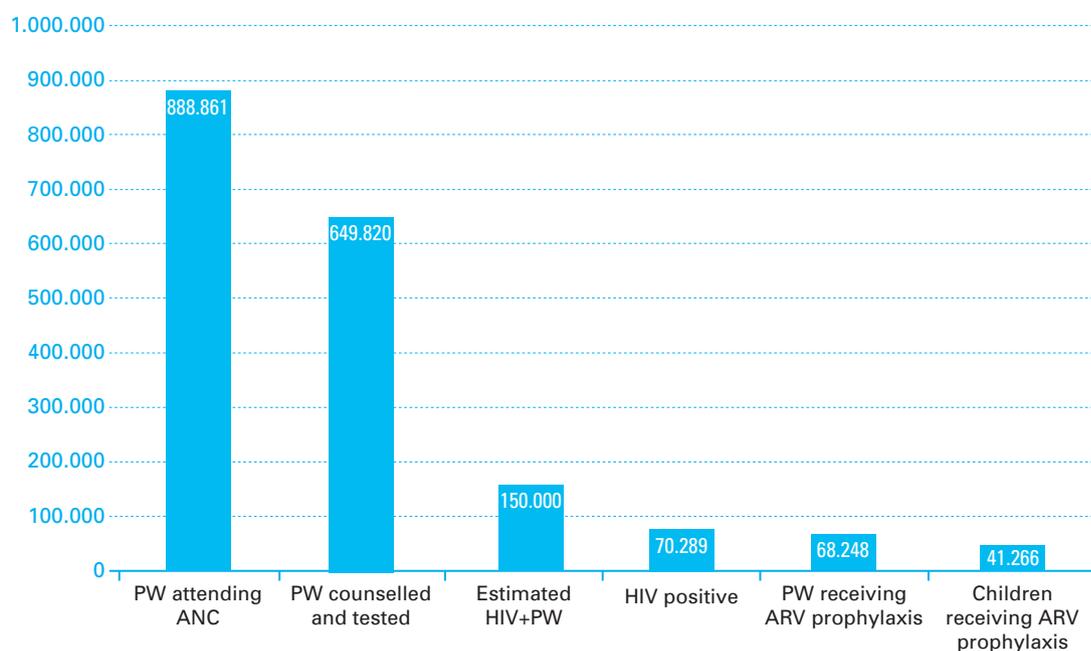
Government priority for several years. The second national strategic plan to fight HIV and AIDS, which covers 2005–2009, set out a target of PMTCT coverage of 90 per cent by the year 2009, building on the Ministry of Health target of 60 per cent coverage by the year 2008.⁹⁰ Mozambique has also committed to the universal access goal to reach at least 80 per cent of pregnant women and their babies with PMTCT interventions by 2010. Targets set in 2009 remain below what is required to reach the goal of universal access, on the grounds that the country did not have the capacity to reach more ambitious targets. Targets have been revised upwards in July 2010, given the very positive progresses made in the previous years, and in particular in 2009 (where the country already achieved what was initially planned as the target for 2011). The revised Ministry of Health targets aim at achieving

the benchmark of 90 per cent coverage of PMTCT in HIV-positive pregnant women latest by the year 2015.

4.5. P3 – Paediatric AIDS

It is estimated that there were about 148,000 children under 15 living with HIV in Mozambique in 2009, and this number is expected to increase to over 150,000 by 2010.⁹¹ More than half of all infected children live in the four central provinces of the country. Among infected children, slightly more than half are under five years old. Estimates show that following an initial rise in the number of new infections among children during the period 2002–2005, the number of new infections apparently started to decrease after 2006 (possibly due to the impact of the PMTCT programme, as well as the natural progression of the epidemic), although it still remains alarmingly high. It is estimated that there were more than 30,941 new infections in 2009, representing about 85 new infections every day (see Figure 6.21).⁹²

Figure 6.20: PMTCT antenatal and post-natal cascade, 2009



Source: Ministry of Health, Annual Report, National Laboratory Services, Maputo, 2009.

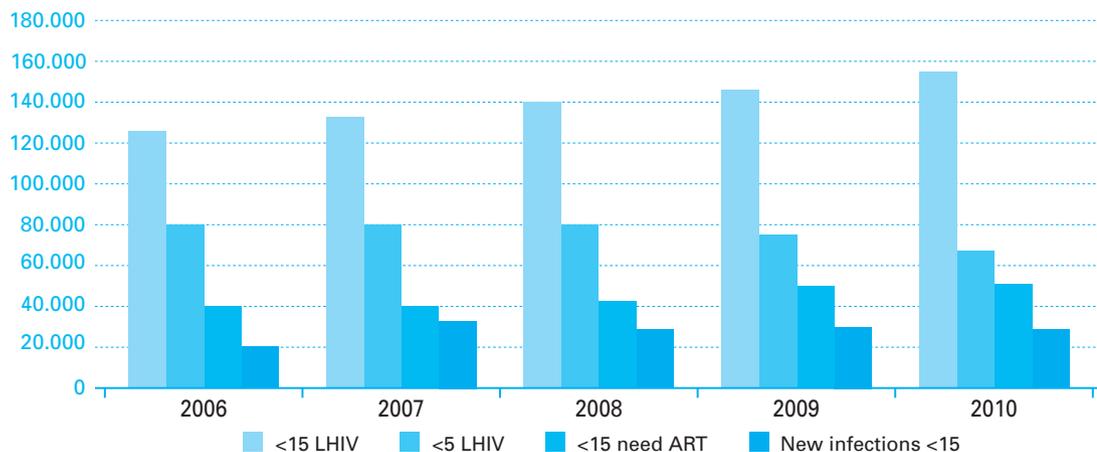
More than half of children living with HIV in Mozambique are likely to die before reaching their second birthday, unless they are treated for opportunistic infections and receive early initiation of antiretroviral therapy. AIDS is fast emerging as a major cause of mortality among children, with an estimated 19,000 child deaths due to AIDS in 2008.⁹³ The 2008 National Child Mortality Study estimates the proportion of deaths due to AIDS among children under five is 10 per cent.⁹⁴ AIDS is threatening to reverse the gains made by Mozambique in reducing child mortality in recent years and represents one of the greatest obstacles in meeting the MDG target of a two-thirds reduction in child mortality by 2015.

