

CHILDHOOD POVERTY IN MOZAMBIQUE

A SITUATION AND TRENDS ANALYSIS

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FOREWORD

The Government of Mozambique ratified the United Nations Convention on the Rights of the Child in 1994, reaffirming its commitment to the progressive realisation of the rights of all Mozambican children. In recent years, the Government has translated this commitment into a solid policy and legal framework for the realisation of children's rights, with the development of its second poverty reduction strategy (the PARPA II), the National Plan of Action for Children and the forthcoming Children's Act.

This Situation and Trends Analysis provides a comprehensive review of the socioeconomic situation of the ten million children in Mozambique, focusing in particular on the issue of childhood poverty. The report is informed by a human rights based approach, acknowledging that children living in poverty face deprivations of many of their rights: to survive, to develop, to participate and to be protected. A focus on childhood poverty as distinct from adult poverty is critical, as children experience poverty differently from adults and the impact of poverty in childhood can be lifelong and intergenerational.

The findings of the report show that while significant advances have been made towards the realisation of children's rights, there remains much to be done. Challenges remain in relation to particular areas of child development, such as nutrition and access to water and sanitation, and the evidence indicates that some groups of children, such as those living in rural areas and those that are orphaned and vulnerable, are not benefiting from growth and poverty reduction as much as other children. The report also highlights the importance of capacity development for sustainable improvements in child friendly services.

The report was written by a lead team comprised of the Ministry of Planning and Development and UNICEF and was developed through a consultative process, with the participation of representatives of the Government, the UN family, bilateral and multilateral donors, non-governmental and civil society organisations and children. It is intended to provide an up-to-date and comprehensive reference for all stakeholders involved in the fight against childhood poverty, highlighting the varied and interrelated challenges faced by both Mozambican children and by development partners seeking to address those challenges. This in turn is intended to inform the development and implementation of policies that help to reduce childhood poverty and strategies to reach the most vulnerable and marginalised children.

As the country commences the implementation of its second poverty reduction strategy and is making progress towards the attainment of the Millennium Development Goals, it is imperative for all development partners to work together, building on the current momentum, to ensure that all children benefit from social and economic gains of recent years and that concrete improvements are made in the lives of Mozambican children.

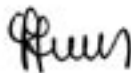
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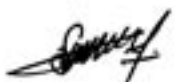
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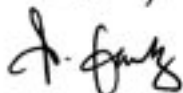
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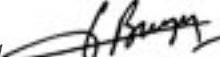
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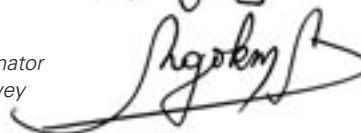
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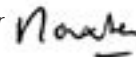
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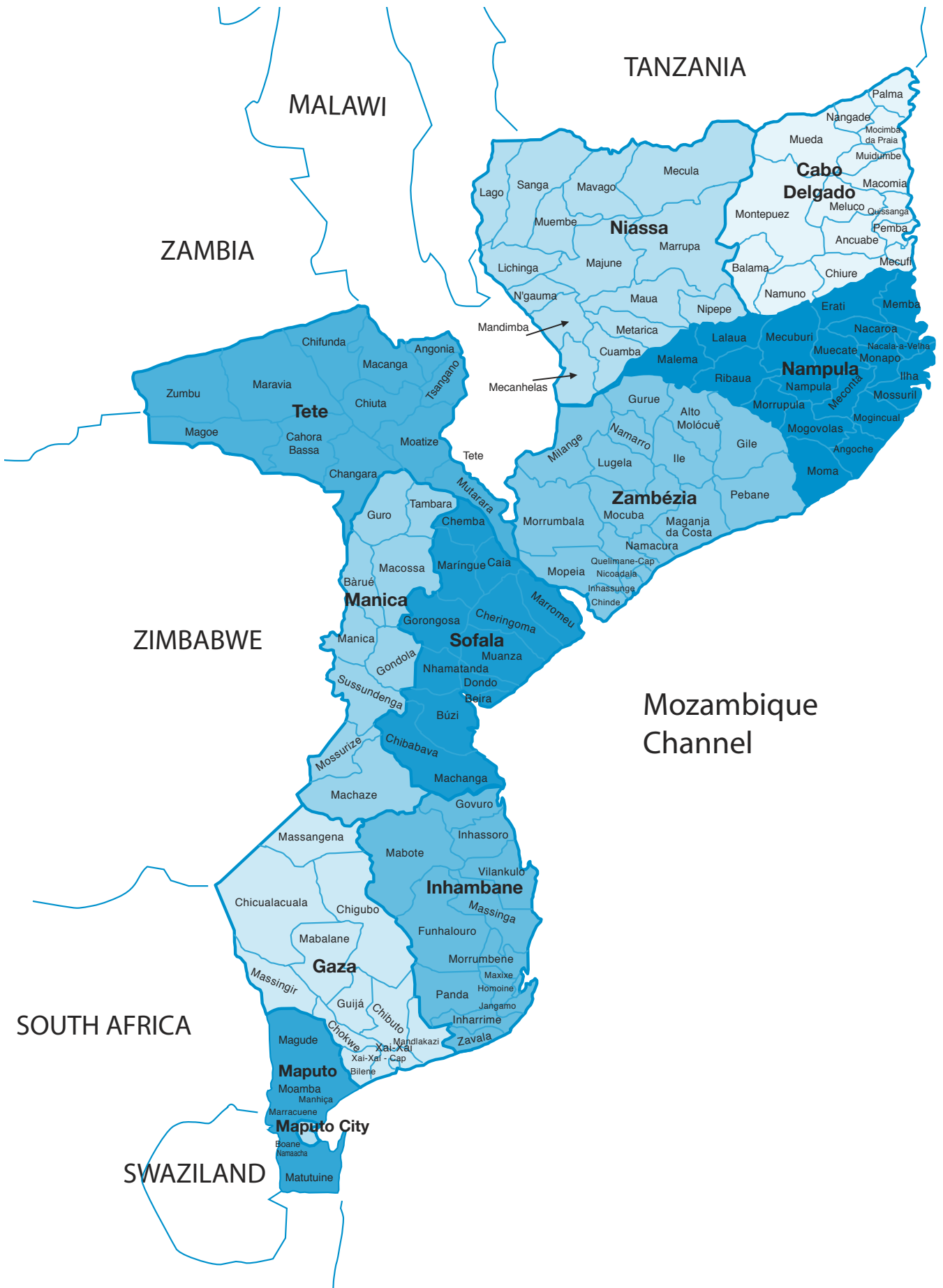
ACRONYMS

ADE	Apoio Directo às Escolas (Direct Support to Schools)
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
ARV	Anti Retroviral
ATS	Aconselhamento e Testagem em matéria de Saúde (Health Counselling and Testing)
BCG	Bacillus of Calmette and Guérin (vaccine against tuberculosis)
BdPES	Balço do Plano Económico e Social (Review of the Economic and Social Plan)
CBN	Cost of Basic Needs
CBO	Community Based Organisation
CFMP	Cenário Fiscal de Médio Prazo (Medium Term Fiscal Framework)
CFPP	Centros de Formação de Professores Primários (Training Centres for Primary School Teachers)
CGE	Conta Geral do Estado (State Accounts)
CNCS	Conselho Nacional de Combate ao HIV/SIDA (National AIDS Council)
CRC	Convention on the Rights of the Child
CRESCER	Cursos de Reforço Escolar: Sistemáticos, Contínuos, Experimentais e Reflexivos (National System for Continuous Professional Development)
CSO	Civil Society Organisation
CUT	Conta Única do Tesouro (Single Treasury Account)
CWIQ	Core Welfare Indicators Questionnaire
DBS	Direct Budget Support
DHS	Demographic and Health Survey
DNA	Direcção Nacional de Aguas (National Water Directorate)
DNO	Direcção Nacional de Orçamento (National Directorate of Budget)
DNP	Direcção Nacional de Planificação (National Directorate of Planning)
DNRN	Direcção Nacional dos Registos e Notariados (National Directorate for Registry and Notaries)
DPE	Direcção Provincial de Educação (Provincial Directorate of Education)
DPS	Direcção Provincial de Saúde (Provincial Directorate of Health)
DPT	Vaccine against Diphtheria, Pertussis and Tetanus
ECSP	Education and Culture Strategic Plan
EDM	Electricidade de Moçambique (Electricity of Mozambique)
EFA	Education For All
EP	Escola Primária (Primary School)
EP1	Ensino Primário do Primeiro Grau (lower level primary education)
EP2	Ensino Primário do Segundo Grau (upper level primary education)
EPC	Ensino Primário Completa (primary education)
EPI	Expanded Programme of Immunisation
ESG1	Escola Secundária Geral do Primeiro Grau (lower level secondary education)
ESSP	Education Sector Strategic Plan
ESG2	Escola Secundária Geral do Segundo Grau (upper level secondary education)
FASE	Fundo do Apoio a Sector Educação (Education sector common fund)
FBO	Faith Based Organisation
FDI	Foreign Direct Investment
FRELIMO	Frente de Libertação de Moçambique (Mozambique Liberation Front)
GAR	Gross Attendance Rate
GATV	Gabinetes de Aconselhamento e Testagem Voluntária (Centres for Voluntary Counselling and Testing)

GBS	General Budget Support
GDP	Gross Domestic Product
GER	Gross Enrolment Ratio
GNI	Gross National Income
GoM	Government of Mozambique
HAART	Highly Active Anti-Retroviral Therapy
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IAF	Inquérito aos Agregados Familiares (Household Income and Expenditure Survey)
IAP	Instituto de Aperfeiçoamento de Professores (Institute for Teachers' Improvement)
IDD	Iodine Deficiency Disorder
IEC	Information, Education and Communication
IFPRI	International Food Policy Research Institute (Ministério da Planificação e Desenvolvimento)
IFTRAB	Inquérito Integrado à Força de Trabalho (Labour Force Survey)
IMAP	Institutos do Magistério Primário
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMMR	Institutional Maternal Mortality Ratio
IMR	Infant Mortality Rates
INAS	Instituto Nacional de Acção Social (National Institute for Social Action)
INE	Instituto Nacional de Estatística (National Institute of Statistics)
INJAD	Inquérito Nacional Sobre Saúde Reprodutiva e Comportamento Sexual dos Jovens e Adolescentes (National Survey on Reproductive Health and Sexual Behaviour among Youth and Adolescents)
ILO	International Labour Organisation
IOM	International Organisation for Migration
IPT	Intermittent Presumptive Therapy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Bednets
LLIN	Long Lasting Insecticide Nets
LOLE	Lei dos Órgãos Locais do Estado (Law on Local State Bodies)
M&E	Monitoring and Evaluation
MAE	Ministério da Administração Estatal (Ministry of State Administration)
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MEC	Ministerio da Educação e Cultura (Ministry of Education and Culture)
MF	Ministério de Finanças (Ministry of Finance)
MISAU	Ministério de Saúde (Ministry of Health)
MMAS	Ministério da Mulher e da Acção Social (Ministry for Woman and Social Action)
MMR	Maternal Mortality Ratio
MOPH	Ministry of Public Works and Housing
MOU	Memorandum of Understanding
MPD	Ministério de Planificação e Desenvolvimento (Ministry of Planning and Development)
NAPC	National Action Plan for Children
NAR	Net Attendance Rate
NER	Net Enrolment Ratio
NES	National Education System
NGO	Non Governmental Organisation

NWP	National Water Policy
OE	Orçamento do Estado (State Budget)
ONUMOZ	United Nations Operation in Mozambique
OP	Observatório da Pobreza (Poverty Observatory)
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
OVC	Orphaned and Vulnerable Children
PAF	Performance Assessment Framework
PAP	Programme Aid Partnership
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, 2006-2009)
PEN	Plano Estratégico Nacional de Combate ao HIV/SIDA (National Strategic Plan for Combating HIV/AIDS, 2005-2009)
PER	Public Expenditure Review
PES	Plano Económico e Social (Economic and Social Plan)
PFM	Public Financial Management
PLWHA	People Living With HIV or AIDS
PMTCT	Prevention of Mother to Child Transmission
PNAC	Plano Nacional de Acção da Criança (National Action Plan for Children, 2005-2010)
POA	Plan of Action
PRS	Poverty Reduction Strategy
PSIA	Poverty and Social Impact Assessment
PVT	Prevention of Vertical Transmission
QUIBB	Questionário de Indicadores Básicos de Bem-Estar (Core Welfare Indicators Questionnaire)
RAP	Relatório Anual da Pobreza (Annual Poverty Report)
RBM	Roll Back Malaria
RENAMO	Resistencia Nacional Moçambicana (Mozambican National Resistance)
REOE	Relatório de Execução do Orçamento do Estado (State Budget Execution Report)
SADC	Southern African Development Community
SCN	Save the Children Norway
SETSAN	Technical Secretariat for Food Security and Nutrition
SISTAFE	Sistema de Administração Financeira do Estado (State Financial Administration System)
SJAM	Statute on Jurisdictional Assistance to Minors
SWAp	Sector Wide Approach
TB	Tuberculosis
U5MR	Under Five Mortality Rate
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UP	Universidade Pedagógica (Pedagogical University)
VAC	Vulnerability Assessment Committee
VAD	Vitamin A Deficiency
VAT	Value Added Tax
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation
YFHS	Youth Friendly Health Services

MAP OF MOZAMBIQUE



EXECUTIVE SUMMARY

This analysis of childhood poverty provides a comprehensive review of the socioeconomic situation of the ten million children in Mozambique and presents an overview of the public policy and service delivery environment for children. The report is intended to serve as an up-to-date and comprehensive reference for all stakeholders involved in the fight against childhood poverty, highlighting the many varied and interrelated challenges faced both by Mozambican children and by stakeholders seeking to address those challenges. This in turn is intended to support the development and implementation of policies which help to reduce childhood poverty and strategies to reach the most vulnerable and marginalised children. This exercise is particularly important, as poverty during childhood can undermine an individual's development for life.

The conceptual framework

Chapter One outlines the conceptual framework of the report, which is informed by a human rights based approach to childhood poverty. It acknowledges that children experience poverty differently from adults, that the impact of poverty in childhood can be lifelong and inter-generational and that children living in poverty face deprivations of many of their rights: to survive, develop, participate, and be protected. The key international legal instrument on children's rights is the Convention on the Rights of the Child (CRC), to which Mozambique is a signatory. The CRC affirms children's fundamental rights – such as the right to education – and childhood poverty can therefore be defined as the deprivation of these basic rights. In order to operationalise this rights-based approach to childhood poverty, the report adopts a deprivations-based approach which uses a series of indicators – known as the 'Bristol Indicators' – to measure children's access to seven rights (nutrition, water, sanitation, healthcare, shelter, education and information). This is presented in conjunction with the standard consumption-based measure of poverty, and the two are regarded as complementary to one another.

The human rights based approach implies the inclusion of two key steps in the analysis: a causality analysis, looking beyond the immediate causes of non-realisation of child rights to identify the underlying causes of the problem; and a capacity gap analysis, exploring the capacity of all those individuals or institutions responsible for respecting, protecting and fulfilling children's rights. The deprivations-based approach provides a basis for causality analysis by establishing a clear link between childhood poverty and the provision of basic public services. In addition, through highlighting areas with widespread deprivations in basic services, the deprivations-based approach helps to identify key capacity gaps. In such cases, there is a need to examine the capacities of all those institutions and individuals responsible for respecting, protecting and fulfilling child rights.

The national development context

By the signing of the peace accords in 1992, after sixteen years of armed struggle, Mozambique was one of the poorest countries in the world. As a result, even though subsequent social and economic development has been rapid and sustained, many children's rights remain unrealised at present. However, this does not mean that a rights based approach cannot be applied in Mozambique. In such contexts, the progressive realisation of children's rights is of fundamental importance – i.e. achieving sustained improvements in child development outcomes to the maximum of the available resources. As the analysis shows, the development trend has

been strongly positive in recent years, although the incredibly low base from which progress began means that there is still a tremendously long way to go.

Chapter Two focuses on three crucial and inter-related areas for child development outcomes (economic growth and stability, fiscal trends and poverty reduction) and asks to what extent children have benefited from the impressive poverty reduction trend in Mozambique. Through an assessment of childhood poverty, this Chapter demonstrates that childhood poverty is a pervasive and deep rooted problem: using the consumption-based measure of poverty, 58 per cent of children were living in poverty in 2003. The deprivations-based measure of poverty further indicates acute provincial disparities in the levels of childhood poverty. 75 per cent of children in Zambezia province were living in absolute poverty (i.e. with two or more severe deprivations) in 2003 as compared with 3 per cent in Maputo City, where public services are much more accessible. Evidence that poverty and inequality are widespread throughout the country is also presented: the poor often live alongside the non-poor and most inequality is accounted for by differences within districts. This makes the design of programmes to target the most vulnerable children effectively particularly challenging.