Children infected with HIV through vertical transmission from their mother, either at birth or during breastfeeding, require treatment with antiretrovirals much earlier than do adults infected through sexual contact. National paediatric guidelines address this by putting all HIV-positive

children (less than 12 months) on antiretroviral treatment immediately. The Ministry of Health estimate that in 2009, 47,500 children under 15 required antiretroviral treatment, with the total predicted to rise to slightly above 50,000 by 2010.⁹⁵

The number of children under 15 receiving treatment in the country grew from fewer than 500 in 2004 to 9,393 in 2008 to 13,510 nationwide by the end of December 2009. This represents 19 per cent of children considered eligible by the Ministry of Health, based on application of the updated Spectrum model.⁹⁶ While representing a significant improvement from the three per cent coverage recorded in 2005, the treatment coverage for children is still far from satisfactory. Despite the increased absolute number of children on antiretroviral treatment, the coverage shows a reduction trend due to the increased number of eligible children resulting from the application of the revised paediatric guidelines referred to above.

Figure 6.21: Estimated number of children under 15 living with HIV, under 5 living with HIV, number of new infections in children under 15, and numbers of children under 15 in need of treatment/antiretroviral therapy, 2006–2010



Source: National Institute of Statistics, Ministry of Health, Ministry of Planning and Development, Centro de Estudos Africanos da Universidade Eduardo Mondlane, Conselho Nacional de Combate ao HIV/SIDA, Faculdade de Medicina, Impacto demográfico do HIV/SIDA em Moçambique: Actualização - Ronda de vigilância epidemiológica 2008, Government of Mozambique, Maputo, 2010.

Similarly, the increase in the number of sites providing antiretroviral therapy has been rapid. In 2009, 220 health facilities were providing antiretroviral therapy services and 173 of them (78 per cent) were treating HIV-positive children, compared with 32 of 150 sites in 2006 (21 per cent). By 2009, 95 per cent of all sites providing antiretroviral therapy were also treating children, although many are not yet operating at full capacity.⁹⁷

Early infant diagnosis remains critical to ensuring access to timely paediatric care and treatment for children, given that AIDS progresses rapidly in infants and children under five. According to WHO guidelines,⁹⁸ all children born to HIV-positive mothers should receive a DNA polymerase chain reaction (PCR) test at 4–6 weeks. It also recommends that children with severe malnutrition and compromised growth should undergo a clinical evaluation that includes HIV testing. When the PCR test is not available, the child should be tested through antibody testing after 9 months and again at 18 months.

All infants under 24 months with confirmed HIV infection should be started on antiretroviral therapy, irrespective of clinical or immunological stage, according to international recommendations and national guidelines issued in October 2008.⁹⁹ In 2009, the PCR test was being performed in two laboratories in Maputo and Nampula, with a third in Beira expected to commence testing in 2010. As of 2009, national universal access data¹⁰⁰ reported at least 287 sites collecting dried blood spot samples at peripheral level health facilities for PCR analysis at referral laboratories.

A number of constraints are hampering effective PCR testing, including long delays due to transportation of samples and intermittent lack of testing materials. One positive innovation was the introduction in 2009, on a pilot basis, of short message service printer technology for feedback of PCR results to facilities. This technology is planned to be rolled out nationally in 2010 and is expected to substantially improve early infant diagnosis in the country.

In 2005, the Government made the scale-up of paediatric treatment a priority in the fight against AIDS and poverty. In PARPA II, a target of treatment for 33,000 children by the year 2009 was established. However, this was not achieved; the evaluation of PARPA II shows that only 11,000 children were receiving treatment in 2009. In 2008 the Ministry of Health decided to drastically reduce the annual targets to 11,500 children receiving treatment in 2008, compared with the PARPA II target of 20,826. This revised target was based on a review of progress and projections of the number of new children starting antiretroviral therapy each month during the previous year. After intense advocacy, and following adoption by Mozambique of the new paediatric antiretroviral therapy norms^{vii} and the expansion of early infant diagnosis through the installation of two PCR machines in the northern and central regions of the country, the Ministry of Health, in collaboration with its partners decided to revise the targets in 2009 (see Table 6.3).

While representing an improvement, these revised targets remain far below the original PARPA II targets and even further from the universal access commitment.

^{vii} Initiate antiretroviral therapy for all seropositive children aged 0–1 year; PCR testing for all children aged 0–9 months using rapid tests; changes to the CD4 cell count norms; use of the four stages of the World Health Organisation, rather than three; and introduction of soluble tablets in place of syrups.

Table 6.3: Paediatric HIV targets, 2009

		2007	2008	2009	2010	2011	2012	2013	2014
Goal of the Projection Model for children on TARV (lower limit)	Children on ARV treatment	6,451	9,393	13,500	18,817	23,818	29,058	34,258	39,743
	Children as a proportion of total on ART	7.1%	7.3%	8.5%	9.9%	10.7%	11.4%	11.9%	12.3%
	Coverage		21%	28%	37%	45%	52%	58%	64%

Source: Ministry of Health, Departamento Nacional de Assistência Médica, HIV Programme Report, Ministry of Health, Maputo, 2009.

4.6. P4 – Protecting orphans and vulnerable children affected by AIDS

There are an estimated 1.8 million orphans in Mozambique, 510,000 of whom have been orphaned by AIDS.¹⁰¹ This number is expected to rise, with AIDS being the likely cause of orphanhood in a majority of cases. This does not take into account additional children who may be vulnerable due to the impact of HIV on their family. A child is considered an Orphan or Vulnerable Child (OVC) if one or both of his/her natural parents is dead, if at least one parent is chronically ill, if there was an adult death in the household during the previous twelve months after a prolonged illness, or if there is a chronically ill adult in the household.

Orphaned children are more exposed to risks than non-orphans. These risks include: an increase in sibling- or child-headed households, lower school enrolment and performance, increased risk of sexual abuse and HIV infection, risk of hazardous child labour, early sexual activity and marriage, increased risk of severe psychosocial problems, and poor health and nutrition.¹⁰² Furthermore, stigma and discrimination against people infected or affected by HIV or AIDS remains a challenging issue. Children and young people with sick or dying relatives are particularly exposed to stigma. They may be ostracised by their communities and

receive minimal support from their families due to the shame and stigma currently associated with an AIDS-related death. In schools, discrimination against children is expressed through teasing and bullying. In some cases, children avoid their HIV-positive peers due to fear that they may become infected. A participatory study on the coping mechanisms of families and communities in the context of AIDS, carried out nationwide by UNICEF in collaboration with the Ministry of Women and Social Action in 2004, found that approximately half of the households surveyed felt that children orphaned due to AIDS were likely to be stigmatised.¹⁰³

4.7. Nutrition and HIV

Undernutrition, food insecurity, HIV infection and AIDS mutually reinforce each other. People living with HIV have increased energy needs, but the HIV infection or related opportunistic infections can reduce their ability to absorb nutrients and reduce appetite. This can lead to them losing weight and becoming weak. A vicious cycle may ensue where they are less able to work, maintain a job and take care of themselves, so they become even weaker. In addition, if they do not receive treatment, they are more susceptible to opportunistic infections and ultimately progress to AIDS. Their family members might also be affected, if they depend on the person with HIV for their food, living expenses and care.