The institutional context within which child development outcomes are pursued is also examined, with a particular focus on the second Poverty Reduction Strategy (PARPA II). The Chapter explores key reforms within the Government such as the decentralisation process, reform of public sector planning and budgeting, public financial management (PFM) reform, and changes in the practices of donors through increasing alignment, harmonisation and the use of different aid modalities. A key observation is that the current climate is 'policy rich yet implementation poor'. It is therefore important that efforts are made to remove constraints to improved service delivery, which often relate to lack of institutional capacity as much as lack of financing. The Chapter also highlights the fundamental importance of the move away from ad hoc bilateral arrangements towards greater harmonisation and alignment of aid, whilst simultaneously strengthening Government capacity. It also cautions that care should be taken to ensure that this important transition does not have a detrimental impact on the development of the current generation of children. Thus, where scaling-up of aid results in large additional inflows of aid, these funds should be used to complement long-term capacity strengthening efforts with short and medium term programmes able to deliver a "step-change" in child development outcomes, such as malaria and immunisation programmes.

The situation in relation to child survival

The current situation in the area of child survival is reviewed in Chapter Three. There have been many positive developments in recent years, including a reduction in the maternal mortality ratio and the under-five mortality rate, putting the country on track to reach its PARPA II targets in this area, as well as two of the Millennium Development Goals. Many challenges remain, however, and the analysis indicates that 17 per cent of children under five years of age experienced severe health deprivation and 20 per cent of children under five years of age experienced severe nutrition deprivation in 2003. About one in six children die before reaching their fifth birthday. Malaria is the primary cause of mortality among children.

In particular, the Chapter highlights a central paradox in the Mozambican development trend: despite rapid reductions in both consumption and non-consumption poverty measures between 1997 and 2003, the situation in several areas relating to child survival and healthy development – in particular key anthropometric indicators – saw no significant improvement over the same period. There was no substantive change

in the nutritional status of children, childbirth care showed little improvement and all household surveys since 2000 show no increase in the use of safe water and sanitation. In 2003, 49 per cent of children under five years of age experienced severe water deprivation, while 47 per cent experienced severe sanitation deprivation. In addition, while AIDS is fast emerging as a major killer of children, with an estimated 99,000 children living with HIV or AIDS, by mid 2006 only 3 per cent of eligible children were receiving paediatric treatment and only 5 per cent of the total estimated HIV positive pregnant women in the country had received treatment for the prevention of mother to child transmission of HIV.

The impact of family child care practices on early childhood development is identified as being of particularly high importance, going some way to explaining the discrepancy between progress in socio-economic and anthropological measures of child development. This in turn suggests a crucial role for information dissemination in changing cultural attitudes to child care and thereby improving child development outcomes.

The situation in relation to education

The situation in relation to education is reviewed in Chapter Four. Since 1992 there have been impressive increases in gross and net enrolment ratios at both primary and secondary level. In spite of these increases, however, 24 per cent of children aged between 7 and 17 were experiencing severe education deprivation in 2003, having never attended school. Furthermore, the rapid increase in enrolment has not been matched by increased investment in the quality of education or adaptive strategies to deal with the corresponding 'access shock'. As a result, the status against indicators on the internal efficiency and quality of education remains poor: less than one third of children successfully complete their primary education, which is particularly worrying given the fundamental importance of basic education for growth and poverty reduction.

In addition, there is now an urgent need to invest in the post-primary school system (i.e. secondary and technical schools) so as to catch up with the increasing demand for places and produce sufficient numbers of qualified teachers to staff primary schools. At present, there is an acute shortage of secondary schools in the country and access to secondary education predominantly benefits children living in urban areas and those from the wealthiest families (often one and the same households). Furthermore, the deteriorating pupil-teacher ratios and increases in the proportion of unqualified teachers appear to have disproportionately affected secondary level education, a situation that is predicted to worsen in the near future, due to the loss of trained teachers to better paid jobs in other sectors, non-teaching posts in the education sector, or as a result of the impact of HIV/AIDS.

While trends in the literacy rate are positive, over half of the population is still not literate, with significant disparities between rural and urban areas (66 per cent and 26 per cent not literate respectively) and between women and men (67 per cent non-literacy among women compared with 34 per cent among men).

In terms of access to information, 39 per cent of children aged between 5 and 17 were experiencing severe information deprivation in 2003. This has serious implications for the survival and healthy development of children, particularly regarding access to information on HIV/AIDS. While knowledge of HIV prevention improved greatly between 1997 and 2003, the level of knowledge remains low, particularly among young women, and shows marked provincial variations.

Child protection concerns

Chapter Five examines the area of child protection from violence, sexual exploitation and abuse, and pays particular attention to the situation of Mozambican children most vulnerable to these abuses. Little is known about the extent and nature of these problems, but the available evidence suggests that such abuses are widespread. Children also bear a substantial economic burden, with the recent labour force survey indicating that 32 per cent of children between 7 and 17 years old are engaged in some form of economic activity, with significant differences between urban areas (16 per cent) and rural areas (40 per cent).

The increasing number of orphaned children, estimated at up to 1.6 million in 2006, 20 per cent of them orphaned as a result of AIDS, is one of the greatest challenges facing the country today, placing an increasing burden on the already overstretched capacities of families, communities and authorities. Recent evidence has highlighted the particular vulnerability of maternal orphans, who are both less likely to be attending school and more likely to be chronically malnourished than other children. Analysis of the situation of other vulnerable children, such as children living on the streets or those living with disabilities, is impeded by the lack of reliable information.

In the last few years, significant steps have been taken by the Government to develop policy and legal instruments such as the National Plan of Action for Children and the comprehensive Children's Act (due to be finalised in 2006) to ensure the protection of all children from violence, abuse and exploitation and to improve access by the most vulnerable and marginalised children to basic services and social protection programmes. There remains considerable concern, however, in relation to the capacity of governmental institutions responsible for coordinating the implementation and enforcement of these instruments and the associated financial resources. For example, the Ministry of Women and Social Action, which is mandated to coordinate the implementation of the Plan of Action for Orphaned and Vulnerable Children, has consistently been allocated less than one per cent of state budget resources.

Conclusions and recommendations

Mozambique has made significant progress since the onset of peace in terms of post-war reconstruction, macroeconomic stabilisation, economic recovery and the rapid reduction of poverty, whether defined in terms of deprivations or consumption. In addition, notable improvements have been witnessed against key indicators of child development in recent years, including significant reductions in the child mortality rate and the maternal mortality ratio and a rapid increase in primary school enrolment.

Despite this progress, the sheer depth of poverty from which Mozambique is emerging means that most children are still living in poverty. The levels of consumption and deprivations-based childhood poverty remain high and progress in relation to the reduction of childhood poverty is being seriously undermined across all sectors by the AIDS pandemic and the resulting weakened capacity of key actors to care for and protect children. In particular, limited improvement has been seen in key areas of child well-being (notably in anthropometric measures), threatening children's lifelong development prospects. In other areas, the limited availability of data precludes comprehensive analysis of the situation of children, such as the causes of child mortality and a range of child protection concerns.

In addition, there is a danger that some groups are not benefiting from growth and poverty reduction. Children in rural areas, for example, are consistently worse off

than their peers in urban areas and additional groups of children are particularly marginalised, such as orphaned and vulnerable children. Underlying the many urban-rural disparities is the very low population density in rural areas, one implication of which is that delivering a given level of public services is considerably more costly in rural areas than in urban areas.

The report concludes that concerted efforts are required from all those responsible for the reduction of childhood poverty – including Government, civil society and international development partners – in order both to reduce the incidence of childhood poverty and mitigate its impact, and also to ensure that specific strategies are in place to reach the most marginalised and excluded children. In this regard, a number of recommendations for addressing childhood poverty are highlighted, as outlined below:

- **Ensuring adequate and equitable resource allocation.** Ongoing analysis of budget mechanisms, allocations and expenditures and specifically the development of an efficient method for tracking expenditures in key sectors for children are imperative to inform the equitable allocation of the available resources and ensure sufficient investment for children.
- **Strengthening Government capacity at national and sub-national levels.** Often the key constraint to delivery is not lack of funds but limited institutional capacity. Increased investment for children must therefore be matched by sufficient Government capacity for the efficient utilisation of available resources. It is therefore critical to ensure significant, sustained investment in strengthening the institutional capacity of Government at the national and sub-national levels. Particular focus needs to be placed on developing capacity for planning, monitoring and evaluation and financial management at the provincial and district levels, and strengthening the capacity for coordination of agencies responsible for multi-sectoral interventions benefiting children, especially in the areas of nutrition and child protection.
- **Targeting the most vulnerable.** Understanding the situation of the most vulnerable children and the factors behind their marginalisation and then targeting initiatives towards these children should be an integral part of the national development agenda. Efforts need to be placed on ensuring the availability and use of reliable and up-to-date data on vulnerable children and the causes of their vulnerability and supporting them to access to basic services and social protection programmes, such as cash transfers. The broad distribution of childhood poverty and inequality and the very low population density in rural areas mean that policies targeting the poorest and most vulnerable children need to be designed very carefully.
- **Accelerating the response to the AIDS pandemic.** It is important that interventions in the areas of paediatric AIDS and the prevention of mother to child transmission are significantly accelerated and scaled up, in order to reduce the impact of AIDS on infant and child mortality, thereby helping to sustain recent improvements in the rates of infant and child mortality.
- **Managing aid inflows for improved child outcomes.** As PARPA II stresses, aid flows ideally need to be tailored to promote long-term Government-led objectives such as capacity strengthening efforts. However, it also recognises that there is a need to manage potential additional inflows of finite duration resulting from 'scaling-up'. These should be targeted towards programmes that can deliver a 'step-change' in development outcomes for children. Large-scale

vaccination or malaria campaigns, which deliver clear benefits for children, are natural candidates, particularly because childhood diseases can undermine development for life and should therefore be addressed as soon as possible.

- **Strengthening the capacity of civil society and promoting community participation.** It is critical that the capacity of civil society is strengthened, in order to ensure enhanced and expanded support for Government in terms of demand creation, alternative mechanisms for service delivery and the targeting of development programmes towards the most vulnerable children. In addition, active and informed participation of communities in the design, implementation and monitoring of development programmes needs to be promoted and facilitated in order to increase their impact and sustainability.
- **Implementing social communication strategies.** Social communication strategies, tailored to the local context and employing a variety of communication channels need to be supported, in order to enhance the sharing of information and knowledge, promote social and behaviour change and mobilise communities in the fight against childhood poverty. This is potentially a very important tool in making progress on anthropometric measures, which the evidence suggests are closely linked to cultural practices and attitudes (such as those regarding breastfeeding).



CHAPTER I

INTRODUCTION AND CONCEPTUAL FRAMEWORK

1. Objective of the Situation Analysis

This Situation and Trends Analysis of Childhood Poverty in Mozambique provides a comprehensive overview of the socioeconomic situation of the ten million Mozambican children, especially with regard to childhood poverty and analyses the current situation of children in Mozambique¹. It also presents an overview of the public policy and service delivery environment for children, identifying areas in which progress needs to be made and making recommendations as to the way forward.

One distinctive contribution of the report is to provide a human rights-based perspective on national efforts to reduce childhood poverty and improve child development outcomes for all children in Mozambique. To this end, a deprivations-based measure of childhood poverty is presented, complementing the official consumption-based measure of childhood poverty, using a definition that examines children's access to water, sanitation, shelter, education, health, nutrition and information. Through this approach the disparities and immediate and underlying causes of childhood poverty are explored, drawing on the rich body of data and analytical work that has been conducted in recent years by the Government and its development partners².

The aim is that all stakeholders involved in the national effort to promote children's development will use this Situation Analysis as a source of information, analysis and recommendations for programming and policy-making.

2. Human rights, child development and childhood poverty

Development is the process through which human beings can fulfil their potential and lead decent and productive lives. To achieve this potential, individuals require certain capacities - that is, the range of things that they can do and be in life. Expanding capacities creates the basis for individuals to enjoy substantive freedoms and make choices that have value in their lives, as well as creating the potential for individuals to make a positive contribution to the broader development environment.

At the most basic level, children and their families must have the capacity to satisfy the material and protection requirements for their survival. Children must be able to avoid hunger, illness, malnutrition and escape a premature death or permanent disabilities that will hinder their development as they become adults. Building on their material well being, enabling capacities such as education and good health allow children to create opportunity in their lives and expand the range of things that they can do and be. For example, education levels are directly tied to future employment opportunity and the income a child can expect to earn when she or he reaches adulthood. Social capacities allow children to participate in family and community life, as well as political processes and decision-making.

There is a direct and mutually reinforcing relationship between the development process and human rights. Human rights involve a claim that one person has over others, be they individuals, societal groups or the State. Such claims can be for civil and political rights, involving a claim to physical security and the integrity of human life, freedoms of thought, religion and association, freedom from discrimination and the right to political participation. Such rights offer protection from interference by others. Such claims can also be for human rights with a social and economic dimension, such as the rights to basic material goods necessary to sustain life,

¹ Children are defined throughout as all citizens under the age of 18 in accordance with the Convention on the Rights of the Child (UN, 1989).

² See Van den Broeck (2005) for an excellent overview of recent poverty data and analysis in Mozambique.

education and health. These are claims for attention and assistance. What all of these claims have in common is that they involve an entitlement to help from others to respect, protect and fulfil their rights in defence of freedoms and capacities (UNDP, 2000 pp. 19-26). Thus, if human development is the process of expanding individuals' capacities and freedoms, then human rights are a claim that individuals have to secure those capacities and freedoms.

What Mozambican Children Say

"...All children must have their rights, which are: parental love, care, the right not to be beaten, the right to study so that tomorrow they might be someone, to be protected by the police and by their elders."

Nilsa, 12 years old, Sofala

Human rights establish a set of principles to which the development process can aspire. A rights-based perspective establishes basic minimum standards to which individuals can lay claim and consequently defines the duty of others to ensure that those rights are realised. Duties imply responsibilities and accountability. Asserting a claim to education is not only saying that education is needed or is a good thing. It is to say that children are entitled to an education. If some children are deprived of education, it is essential to engage in a process through which the persons or systems responsible for the deprivation of the children's rights are identified and actively involved in finding solutions to ensure the progressive realisation of children's right to education.

Children's rights are formally set out in international and national law. Mozambique is a signatory to the main international human rights conventions related to children (see Box 1.1 below). Through these commitments, the Government has assumed the primary responsibility for working to respect, protect and fulfil children's rights in all of their dimensions.

Box 1.1: Human rights conventions related to children ratified by Mozambique

The key convention for children's rights is the Convention on the Rights of the Child (CRC, United Nations, 1989), setting minimum standards in guarantees of protection and development for children. The Convention starts from the premise that the family is the best environment for the growth and well-being of children and that government must render appropriate assistance to parents or guardians.

Defining children as "every human being below the age of eighteen years", the CRC establishes a series of entitlements and protections for children, including an entitlement to education and to the enjoyment of the highest attainable standard of health, as well as protection from sexual abuse, violence and trafficking. The Convention recognises explicitly that many States need to work towards the progressive realisation of the provisions of the CRC, and stresses the importance of international cooperation for improving the living conditions of children in developing countries.

The Government of Mozambique ratified the CRC in 1994 (with no reservations) and the country's initial report was considered at the Committee on the Rights of the Child's January 2002 session. The Government has also acceded to the two Optional Protocols to the CRC on the sale of children, child prostitution and child pornography and on the involvement of children in armed conflict, in 2003 and 2004 respectively.

Mozambique has also ratified the following conventions outlining specific rights to be realised by children:

- *The African Charter on the Rights and Welfare of the Child, Organisation of African Unity, entered into force on 29 November 1999 and ratified by Mozambique on 15 July 1998.*
- *The Convention concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour, International Labour Organisation (ILO), ratified by Mozambique on 16 June 2003.*
- *The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), ratified by Mozambique on 21 April 1997.*

The movement to integrate human rights explicitly into development policies and programmes has gained momentum in recent years and is referred to as a human rights-based approach to development. However, defining, interpreting and implementing human rights-based approaches and developing a common understanding of the implications for development processes is a process still underway (Ljungman, 2004).

What Mozambican Children Say

"...We want our rights but we are not heard. I want my dream to be heard."
Claudio, 11 years old, Nampula

As well as raising conceptual difficulties, putting any such approach into practice in the Mozambican context is particularly challenging because of the scarcity of both financial and human resources and the wide array of actors in the development process. The Government in particular is subject to many competing demands and obligations, from maintaining macroeconomic stability to increasing the quantity and quality of its services and ensuring acceptable standards of governance, justice and representation for its citizens.

As a result, many children's rights remain unrealised and severe resource and capacity constraints, as well as cultural and behavioural norms, mean that progress

towards realising these rights will take considerable time, even under optimistic scenarios. There are also trade-offs to be made in resource allocation, leading to difficult choices in prioritising which rights to address. However, this does not mean that a rights based approach cannot be applied in Mozambique: the progressive realisation of children's rights is of fundamental importance – i.e. achieving sustained improvements in child development outcomes to the maximum of the available resources.

Two key steps are used in this Situation Analysis to examine childhood poverty and children's socioeconomic situation in Mozambique from a rights-based perspective:

1- A causality analysis, looking beyond immediate or proximate causes in order to identify the underlying causes of a problem. For example, discrimination based on gender is an underlying cause explaining many manifestations of girls' and boys' situation in Mozambique. An analysis of causality is essential in understanding the systematic nature of children's rights violations.

2- An analysis of gaps in capacity, starting from the premise that rights violations often occur because specific duty-bearers lack the capacity to fulfil their obligations. A capacity analysis explores capacity in terms of recognition of responsibilities, possession of legitimate authority to act on duties (whether legally, politically, socially or culturally legitimate), human, economic and organisational resources, capability to make informed decisions and learn from the results and capability to communicate (i.e. to access and participate in the generation and sharing of information).