For children, who need energy and nutrients to grow, the impact of HIV infection on their nutritional status can be even more severe. OVC are especially vulnerable to undernutrition, depending on whether they live in a family environment or not and on their access to the necessary resources. The deprivation-based poverty study examined OVC as a group and found that 22 per cent had severe nutritional deprivation (either severe stunting, underweight or wasting).¹⁰⁴

Antiretroviral treatment can help to improve the nutritional status of people living with HIV since it improves people's health status. At the same time, however, the medicines can have side effects, which can be exacerbated when food consumption is not adequate. People's appetite usually increases when their health improves, and in an environment of food insecurity and poverty this can be challenging. Anecdotal evidence suggests that lack of food can be an important reason for abandonment of treatment.

An analysis of the nutritional status and vulnerability of 920 people living with HIV and receiving antiretrovirals in 33 districts¹⁰⁵ found that one quarter of them were undernourished (body mass index below 18.5 kg/m²). One fifth received food support. Food security and vulnerability were measured based on food consumption and the use of survival strategies. The study concluded that two thirds of the interviewees were vulnerable and food insecure.

4.8. Conclusions

It is estimated that in 2010 more than 1.7 million Mozambicans are living with HIV, including almost 150,000 children under 15. In urban areas such as Maputo City, AIDS has become a common cause of death for

children under five. Concentrated in the population between 15 and 49, HIV and AIDS is having a wide-ranging social and economic impact. Skilled labour needed for both economic growth and the provision of social services such as health care and education has been reduced. Mozambique is responding to the epidemic through a Four P campaign: Primary prevention, PMTCT, Paediatric AIDS and Protection of orphans and vulnerable children.

Despite the progress made in implementing the PMTCT programme, the lack of follow-up of mothers and children remains a major constraint. The health system faces a lack of human resources which has compromised access to and provision of quality services. On the other hand, the stigma and discrimination associated with HIV may prevent many pregnant women and their newborns from accessing and adhering to PMTCT interventions. Mothers fear they will lose their families as a result of getting tested or disclosing their HIV status to their partners.

The Mozambican health system needs to develop strategies to create an enabling environment that encourages the active involvement of partners and families in maternal and child health (e.g., couple counselling and testing, births assisted by skilled staff, etc.). The PMTCT programme should be made more comprehensive and acceptable to male participation, and should be linked to community health interventions to facilitate active follow-up for mothers and children who currently drop out. Experience from Rwanda shows that when partners are involved and informed, a woman is more likely to participate in PMTCT services and actively seek other maternal health and HIV services.

5. Environmental issues and climate change

Children around the globe, and particularly in developing countries, are among those least responsible for environmental degradation and climate change. Likewise, children are not the primary focus of most environmental impact assessments or climate change studies, nor are they the primary targets of most policies or interventions related to environmental issues or climate change.

Children are among the most vulnerable to the devastating impacts of many types of environmental hazards. Even natural disasters of relatively short duration can have long-lasting effects on children's development. Health, nutrition, and water and sanitation challenges are often caused or exacerbated by unfavourable environmental conditions, while education, child protection and other areas also face challenges as indirect consequences of environmental issues. With climate change threatening to increase the incidence and severity of many environmental hazards in Mozambique, it is particularly important to focus attention on how children can be spared from its negative effects.

Environmental hazards affect children both as part of a greater household and also in unique ways. Children are at greater risk of many potential health effects simply because of their physiology: their organs, immune systems and nervous systems are still developing; their metabolisms and respiratory rates are faster; and they have a higher surface area to body mass ratio than adults. Their natural behaviour and curiosity also place them at greater risk of acquiring certain diseases and injuries because their propensity to explore the world around them often leads to greater exposure to contaminants, pollutants (particularly due to a lack of unpolluted play space in urban areas). Children are more likely to pick up and chew on soil, pieces of waste and landmines. Their smaller size and relative

lack of strength and speed also make them particularly vulnerable in emergency events such as floods, cyclones and landslides. Children are also likely to be in close proximity to their mothers during cooking, increasing their exposure to pollutants from the burning of fossil fuels. Some researchers assert that climate change, because of its wide-reaching and cross-sectoral impact, poses the single greatest threat to the world's children.¹⁰⁶

5.1. Environmental issues in Mozambique

The country's 13 largest river basins are heavily populated and are characterised by relatively high levels of soil fertility, but these areas are also vulnerable to flooding, droughts and saline intrusion, as well as the effects of water demand, poor rainfall and pollution in the neighbouring countries in which most of the rivers originate. The central region, characterised by many large river deltas and a wide coastal plain, is particularly vulnerable to environmental hazards, as it is the area with both the largest coastal population and the greatest risks of cyclones and flooding. The northern region is characterised by moderate to low soil fertility and a narrow coastal plain. Soil fertility is lowest and risk of drought the highest in the southern region, particularly in the arid inland areas.¹⁰⁷

More than 60 per cent of the population lives along the coast, a bioregion that is susceptible to cyclones, over-fishing, erosion and saline intrusion into river systems. Mozambique can be divided into bioregions based on latitude (north, central and south) and on geographic features (coastal, flood plain and inland).

The physical state of the environment is not only subject to uncontrollable weather events such as cyclones and droughts, but also to the effects of human activity such as

unsustainable use, exploitation and pollution of the land, water and natural resources.

This section lays out the current environmental conditions and challenges and future predictions for Mozambique, followed by the country's institutional framework for environmental and disaster management. In this context, the cross-cutting vulnerability of Mozambique's children to environmental hazards is examined, and the section concludes with priority areas to be addressed.

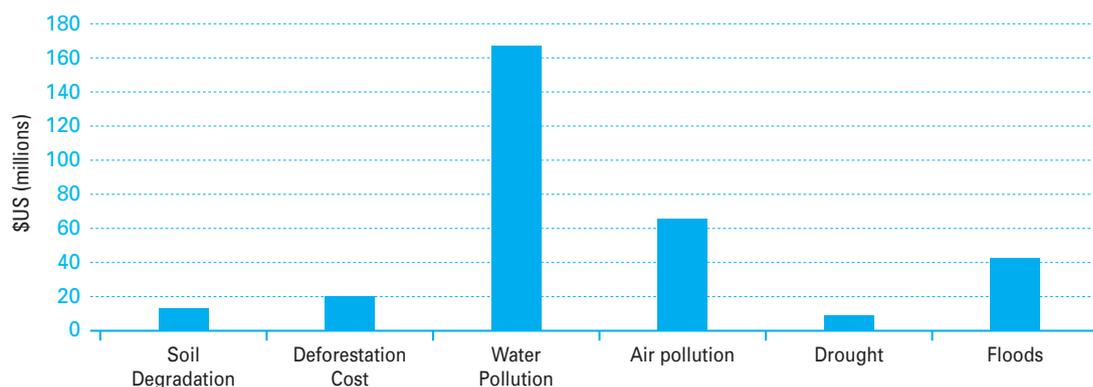
5.2. Sustainable development in Mozambique

Economic theory tells us that there is a strong link between changes in wealth and the sustainability of development: if a household (or a nation) is running down its assets, it is not on a sustainable path. In Chapter 1 of this study, poverty analyses were presented using consumption-based and deprivations-based measures. However, when discussing the wealth of a child or a nation, we can also consider

access to exhaustible resources, renewable resources and agricultural land. A 2009 study¹⁰⁸ measured the per capita wealth of Mozambique using an expanded definition of wealth. In addition to the produced output of the economy, the authors included in their calculations the accumulation of other assets: human capital, the environment and natural resources.