3. Deprivation-based approach to childhood poverty

Childhood poverty examines the poverty specifically experienced by human beings in any society, during their childhood. Such poverty clearly has immediate effects on the situation and experience of poor children while they are children. However, childhood poverty is distinctive in that some of its effects are felt throughout the child's life, passing on into adulthood, regardless of the adult's poverty status. For example, stunting, reduced mental development, or psychological trauma experienced in childhood affect a person for the rest of her or his life. Furthermore, all evidence shows that poor children have a high chance of growing up to become poor adults and in turn, have poor children. The inter-generational nature of childhood poverty therefore also needs to be recognised and addressed.³

Mozambique's first Poverty Reduction Strategy Paper, the 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" (GoM, 2001, p.10).⁴ This is consistent with the official national consumption-based poverty measure, by which households' levels of consumption are assessed and compared to poverty lines constructed from a basket of basic foodstuffs conforming to a basic caloric minimum.

Many observers subsequently proposed that this definition of poverty should be supported by more multi-dimensional measures in order to present a broader, more pluralistic analysis and support rights-based analysis (e.g. Isaksen et al., 2005; G20, 2004). This view was formally adopted by the Government in the country's second Poverty Reduction Strategy Paper, the PARPA II (2006 - 2009). While reporting on the consumption-based measure in its poverty analysis, PARPA II adopts a new definition

³ For a detailed overview of childhood poverty, see Childhood Poverty Research and Policy Centre website (childhoodpoverty.org).

⁴ PARPA (Plano de Acção para a Redução da Pobreza Absoluta) is equivalent to Mozambique's Poverty Reduction Strategy Paper (PRSP).

of poverty, defined as: "Impossibility, due to incapacity or through lack of opportunity of 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 monetarist 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." (GoM, 2006, p. 8).

In line with this new approach, the analysis presented here uses a "deprivations-based" measure of childhood poverty. The indicators used to quantify this measure were originally developed for UNICEF by a team at the University of Bristol – hence they are often referred to as the Bristol Indicators – and presented in the report 'The Distribution of Child Poverty in the Developing World' (Gordon et al., 2003). The Bristol indicators are based on the 'deprivation approach' to poverty, drawing upon the definition of absolute poverty agreed at the World Summit for Social Development, as "...a condition characterised by severe deprivation of basic human needs" (United Nations, 1995).

The indicators comprise seven measures of severe deprivation: food, safe drinking water, sanitation facilities, health, shelter, education and information. They define the proportion of children living in absolute poverty as those children facing two or more types of severe deprivation. One reason for adopting this multiple deprivation threshold for absolute poverty is that, in rare cases, single severe deprivations could result from causes other than a lack of sufficient resources over time. For example, severe anthropometric failure can result from ill health rather than from lack of income (Gordon et al., 2003: 45). The indicators are also designed to improve international comparability of national childhood poverty estimates.⁵

Developing a universal set of indicators for all poor countries is, however, unrealistic. Therefore, in this Situation Analysis, the Bristol Indicators have been adapted to reflect the context of children in Mozambique, whilst avoiding a degree of alteration that would prevent indicative international comparisons. The indicators used in this Situation Analysis are listed in Table 1.1 and details of their modification from the international indicators are given in Annex I. The resulting deprivations-based measures of childhood poverty in Mozambique, based on data from the 2003 Demographic and Health Survey (DHS), are presented and discussed in subsequent chapters.

All measures of poverty have their limitations and the deprivations-based approach is no exception. Of particular importance is the question as to whether to assign weightings to different deprivations to reflect their relative importance. For example, one might consider the lasting benefits of immunisation (part of the severe health deprivation indicator) to be substantially more important than access to a radio at a given time (a component of severe information deprivation), particularly given that children may be able to access radios in neighbouring households. However, the analysis presented here does not ascribe weights to the differing deprivations. This is done in part to maintain a degree of indicative comparability both internationally (the standard methodology developed by Gordon et al. does not use weights) and over time, and in part because any such exercise would be highly subjective. The reader is therefore presented with data on the different deprivations and left to decide upon their relative importance in the context of the associated analysis in each chapter.

⁵ See Deaton (2001) for a discussion on international comparability of poverty estimates.

The deprivations-based approach does, however, have some inherent strengths. As will be discussed in Chapter II, the consumption-based measure of poverty does not capture consumption of key public services, while the deprivations approach, at least to some extent, is able to do so. This is highlighted particularly sharply by the contrasting results of the respective measures for the nation's capital, Maputo City. An added advantage of this is that the link between stakeholder resource allocation, actions and the resulting changes in childhood poverty is made much more explicit. For example, the increased allocation of funds toward rapid expansion of immunisation programmes would have an immediate and direct impact on child poverty under the deprivations-based measure, but would feed through to the consumption-based measure somewhat more slowly.

Finally, the inclusion of access to basic services reveals far greater differences between rural and urban households in comparison with the consumption-based measure (see data presented in Chapter II) mainly due to the very low population density in rural areas, which makes the provision of public services much more costly. However, as Filmer and Pritchett (2001) observe, this means that urban-rural comparisons using poverty measures that include access to services should be treated cautiously because they capture systematic differences resulting from a household's urban/rural status. They should therefore be complemented by the consumption-based measure to try to overcome this difficulty.

Table 1.1: Deprivation-based indicators for Mozambique

Form of Severe Deprivation	Indicator	Associated CRC Article
Severe Nutrition Deprivation	Children under five years of age whose heights and weights for their age are more than -3 standard deviations below the median of the international reference population, i.e. severe anthropometric failure	Health: combat of disease and malnutrition 24 (2) (c)
Severe Water Deprivation	Children under 18 years of age who only have access to surface water (e.g. rivers) for drinking or who live in households where the nearest source of water is more than 30 minutes away	Health: provide clean drinking water 24 (2) (c)
Severe Sanitation Deprivation	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	Health: support hygiene and sanitation 24 (2) (e)
Severe Health Deprivation	Children under five years of age that have never been immunised or those that have suffered from a severe episode of ARI that was not treated	Health: right to health and health facilities, combat of disease and malnutrition 24 (1)/(2)(c)
Severe Shelter Deprivation	Children under 18 years of age living in dwellings with more than five people per room (severe overcrowding)	Standard of Living: measures to provide housing 27 (3)
Severe Education Deprivation	Children aged between 7 and 18 who have never been to school and are not currently attending school	Education: compulsory free primary education 28 (1) (a)/(b)
Severe Information Deprivation	Children aged between 5 and 18 with no possession of and access to radio, television, telephone or newspapers at home	Information: access to information 13/17

Note: See Annex I for details of adaptation from international indicators to suit Mozambican context.

Source: Adapted from Gordon et al. 2003 by UNICEF Mozambique.

4. Actors and their role in the fight against childhood poverty

Children living in poverty face deprivations of many of their rights. While the Government of Mozambique holds the primary responsibility for respecting, protecting and fulfilling the rights of Mozambican children, there are many actors in the fight against childhood poverty and all sectors of society have a role to play in this regard, starting with children themselves. The human rights based approach to development means that children are viewed as actors in their own development. While not placing the responsibility for improving development outcomes with children themselves, their right to participate in the process and be consulted must be emphasised. Children have a right to participate in decision-making processes that may be relevant in their lives and to express their views in all matters that affect them. Children must therefore be supported to realise this and other rights by their families and communities, civil society organisations, the Government, the Parliament and international development cooperation partners.

A. Children

Children's right to participate in the development process is paramount. In recent years, the participation of children and young people has received increased attention in Mozambique, through, for example the "Chokwe Declaration"⁶, the participation of young people in the Provincial Poverty Observatories during the elaboration of the PARPA II, and the series of national and provincial "Children's Parliaments"⁷.

B. Family and community

Families and communities are the primary caregivers of children and the first duty bearers responsible for respecting, protecting and fulfilling children's rights to survival, development and participation. Families are responsible for the adequate care of children. As families live in communities, communities have a responsibility in demanding services for their members and for ensuring that all children in the community are well cared for, protected and have access to the services they need. These responsibilities need to be matched with material, enabling and social capacities and require that families and communities are provided with adequate access to resources and information to enable them to fulfil their duties towards children.

C. Civil society organisations

Civil society and organisations within civil society, such as non-governmental organisations (NGOs), community based organisations (CBOs), faith based organisations (FBOs), religious groups, trade unions, media organisations, private sector associations and academics are the channels through which people participate in the political and social life of their society. Civil society organisations (CSOs) can make demands, advocate for the rights of children at local and national level and engage in policy dialogue with the Government. CSOs can play a role in monitoring and evaluating government actions in relation to poverty reduction, making demands and requiring explanations when necessary. They can also provide effective and efficient services, extending government capacity through partnerships for implementation and can build capacity at district and provincial level during the process.

D. Government

As a signatory of the CRC and other international child and human rights conventions and with a democratic mandate, the Government of Mozambique bears the primary responsibility for the progressive realisation of child rights. The Government of Mozambique is organised in central and territorial levels. At the central level, the Executive is headed by the President of the Republic, who presides over the Council of Ministers and specific Ministries and subordinated institutions. At the territorial level, the Constitution provides for 11 provinces, which are made up of 146 districts, 343 administrative posts and 1,048 localities. Mozambique also has 33 municipalities covering urban areas, which have some budgetary autonomy.

The Ministries of Health (MISAU), Education and Culture (MEC), Public Works and Housing (MOPH), Women and Social Action (MMAS) and the National Council for the Fight Against HIV/AIDS (CNCS) are of particular importance for children.

⁶ The "Chokwe Declaration" emerged from the National Meeting of Youth held in the town of Chokwe in 2002. The declaration highlights a wide range

⁷ The series of provincial and national children's parliaments conducted from 2002-2005, whilst somewhat limited in their scope and degree of representation, highlighted the need to listen to the views of children and young people, though the place of Children's Parliaments in the country's democratic processes is still being defined (UNICEF and Ministry of Youth and Sports, 2005).

The Ministries of Planning and Development and of Finance are also of particular importance, as they produce the State Budget and other key planning and budgeting instruments.

The process of decentralisation, enshrined in the Law Governing Local State Organs (LOLE, Law 08/2003) and its regulations (2005) has significantly altered the subordination in favour of territorial (horizontal) hierarchies, compared with sectoral (vertical) hierarchies. However, decentralisation is in its early stages and planning, resource allocation, policy making and implementation are as yet strongly shaped through vertical lines of authority.

E. Parliament

The Parliament includes 250 representatives who are elected from party lists every five years in national elections at the same time as presidential elections. In addition to approving legislation, Parliament is responsible under the 1990 Constitution for approving the State Budget. Parliament is therefore a key duty-bearer for children's rights, not only for ensuring that national legislation is in line with the CRC, but also for fighting childhood poverty through ensuring sufficient and equitable allocation of resources for social services.

F. International development cooperation partners

As is stressed in the CRC, the Government's international cooperation partners, operating at national, provincial and district levels, also have a responsibility for improving the situation of children. In Mozambique, external funding financed about 42 per cent of the Government's budget in 2005 (Ministry of Finance, 2006). There are at least 44 different international development organisations operating in Mozambique (Directory of Development Organisations, 2006), many of which are concentrated in key sectors for children. For example, in the education sector alone there are 26 agencies in operation (Killick et al., 2005, p. 48). External development cooperation partners have made substantial changes to the way that external development assistance is provided to Mozambique, with shifts towards direct budget support and greater harmonisation between donors and alignment of donor plans with government priorities. 80 per cent of external development assistance to Mozambique is now provided by a group of 18 donors, joined under the Programme Aid Partnership (PAP), who are committed to ensuring that the Government has greater control over financial resources available for development and is supported in developing the capacity to plan, implement and review its actions.

5. Sources of data

This Situation Analysis draws in particular on the data produced by the National Institute of Statistics (INE) through household surveys, including:

- The Demographic and Health Surveys (DHS) conducted in 1997 and 2003. The 2003 DHS provides the data used in the formulation of the deprivations-based measure of childhood poverty.
- The Household Surveys on Living Conditions (IAF) conducted in 1996/1997 and 2002/2003. The IAF is used to produce the official consumption-based measure of absolute poverty.
- The Labour Force Survey (IFTRAB) conducted in 2004/2005, which includes a Core Welfare Indicator Questionnaire (CWIQ, known in Portuguese as QUIBB) and provides the most up-to-date data.

This Situation Analysis also makes extensive use of other data and studies from the Government, civil society and international development cooperation partners (see bibliography). Data on the allocations and flows of public funds are drawn from the State Budget and audited budget execution reports (the CGE and REOE).

CHAPTER II

THE DEVELOPMENT CONTEXT



1. Introduction

This chapter focuses on three crucial and interrelated areas for child development outcomes: economic growth and stability, fiscal trends and poverty reduction. An assessment of childhood poverty is presented, both in terms of the official consumption-based measure and a deprivations-based measure.

The institutional context within which child development outcomes are pursued is also examined in more detail. Analysis is focused on key reforms within Government such as the decentralisation process, reform of planning and budgeting, public financial management (PFM) reform and changes in donor practices through increasing alignment, harmonisation and the use of different aid modalities.

Although Mozambique ranks poorly on many absolute indicators, performance since the end of the civil war with respect to relative indicators – that is, the development trend – has been and continues to be, positive. This should not be a cause for complacency, however, as more than half of Mozambican children live in poverty and there are acute disparities in patterns of poverty and deprivation. Sustaining and accelerating this development progress and reducing existing disparities remain enormous challenges for the years ahead.

2. Development trends

A. Transition to peace, democracy and market economy

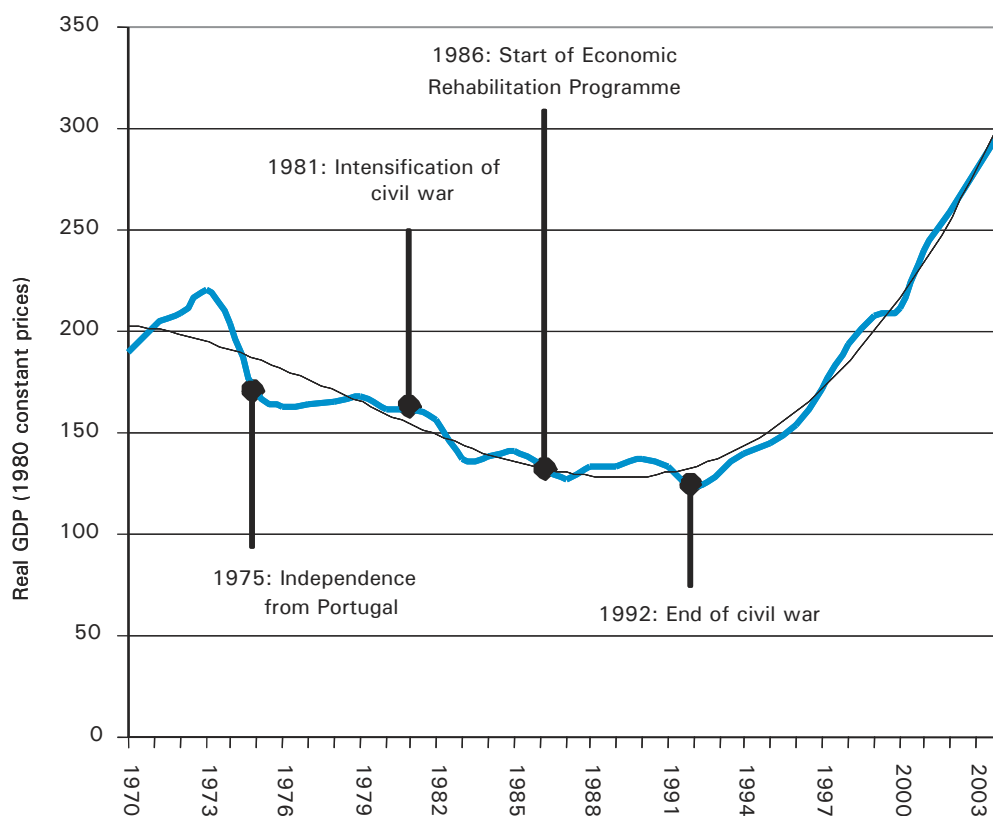
The present national situation for child development is the product of a modern history that has been blighted by colonialism, the poor preparation for independence and a long period of armed conflict. A few years after gaining independence from Portugal in 1975, the country was plunged into 16 years of unrest, with armed conflict between the Government, led by the Mozambique Liberation Front (FRELIMO), and the Mozambican National Resistance (RENAMO). Public infrastructure was deliberately targeted, with schools and teachers in particular singled out. By the early 1990's, the end of the Cold War, political change in the Republic of South Africa and the effects of regional drought and sheer exhaustion on both sides brought the combatants to the negotiating table. After two years of talks in Rome, the parties signed a General Peace Agreement on 4th October 1992. As part of the Agreement, the UN Security Council established the United Nations Operation in Mozambique (ONUMOZ) to monitor and support a ceasefire, the demobilisation of forces and the holding of national elections.