This study found that 49 per cent of Mozambique's wealth is derived from natural capital, including mineral resources, agricultural land, forests and marine reserves. This is far higher than the sub-Saharan average of 24 per cent, implying a high dependence on natural resources. The study also found that degradation of Mozambique's natural capital costs the country \$US 360 million per year, or around 6 per cent of GDP. Water pollution (unsafe water supply, sanitation and hygiene) constitutes the biggest environmental cost in Mozambique (see Figure 6.22). While the depletion of natural capital was found to be relatively low in Mozambique overall,^{viii} the effects of climate change are likely to be high.

Figure 6.22: Cost of environmental degradation per year, 2009



Source: Ollivier, T, et al, 'Natural Resources, Environment, and Sustainable Growth in Mozambique, Agence Française de Développement, 2009.

^{viii} The study noted, however, that national figures include many areas with very low population density and may obscure some of the unsustainable and exploitative agricultural practices that take place at local levels.

Sustainable development is inherently an intergenerational as well as intragenerational question. Fulfilment of human rights by adults today (e.g., right to food and shelter) affects the ability of today's children and of future generations to fulfil their human rights in the future. Environmentally destructive consumption patterns by today's adults (e.g., over-fishing, over-logging, poor soil conservation) will have a serious impact on future generations' ability to fulfil their human rights.

5.3. Impact of environmental degradation and emergencies on children in Mozambique

Pollution

Pollution^{ix} was found to take a significant toll on the country's environment, health and economy in the study referred to above. The health effects of polluted water supplies alone were estimated to have cost nearly 3 per cent of GDP in 2008,^x while those of indoor air pollution (mainly from the carbon monoxide released by burning fossil fuels) cost an additional 1 per cent.¹⁰⁹ Only 10 per cent of the Mozambican population were connected to the electricity network in 2008.¹¹⁰ This has a double environmental impact: first, it increases air pollution through cooking with fossil fuels, and second, it increases the use of natural resources for firewood.

Polluted marine environments and overexploitation of fisheries have become an increasing problem in many coastal areas for the communities that depend on the diminishing stock of fish for their livelihood.¹¹¹ PARPA II explicitly noted the economic importance of the fisheries and acknowledged that overfishing, pollution

and habitat degradation are diminishing coastal communities' ability to maintain their livelihoods. The plan identified several actions for promoting environmental sustainability while increasing economic productivity;¹¹² however, the PARPA II evaluation report suggested that these goals were not entirely met.¹¹³

Health

A 2006 report commissioned by the WHO found that while 23 per cent of all premature deaths were attributable to modifiable environmental factors, that number rose to 36 per cent among children under 15. Researchers and health professionals have long noted the link between environmental factors such as air pollution and health effects such as asthma, but recently they have begun to sound the alarm with more urgency. Among those whose health is threatened by environmental hazards, children represent the biggest group. Younger children are even more vulnerable: the number of healthy life-years per capita lost to environmental factors was about five times greater in children under five than in the total population. Malaria and respiratory infections, the leading causes of child mortality in Mozambique (see Chapter 3), are also some of the diseases most strongly linked to modifiable environmental factors. Diarrhoea, a major underlying cause of child mortality, has an environmental burden of disease of 94 per cent.¹¹⁴

Natural disasters affect children's health by disrupting access to health facilities.

Cyclones and floods, in particular, can damage health infrastructure and roads, which can make delivery of medical supplies difficult or impossible. Families who have been displaced from their homes due to emergencies are often unable to access health care or continue regular treatments, such as for HIV.

^{ix} Pollution includes outdoor air pollution, indoor air pollution and water pollution.

^x As discussed in Chapter 3, less than half of households have access to safe drinking water.

Water and sanitation

Water stress increases many health threats.

Poor sanitation is often made worse by environmental conditions such as floods and droughts, with the former typically leading to an increase in water-borne diseases, such as cholera, and the latter leading to an increase in water-washed diseases, such as trachoma.¹¹⁵ An additional water-related health risk that sometimes arises, particularly in northern Mozambique, is the higher levels of cyanide that become concentrated in the cassava root during times of drought. High concentrations of the toxin are a cause of spastic paraparesis (also known as konzo or mantakassa), especially among children and women who may already be undernourished.^{116, 117}

Most of the country's vulnerability to environmental hazards is directly linked to water, whether there is not enough or too much.

Both droughts and floods can have devastating effects on children's access to safe drinking water and sanitation. Shallow wells that normally sustain a community can dry up in times of drought, putting excess pressure on any deeper wells that may exist. Floods can contaminate drinking water supplies, especially in areas that also have poor sanitation. Weak water and sanitation infrastructure can be easily damaged by floods and cyclones, and areas with poor drainage can increase the risk of cholera and other waterborne diseases, as well as becoming breeding grounds for mosquitoes that carry malaria and other vector-borne diseases.¹¹⁸ As noted earlier, children are particularly vulnerable to sanitation-related diseases because of their physiology and because their behaviour often places them in greater contact with contaminated water.¹¹⁹

Nutrition

Food security and nutrition in Mozambique are strongly linked to environmental conditions.

Both flooding and drought cause extensive agricultural losses to households dependent on subsistence farming. Over 70 per cent of the population rely on

rain-fed agriculture, making the country particularly vulnerable to the water stresses that occur regularly, though not always in the same places at the same time. For example, in 2001–2002, droughts in southern Mozambique caused the loss of about one third of the expected harvest, leading the Government to request additional international aid to feed some 650,000 people. The very same year, however, the northern part of the country saw a surplus in food production, much of which was sold through informal markets to neighbouring Malawi.¹²⁰ In 2006, the Technical Secretariat of Food and Nutritional Security (SETSAN) determined that about 35 per cent of the population was chronically food insecure,¹²¹ though the number of people with acute food insecurity at any given time varies; the October 2009 figure published by SETSAN was 281,300, or less than 2 per cent of the population in immediate need of assistance.¹²² On average, rural households only have enough stable crop for 6–8 months.¹²³

Decreased food security often leads resource-poor households to engage in coping mechanisms that are not in the best interests of child nutrition.

The effects of undernutrition on children can be severe and lifelong. The main strategies used by rural, food-insecure households are to eat less-preferred foods, reduce the number of meals eaten per day, and eat all or part of the seed stock for the next growing season (see Table 6.4). While adults may be able to adapt to such changes in their diet, at least in the short term, the effects on children are more severe because of their different nutritional needs.

Soil depletion and erosion also affect food security in Mozambique.

Without enough fertiliser to sustain the land, levels of nutrients in the soil, and consequently agricultural yields, rapidly decline. Growers must then clear and cultivate new land, at the expense of wildlife and forests. Farmers in Mozambique have traditionally cleared land, grown crops and then moved on to clear more land, leaving the land fallow to

Table 6.4: Coping strategies used in rural Mozambique during the lean season each year, 2009, percentage

Rural Households experiencing food shortage (%)		Agricultural season			
		2005	2006	2007	2008
		38	37	27	31
Coping strategies used during the lean season (%)	Eat less-preferred food	88	90	87	87
	Reduce number of meals	82	85	82	82
	Eat all or part of seeds	54	49	41	54
	Increase income-generating activities	38	51	50	41
	Share food with family/neighbours	40	38	47	39
	Sell assets abnormally	18	26	19	18
	Borrow money	11	17	15	12
	Seek government/church/NGO assistance	4	5	4	3
	Send children to other households	3	3	4	3
	Remove children from school	2	2	2	2
	Other	2	2	3	2

Source: Cunguara, Benedito and Brendan Kelly, 'Trends in agriculture producers' income in rural Mozambique', study as input to Impact Evaluation Report of PARPA II, MPD, 2009.

regain fertility. In areas of higher population density, however, farmers grow crop after crop, 'mining' or depleting the soil of nutrients while giving nothing back. With little access to fertilisers, the farmers are forced to bring less fertile soils on marginal land into production, at the expense of wildlife and forests.

Short-term environmental disasters in areas that had previously been relatively food-secure may lead to higher rates of acute undernutrition among children, while long-term crises may increase the numbers of underweight and stunted children.

Education

Children's education is another area that is affected by both long-term and short-term environmental conditions. Poorly constructed schools are often damaged or destroyed by severe storms and cyclones. In 2008, for example, cyclone Jokwe disrupted education for more than 38,000 students.¹²⁴ Long-term disasters, such as droughts, often cause children to drop out of school, either because they must perform additional work,

such as fetching water, or simply because they lack the energy to focus on their studies as a result of undernutrition.

Environmental pollution and natural resource management affect the success of Government interventions in education.

Illnesses caused by environmental factors like air and water pollution have an impact on school attendance rates. Undernourishment, whether due to soil depletion or loss of harvest, will affect children's ability to absorb instruction. Deforestation and lack of safe water close to the household may also affect children's attendance rates, as they spend more time collecting firewood and water. These situations can also affect teachers and their attendance rates.

Children who have been displaced because of natural disasters face additional challenges with regard to their education.

The impact of extreme climatic events and the increasing scarcity of water due to climate change are likely to increase the number of displaced people in Mozambique. Temporary migration can cause children to miss school and can

also cause overcrowding in locations that receive many environmental refugees. The term ‘environmental chaos’ has been used to describe situations with high levels of noise and crowding and lack of structure or daily routines, which is the situation faced by many children in post-disaster settings. This sort of chaos has been observed to negatively affect children’s learning and social interactions.¹²⁵

Deforestation

Commercial logging has increased dramatically, and often illegally, in recent years. Some analysts estimate that tropical hardwoods from slow-growing, semi-arid and dry tropical forests are being depleted at a rate that could see the resource exhausted in 5–10 years.¹²⁶ A 2006 study concludes that, “Asian timber buyers, local business people and members of the Government of Mozambique and their forest services

are colluding to strip precious tropical hardwoods,”¹²⁷ with large quantities of illegal, unprocessed hardwoods being exported through Nacala port in northern Mozambique. The same study estimates that illegal logging is at least as large in scale as legal logging.

Almost half of Africa’s forest loss is a result of people chopping trees for firewood or charcoal.¹²⁸ Charcoal is the main fuel source for an estimated 80 per cent of the population of Mozambique,¹²⁹ and it is estimated to have an even greater effect on deforestation than commercial logging. Deforestation may lead to children missing school as more time is needed daily to collect cooking fuel. A rights-based approach may be effective in combating deforestation in Mozambique. When individual and community rights over a particular area are recognised and enforced, people may act to safeguard some of its conservation

BOX 6.2. Emergency Preparedness

In early 2000, severe flooding devastated five provinces in Mozambique. In addition to approximately 700 people who lost their lives in the floods, almost two million people were otherwise seriously affected and in need of external assistance.¹³⁰ 2001 brought more flooding, causing additional damage and placing additional stress on many areas that had not yet recovered from the previous year’s disaster. At a workshop funded by the United Nations Office for the Coordination of Humanitarian Affairs in July of 2001, some 130 delegates – including governors and district administrators from affected provinces and other representatives of the Government, UN agencies, bilaterals, and non-governmental organizations – met to draw lessons from the rescue and relief operations. Among the group’s conclusions and recommendations were several that concerned preparedness, efficiency and coordination. One key recommendation was for greater integration of activities by the various parties involved in emergency response.¹³¹

One key measure of progress in this area is the full integration of sectoral contingency plans into the National Institute for Disaster Management (INGC) contingency plan. In several sections within the contingency plan, specific attention is paid to children’s needs in an emergency. More recently, INGC, together with Save the Children, UNAIDS, UNFPA and UNICEF, developed and approved the Code of Conduct for Humanitarian Workers in the context of Mozambique, based on the UN Secretary-General’s Bulletin on Special Measures for Protection from Sexual Exploitation and Sexual Abuse (October 2003).¹³² This effort builds upon the experience gained during the emergency response in 2008, which revealed that humanitarian agencies and workers active in the field (both Government and non-governmental) had little knowledge and had not developed mechanisms or approaches to address sexual abuse and exploitation against women and children by their own staff.

value. A rights-based approach is necessary not just for sustainable conservation and management of forests, but also for accountability and equitable economic returns in the sector.

Child Protection

The protection of children is a particular challenge in emergency situations, as children are exposed to greater risks of family separation, sexual exploitation and psychosocial trauma. Disruption of social services particularly affects orphans and vulnerable children in their access to basic services.

Although there has been little research conducted on the impact of emergencies on child protection concerns in Mozambique, reports from a mission of the Government's vulnerability assessment committee in 2005 raised concern over the use of negative coping strategies by children in drought-affected areas, such as 'survival sex' for money, which increases their vulnerability to HIV and other sexually transmitted infections.