The development prospects for African nations emerging from civil conflict are generally poor, with sixty percent suffering a relapse into fighting within ten years (Collier et al., 2003). In contrast, Mozambique's transition to a lasting peace settlement represents a success story. Since the signing of the peace accord, the nation has avoided conflict-related setbacks to its development, successfully bringing about reconciliation and managing potential conflicts. Three successive rounds of general and presidential elections have now been held (in 1994, 1999 and 2004), with FRELIMO having won both presidential and parliamentary majorities and RENAMO leading an electoral union of opposition parties. Multiparty municipal elections have also been held in 1998 and 2003. The transition to peace and democracy has been accompanied by the progressive adoption of a liberal free market economic model, replacing the socialist planning model that had been introduced by FRELIMO after independence. These changes also led to the entry of substantial inflows of external assistance as donors sought to support the new national development model.

The armed struggle had a devastating overall effect on the country, displacing millions of people from their homes, and destroying both human and physical productive resources. Development was set back to such an extent that when the peace accords were signed in 1992, Mozambique was ranked as the poorest country in the world both by the UN's Human Development Index (HDI) and according to World Bank estimates of Gross National Product per capita (WB 1997).

The country remains one of the poorest in the world, ranked by the 2006 HDI as 168th of 177 countries. However, progress since 1992 has been sustained and impressive when seen in the context of the preceding years. Trends in real GDP since 1970 indicate that expansion since the transition to peace and democracy has been rapid and sustained, with 131 per cent real growth between 1991 and 2004 (see Figure 2.1). Only in 2001 did real GDP surpass its pre-independence level, but real growth (including agricultural growth benefiting rural areas) has continued apace since then, suggesting more profound forces are at work than the simple "bounce-back" effect after a long period of conflict (Arndt et al. 2006).

Figure 2.1: Mozambique real GDP 1970-2004, in billions of metical at constant 1980 prices



Source: Jones (2006)

This pattern of rapid progress from a very low base is also reflected in the national report on progress towards the Millennium Development Goals (MDGs). Mozambique has the potential to achieve several targets that define progress relative to some previous national benchmarks (i.e. those on poverty reduction, child mortality and maternal mortality) due to this strong development trend. More generic targets that define progress relative to absolute thresholds such as universal primary education and gender equality remain more distant prospects due to the sheer depth of poverty and underdevelopment from which the nation is emerging. Of 11 MDG targets for which data were available, the second national MDG progress report in 2005 estimated that Mozambique had the potential of achieving five (see Table 2.1).

Table 2.1: Progress towards the MDGs

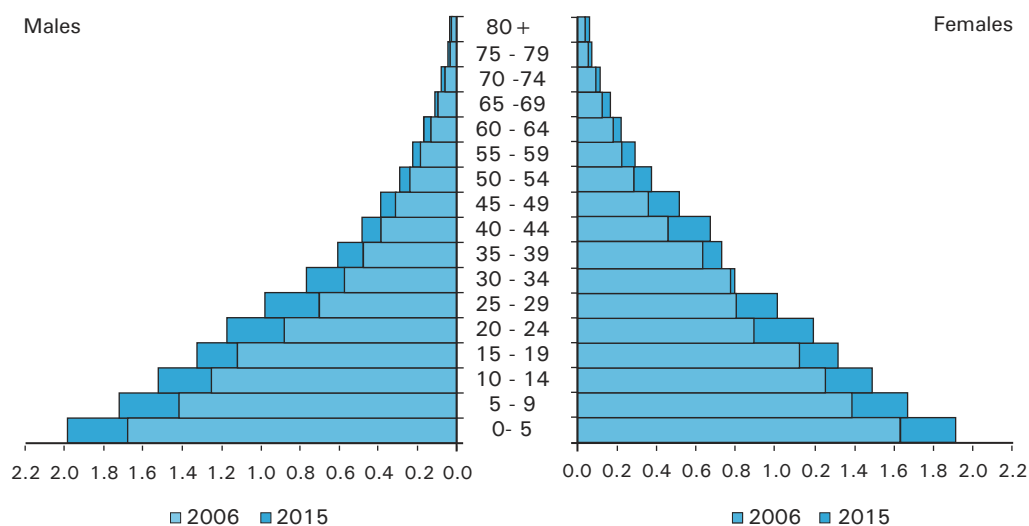
Target for 2015	Potentially on Track?
Halve the proportion of people living in extreme poverty	Yes
Halve the proportion of people who suffer from hunger	No
Ensure that all boys and girls are able to complete a full course of primary schooling	No
Eliminate gender disparity in all levels of education	No
Reduce by two-thirds the under-five mortality rate	Yes
Reduce by three quarters the maternal mortality ratio	Yes
Have halted and begun to reverse the spread of HIV/AIDS	No
Have halted and begun to reverse the incidence of malaria and other major diseases	Yes
Integrate principles of sustainable development into country policies and reverse loss of environmental resources	No
Halve the proportion of people without access to safe drinking water and sanitation	No
Develop further an open, ruled based, predictable, non-discriminatory trading and financial system	Yes

Source: GoM and UN 2005

B. Demographic trends

Official population estimates are produced by the National Institute of Statistics (INE), based on projections from the 1997 National Census data.⁸ These estimates reveal that the population is strikingly young. In 2006, of a total population of 19.9 million, half were children (10 million). Figure 2.2 provides an overview of the age structure of the population broken down by sex and by five-year age groups. Population density in Mozambique is very low, at 25.3 inhabitants per km² (compared to densities of 109 and 39 inhabitants per km² in neighbouring Malawi and South Africa (UN Population Division, 2006)), and there is a relative abundance of arable land.⁹ The population is predominantly rural (69 per cent). At provincial level, the neighbouring coastal provinces of Zambezia and Nampula together account for 38 per cent of the total population and 39 per cent of the nation's children. The size of an average household is estimated to be 4.7 members in urban areas and 4.2 members in rural areas, giving a national average of 4.3 (INE, 2006 IFTRAB).

Figure 2.2: Projected age structure of the population by sex in 2006 and 2015 (in millions)



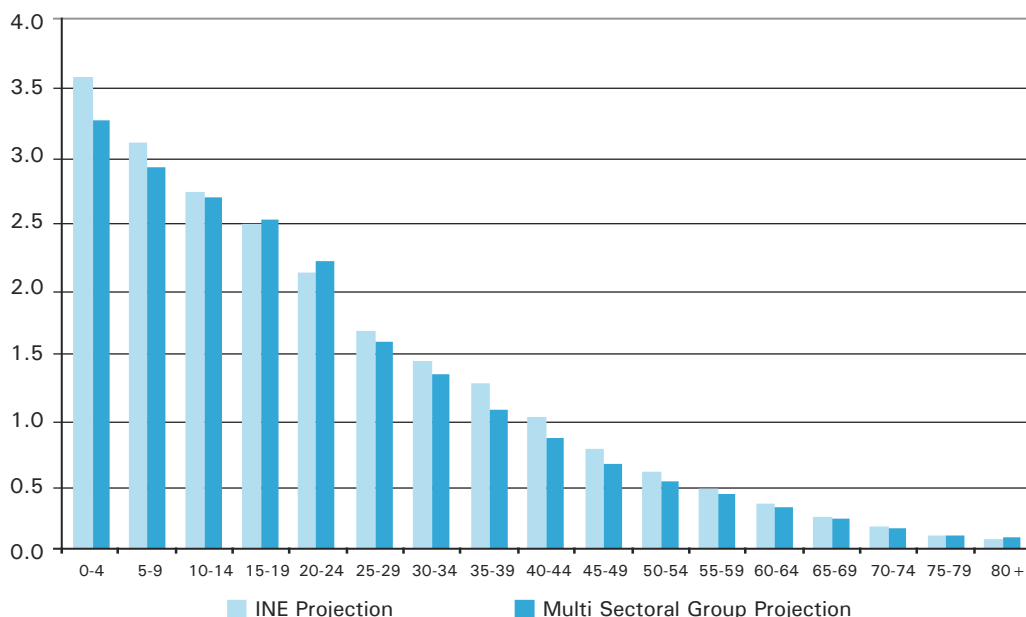
Source: INE 2004a

Dependency ratios, estimated by dividing the number of children of 0 – 14 years of age plus the number of those who are 65 and above by the “active” population of 15 – 64 years, were estimated in 2006 at 71.6 per cent and 92.1 per cent for urban and rural areas respectively, with an overall national ratio of 85.2 per cent (INE).

The AIDS pandemic is having a dramatic demographic impact. The latest round of sentinel surveillance data produced a national HIV prevalence estimate for 2004 of 16.2 per cent among people between 15 and 49 years of age (Ministry of Health, 2005).¹⁰ The worst affected region of the country is the central region with an estimated prevalence of 20.4 per cent, while the southern region has a rate of 18.1 per cent and the northern region has a rate of 9.3 per cent.¹¹ Sofala province is by far the most affected, with 26.5 per cent HIV prevalence recorded in 2004.