Landmines

Landmines present an environmental challenge in Mozambique. Although de-mining efforts have continued steadily since 1993, and four provinces (Cabo Delgado, Niassa, Nampula and Zambezia) were recently declared to be mine-free, the National De-mining Institute estimated that more than ten square kilometres of mined areas remained at the end of 2008, representing 386 sites scattered across 59 districts in the other 6 provinces.¹³³ In PARPA II, de-mining joined natural disasters and environmental issues as a cross-cutting theme that must be addressed in order to achieve poverty reduction; the 2009 evaluation found that much progress had been made on this front, significantly decreasing the hazards posed by landmines.¹³⁴ The Government's national mine action plan aims to clear all known minefields before the Mine Ban Treaty extension deadline of March 2014.

Climate change

A comprehensive report conducted by the National Institute for Disaster Management (INGC) paints a sobering picture of the environmental conditions that are anticipated if current climatic trends continue.¹³⁵

Data collected over the course of several decades were used to generate predictions by applying seven different climate change models. Increases in average temperatures, maximum temperatures and duration of heat waves have already been recorded throughout the country, and this trend is expected to continue. Mean temperatures are predicted to rise by 1.8 to 3.2°C by 2075. Rainfall will also decline by two to nine percent, especially between November and May, the key growing season. The data regarding rainfall suggest that the country is already seeing increasing delays in the start of the rainy season. The climate change models predict that precipitation will become even less predictable in the next several decades, with increased rainfall expected in most of the country from December to May, surpassed by even greater increases in evapotranspiration during the rest of the year.

Rising sea levels present yet another challenge. The lack of reliable data in the past makes it difficult to know precisely to what extent sea level rise has already affected Mozambique, but the projections discussed in the INGC report show that this particular result of climate change is bound to have serious consequences. Even in a low-sea-level-rise scenario, tropical cyclones will present a greater risk to the coast and will contribute to greater coastal erosion. Urban centres will sustain infrastructure damage due to more frequent flooding, and in a high-sea-level-rise scenario, many ports and homes along the coast would be completely submerged by the end of the century. Beira, Maputo and Quelimane are all expected to be heavily affected even by low sea level rises; in the high-sea-level-rise scenario, present-day Beira would become an island, while the Maputo port, train station and Costa do Sol areas would disappear underwater.

Many environment-related health hazards are predicted to intensify in developing countries as a result of global warming.

A 2009 Lancet Commission report called climate change “the biggest global health threat of the 21st century.”¹³⁶ In Mozambique, one of the predicted consequences of increasing temperatures and changes in precipitation noted in the INGC study is an increase in the range and seasonality of vector-borne diseases, including malaria and African sleeping sickness.¹³⁷ Other diseases that may increase in Mozambique as a result of climate change include chikungunya fever, meningococcal meningitis, cholera and other diarrhoeas, and rodent-borne diseases. Increasing temperatures and the gradual loss of shade trees may also increase the effects of heat stress on children. Because children (and the elderly) sweat less and have higher surface area to body mass ratios than adults, they tend to suffer greater health effects as a result of heat stress.¹³⁸

5.4. The institutional context

Environmental issues in Mozambique did not make their way onto the national agenda until the worst years of the civil war had come to an end. Article 90 of the constitution confers upon Mozambican citizens the right to live in a balanced environment, as well as the duty to defend it. The article further states that State and local authorities shall adopt policies to protect the environment and promote the rational use of natural resources.¹³⁹ The national environmental commission was formed in 1990, followed in 1994 by the creation of the Ministry of Coordination of Environmental Affairs. The new ministry, in turn, developed the legal framework for environmental management, which includes a wide range of policies, laws, strategies and action plans.¹⁴⁰

In 1999, another governmental body was created specifically to address the country’s vulnerability to environmental crises: (INGC). The INGC is separate from MICOA, although the World Bank noted in 2009 that “unresolved coordination issues between

INGC and MICOA”¹⁴¹ constitute a major challenge to Mozambique’s ability to respond to natural disasters. Coordination issues with other ministries are gradually being resolved, at least in terms of how to deal with emergencies; for example, INGC now publishes an annual contingency plan¹⁴² that includes sector-specific activities for nine different ministries to undertake before, during and after a natural disaster. The impending threat of climate change, which has begun to attract more attention in recent years, has also involved both MICOA and INGC; for example, the ministry developed a national action plan for adaptation to climate change in 2007,¹⁴³ while in 2009 INGC produced a comprehensive report detailing the predicted effects of climate change on the country.¹⁴⁴

The 2009 PARPA II evaluation was generally favourable to the environmental component. The review noted that several new strategies and policies were developed during the timeframe covered by PARPA II, and environmental management had been integrated into some of the district development plans. Addressing the challenges presented by climate change, environmental degradation and sustainable management of natural resources was identified as a high priority for the development of subsequent medium-term Government plans. The evaluation was also complimentary of the Government’s attention to the natural disasters component of PARPA II, noting in particular the strengthening of the INGC, which was credited with keeping losses to a minimum during the floods of 2007–2008. Among the achievements reported in the evaluation were increased training for communities and other sectors involved in reducing the risk of disasters, creation of local committees for disaster risk management, and resettlement of 44,000 families from high risk areas. Continued challenges include integrating disaster management into the Social and Economic Plans and allocating more sufficient funds provinces and districts.¹⁴⁵

5.5. Conclusions

Environmental issues affect children in myriad ways, and the effects of environmental degradation are likely to intensify in coming years. Environmental degradation negatively affects the development of Mozambique as a country and has profound negative effects on children individually. Children are particularly vulnerable to emergencies in terms of their education, health and safety. Emergencies are likely to intensify as climate change increases the occurrence of cyclones in Mozambique.

The environment is considered a cross-cutting issue by the Government of Mozambique. However, actions to address climate change, the environment and

disaster management have not been sufficiently integrated across the sectors. Insufficient funds have been dedicated to addressing environmental degradation, both by the Government of Mozambique and its partners, possibly due to the long-term return on these investments. Without such investments, however, environmental degradation has the potential to significantly reduce or even reverse progress made on child survival, education and protection. Urgent action is needed to sensitise communities to the need to reduce environmentally destructive practices and to ensure that public and private sector initiatives are conducted in an environmentally sustainable manner. Climate change is an issue that must be tackled in cooperation with Mozambique's regional and international partners.



6. Communication for Development

At the United Nations General Assembly in 1996, a resolution was adopted stressing “the need to support two-way communication systems that enable dialogue and that allow communities to speak out, express their aspirations and concerns and participate in the decisions that relate to their development.”¹⁴⁶

These communication systems and the emerging field of communication for development (C4D) are receiving increasing acknowledgment in Mozambique for the integral role they can play in advancing the human rights situation of children and communities.

Since the adoption of a new constitution in 1990, Mozambique has seen its media sector grow in both breadth and depth.

Private media outlets have proliferated, state-run media have worked to adopt a public service format, and increasing numbers of community-based radio stations serve rural areas. Though still nascent, growth of the information, communication, and entertainment industries has created an important enabling environment for C4D activities. The improving organisation and capacity of civil society agencies, including those specialising in C4D, health promotion, HIV prevention, and human and child rights advocacy, has facilitated coherent – and increasingly decentralised – communication planning and implementation.

6.1. Mass media development in Mozambique

The development of the media sector in Mozambique has been playing a crucial role in supporting governance, development, and information dissemination since the 1975 founding of the state-owned Rádio Moçambique (RM) and Agência de Informação de Moçambique (AIM), the country’s domestic news agency. The emergence of free and independent media

was enabled through the Constitution,¹⁴⁷ which provides for freedom of expression and the citizen’s right to information. Article 74 of the Constitution states that “the mass media play an important role in implementing these rights, as well as giving value to the other individual and collective rights enshrined in the Constitution.” A comprehensive Press Law,¹⁴⁸ approved in 1991 and under revision in 2009, further promotes freedom of the press and covers most aspects of media and journalistic work. Media regulation in Mozambique is under the leadership of the Information Bureau (GABINFO), the state body tasked with the administrative registration of all media. GABINFO also issues licences for new print and broadcast media outlets, though the Instituto Nacional das Comunicações de Moçambique (INCM), part of the Ministry of Transport and Communications, provides licenses for the use of radio frequencies.¹⁴⁹

Acknowledging that interventions focused on information and communication are central to bringing about participation of all citizens, meeting their information needs and hearing their voices, the country’s Plan of Action for the Reduction of Absolute Poverty “PARPA II” placed special attention on access to information and knowledge as essential means to increasing participation and dialogue, and engaging citizens in the fight against poverty. This strategic commitment, combined with the Constitution and Press Law, has facilitated rapid improvements in general access to information in Mozambique, and the country has witnessed expansion from limited, State-owned networks to a more pluralistic media sector comprising radio, print, television stations, internet and mobile services, owned and operated by various State, community, faith-based and private sector bodies.

Radio remains the mass medium with greatest coverage. The national public broadcaster, Radio Mozambique, reaches

80 per cent of the population, broadcasting via 11 affiliates in 21 languages, including Portuguese and English for national service and local languages for provincial news and programmes. According to a 2005 study conducted by the African Media Development Initiative, 98 per cent of the urban population had listened to the radio in the past 12 months, of which 91 per cent had listened to radio in the past seven days.¹⁵⁰ Although Radio Mozambique controls the most widely listened-to radio stations in urban areas, the National Forum of Community Radios (FORCOM), created in 2004, has registered over 60 community radio stations across the country, up from only one in 1994.¹⁵¹ The community radios cover nearly half of Mozambique's 128 districts¹⁵² and broadcast in both Portuguese and local languages. Most are non-profit community radio stations, many of which were established with the involvement of the UNESCO Media Project; others pertain to religious organisations (mainly the Catholic Church), municipal authorities, or the Institute of Social Communication (ICS), a Government department under GABINFO with the mandate to develop rural communications.

In a country where only 40 per cent of the population speak Portuguese (and only 6 per cent as a mother tongue),¹⁵³ these community-based radio stations with programming in local languages are a key vehicle for mobilising community leaders and promoting participation of children, young people and women in community debates. A 2006 assessment of the impact of eight community radio stations found that almost 100 per cent of the interviewees said they listen to local community radio; many expressed opinions that radio belongs to the community, as it provides local information, gives opportunities for people to express their opinions and concerns, and promotes local culture.¹⁵⁴

In the print media sector, the number of registered newspapers, magazines, pamphlets and information bulletins grew to 254 in 2006.¹⁵⁵ There are three

major daily newspapers (*Notícias*, *Diário de Moçambique* and *O País*), and several additional periodicals have established themselves in the market in the past years, including the first free newspaper, *A Verdade*. Despite the increase in print media, the issues of availability and price – compounded by illiteracy rates of 48 per cent among those aged 15 or older¹⁵⁶ – result in low access, such that only one per cent of the population makes use of print media.¹⁵⁷

At the TV broadcasting level, there are four television broadcast stations, including public and private television networks. *Televisão de Moçambique* (TVM), the state-owned network launched in 1981, continues to dominate broadcasting and now reaches most of the country as the result of the establishment of relay stations in 1992, followed by a move to satellite. Private broadcast companies have been gaining in economic strength and visibility and are beginning the process of setting up offices and repeaters in the provinces. Though household television ownership went from five to ten percent between the years 1997 to 2007^{158,159} and group viewing patterns mean that even those without a television set are sometimes able to watch broadcasts, television remains out of reach for the majority of Mozambicans: access to television depends on access to electricity and penetration of service, and as such remains largely confined to urban centres.

Mobile service penetration and number of subscribers in Mozambique increased significantly during the first decade of the new century, with two mobile network operators, Mcel (owned by Telecomunicações de Moçambique) and Vodafone, dividing the market. In 2000, less than one per cent of the population had access to a mobile phone; this number increased to about 23 per cent¹⁶⁰ in less than ten years, with total subscribers estimated at 4.2 million in 2008.¹⁶¹ Internet access, on the other hand, is almost entirely confined to urban centres and remains even more limited than television. Data from 2006 indicated there were over 18

internet service providers nationally. Only two per cent of the population have internet access.¹⁶² Nevertheless, the internet is being increasingly used by the media sector, represented by several online news sites and a growing number of blogs and discussion fora.

6.2. The changing role of the media: communication for development and community mobilisation

Not only has the reach of the media expanded over the years, but so has the content and purpose of programming. In addition to the more traditional use of media as a means of disseminating public information and broadcasting music, radio and other forms of media now also include social education and community development programmes designed to prompt people to adopt and maintain healthy behaviours. Media activities and strategies have been developed to raise awareness of development issues among mass audiences and opinion formers, to influence attitudes and behaviour at individual and collective levels, and to empower vulnerable and marginalised groups including children and young people.

This kind of media support has also received special attention as a critical driver for securing the necessary participation, ownership and accountability for achieving the MDGs.¹⁶³ In this light, communication for development strategies and approaches relating to key child survival interventions (such as the Child Health Weeks and the National Sanitation Campaign), and promotion of child rights (such as birth registration and prevention of violence and abuse) are currently being developed and promoted nationally. They aim to provide caregivers and community members with essential information to develop the skills and self-confidence to make informed decisions on issues that affect their lives and their children's well-being.

6.3. Promising initiatives in Mozambican media

Besides the more conventional forms of radio, television, and print media, several alternative forms of media have been gaining increased popularity in Mozambique. By using an approach that combines several forms of media and dialogue, these initiatives have a tremendous potential to engage more people, particularly youth, in educational activities, public dialogue and debate. These initiatives include Community Multimedia Centres (CMCs), Multimedia Mobile Units, Child-to-Child Radio, and Community Theatre programs.

Community Multimedia Centres combine community radio with other forms of Information and Communication Technology (ICT).

By having a physical 'telecentre' with computers, internet service, telephones, fax machines, photocopiers and printers, individuals and community organisations are able to make better use of information and media. The Community Multimedia Centres also provide training opportunities and enable the community organisations that run them to earn a small income from fees charged for training, use of the internet, or other services. By 2007, 18 Community Multimedia Centres were operational across the country, with at least one in each province.¹⁶⁴ The institutional framework of the Community Multimedia Centres is still weak,¹⁶⁵ and their utility and success will depend on increased public sector ownership and investment.

A second promising initiative, run by the Institute of Social Communication, makes use of Multimedia Mobile Units. The twelve units – each vehicle equipped with a video projector, a giant screen for projection of films, a radio, a tent and supplies for HIV testing, and educational materials – travel to rural communities where they typically stay for four days at a time. Once there, the mobile unit team mobilises the community around key issues using audiovisual presentations to engage participants in dialogue and debate. The

activities are designed with the participation of local leaders and, where available, youth association members. The units also provide an opportunity for testing and counselling on HIV and AIDS.

To stimulate engagement and participation of more children and young people in the media arena and provide them with a more regular platform to express their opinions, Radio Mozambique established the Child-to-Child programme, comprising community radio broadcasts for children by children. The Child-to-Child programme facilitates the link and communication between parents and children at the community level on key child rights issues. The programme also contributes to the fulfilment of articles 12, 13 and 14 of the Convention of the Rights of the Child, which establish children's rights to freedom of expression, freedom to seek and impart information, and freedom of thought, conscience and religion. Over one thousand children and adolescents ranging from 11 to 18 years – of whom 60 per cent are female¹⁶⁶ – are actively involved in the development, production and presentation of the radio programmes. In 2007, Radio Mozambique's child-to-child programme won the International Children's Day of Broadcasting Award competition for "Radio Excellence" in recognition of the central role that children play in addressing child rights issues through developing, producing and presenting radio programmes for their peers.

Across the country, but especially in areas with more limited access to technology, community theatre has proven to be an effective interpersonal communication means to strengthen community knowledge and to stimulate and encourage debate on matters of social interest, particularly for children and young people. The Community Theatre Network, comprising over 100 theatre groups nation-wide, uses the 'Teatro do Oprimido'^{xi} approach to stage drama performances that invite members of the audience to actively participate as

performers. Through their performances, they raise awareness and promote positive attitudes and behaviours¹⁶⁷ in the areas of child survival, girls' education, gender awareness and HIV prevention. At the end of each play, a dialogue is established between the actors and the audience.

6.4. Child-friendly networks and partnerships

In addition to the initiatives being carried out at local levels, national networks and partnerships with key players in the media and communications industry are starting to show potential as vehicles to spread messages about children's rights throughout the country.

To report on the situation of children's rights in Mozambique, the non-governmental organisation Media Institute of Southern Africa established a Child-Friendly Media Network (Rede de Comunicadores Amigos da Criança) in 2007, involving more than 300 journalists nation-wide. The network uses the mass media to publish articles on child rights, disseminate information and knowledge on children's issues, and denounce violations of child rights. In addition, the network conducts training for capacity building of journalists, publishes regular reviews and recommendations for the media on how to cover issues related to children, engages in public debates with experts on topics related to child rights, and participates in advocacy campaigns for the adoption and implementation of child-friendly policies and legislation.¹⁶⁸

In terms of partnerships with the private sector, mobile telephone service providers have been leveraged to disseminate occasional pro-social messages. Mcel, which claims over 3 million subscribers and a market share of 70 per cent, has been supporting activities which promote the well-being of children in Mozambique. In 2008, a partnership for Child Rights in Mozambique

^{xi} Theatre of the Oppressed – a style of drama developed in Brazil as a tool of exploring real life experiences.

was able to build on Mcel's marketing power by using its distribution channels to disseminate child rights messages. Information related to the Children's Act and general child rights messages were printed on over 10 million Mcel recharge cards. This collaboration grew into a national campaign, with television and radio spots, newspaper advertisements and out-of-home media.

6.5. Information deprivation

Unfortunately, the recent growth in the media sector has yet to decrease the incidence of Mozambican children experiencing severe information deprivation, defined as the proportion of children between 5 to 18 years of age with no possession of or access to a radio, television or newspaper at home. A 2009 analysis of childhood poverty¹⁶⁹ commissioned for the Impact Evaluation of PARPA II using a deprivations-based measure of poverty drawing on the Bristol Indicators¹⁷⁰ revealed that 40 per cent of children were experiencing severe information deprivation in 2008. There was no evidence of any change in the proportion of children experiencing severe information deprivation between the 2003 Demographic and Health Survey and the 2008 MICS, on which the 2009 analysis was based. The analysis also reported that severe information deprivation is highly correlated with the wealth of a child's household. Children in the poorest households are nearly seven times more likely to experience severe information deprivation than those in the wealthiest households.

6.6. Conclusions

Despite the progress made in the communication sector, the full potential of the media to disseminate information, engage communities in debate, and contribute to an improved environment for children has yet to be realised. Overall, the reach of the media and its usefulness

in effecting change in child welfare are still limited in the country, especially in relation to the print media, television, and internet. The reinforcement of freedom of expression and sustainability of the newer initiatives are among the greatest challenges to the media sector. The high and unchanging level of information deprivation suggests that messages transmitted through conventional forms of media are unlikely to reach a large proportion of children. Increased attention therefore should be placed on the alternative forms of media and communication that are gaining strength in Mozambique, especially in rural areas. Communication for Development strategies focusing on children need to involve more local leaders, social mobilisers and activists in the interventions.

The Child-Friendly Media Network demonstrates that journalists across the country can unite behind children's issues, but additional work in local languages using mass media and community media still needs to be mainstreamed to disseminate the communication messages more intensively. Partnerships with the private sector can also be strengthened. As proven by the 2008 Mcel campaign, there is room to explore the systematic use of mobile telephony for development and rights-oriented results; other partnerships may also hold great potential if strategically developed.

A final challenge is that monitoring and evaluation of C4D interventions remains expensive—and therefore—limited, with heavy reliance on qualitative data that are difficult to apply across programmes and geographic locations. This situation should change in the coming years with the growing recognition that achievement of the Government's poverty reduction objectives – as well as the MDGs – will depend significantly on the expansion, consolidation, and alignment of communication efforts across the public, private, and civil society sectors.

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