Based on HIV/AIDS estimates from the 2002 surveillance round, projections of the future impact of the epidemic to 2010 suggest that life expectancy at birth is presently 37.1 years and will decline to 35.9 years by 2010 (Multisectoral Technical Group for the Fight against HIV/AIDS, 2004).¹² Projections also indicate that there will be around half a million fewer children in the 0 to 14 age range than INE figures suggest by 2010 (see Figure 2.3) and that the AIDS pandemic will be responsible for 626,000 orphans by the year 2010, compared with 64,000 in 1998 and 382,000 in 2006.

Figure 2.3: Projected age structure of the population in 2010: comparing INE and Multisectoral group figures (in millions)



Source: INE 2004a and Multisectoral Technical Group for the Fight against HIV/AIDS 2004

⁸ The data presented here are drawn from INE (2004a) unless otherwise stated. United Nations Population Division (2006) “Medium variant” projections for Mozambique are also used. See Klasen and Woltermann (2004) for a detailed discussion of the two somewhat different sets of projections. The analysis presented here also draws on this article.

⁹ Calculation based on total land area of 786,380 km² (INE, 2006).

¹⁰ Estimates based on a network of 36 ante-natal care sentinel sites. While the national sero-surveillance network is regarded as a relatively strong one (Garcia-Calleja et al., 2004), there are well recognised concerns about the accuracy of the national prevalence estimates (Arnaldo and Francisco, 2004).

¹¹ The central region comprises Sofala, Manica, Tete and Zambezia (42.1% of the population in 2006) while the southern region comprises Maputo City, Maputo Province, Gaza and Inhambane (25.5% of the population in 2006) and the northern region comprises Niassa, Nampula and Cabo Delgado (32.4% of the population in 2006).

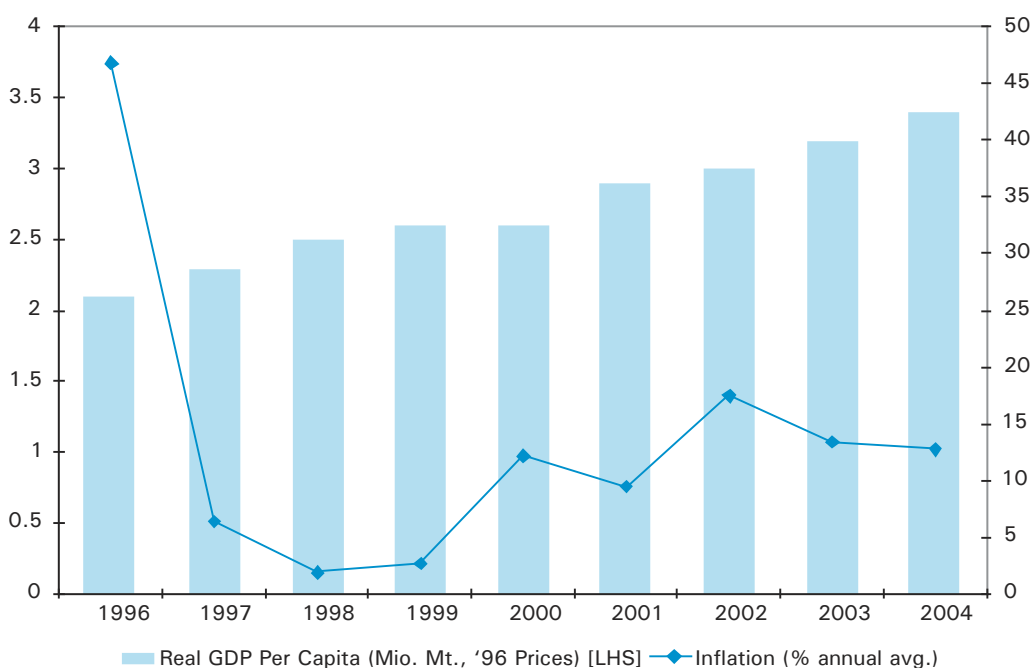
¹² Life-expectancy at birth projection significantly varies from the latest population projection data produced by INE based on the 2003 DHS, which indicates that in 2006 life expectancy at birth was 45.9 in rural areas and 51 years in urban areas, or a national average of about 47.4 years. The implementation of the population census in 2007 will clarify these differences and help better understand the demographic impact of AIDS.

3. Economic growth and macroeconomic stability

Sustainable progress in poverty reduction for present and future generations of Mozambican children requires real economic growth to be greater than population growth and to be accompanied by macroeconomic stability. In this regard, Mozambique has been successful in recent years, with real GDP growth averaging 8.5 per cent per year between 1996 and 2004. Per capita growth has also been strong, averaging 6.2 per cent over the same period. This growth has been supported in particular by robust recovery of the agricultural sector, which accounted for 23.6 per cent of real GDP growth between 1991 and 2004, suggesting a relatively broad-based economic recovery with benefits for poor rural families.

Despite the economy's vulnerability to natural disasters, with repeated drought and severe flooding in 2000, economic growth has been accompanied by the development of a reasonably stable and predictable macroeconomic environment. Exchange rate and reserve management have been strong, while participation in the Highly Indebted Poor Countries (HIPC) initiative has meant that debt levels have become more sustainable. Although inflation rates have been moderately high for the past several years, due in part to drought and high food prices, they have not been high enough to be a drag on growth (Radelet, 2004) (see Figure 2.4).¹³

Figure 2.4: Real GDP per capita and inflation, 1996 - 2004



Source: INE, 2004

4. Fiscal trends and resource allocation

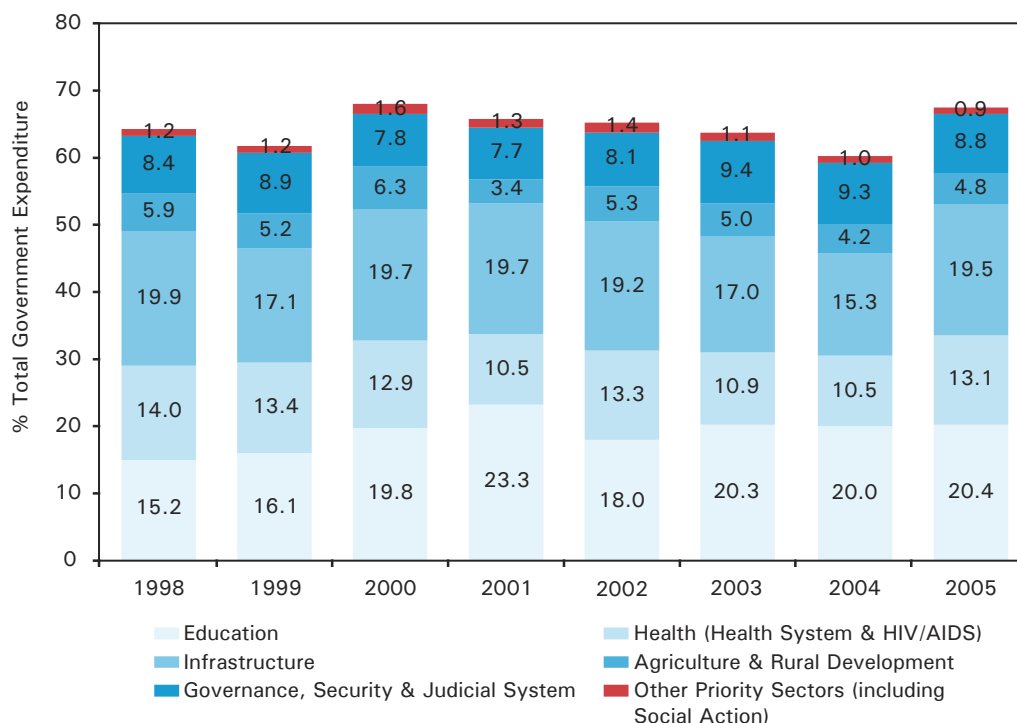
Strong macroeconomic performance is an important but not sufficient condition for sustainable poverty reduction for children. In order for real economic growth to translate into increases in living standards for poor children, growth must be distributed in an equitable way. The pursuit of pro-poor policies by the Government is vital, such as allocation of public resources to sectors that have direct benefit for children, including education, health, water, sanitation and social protection.

¹³ For a more detailed discussion of the recent macroeconomic record, and in particular growth performance, see World Bank (2005), IMF (2005) and Jones (2006).

The public budget is the Government's primary tool for allocating resources for childhood poverty reduction. Within sectors, the equitable allocation of resources across provinces and programmes is also fundamental for reducing prevailing disparities. According to official figures contained in the Government accounts (CGE), total expenditure averaged around 27 per cent of GDP over the period 2000 to 2005 and was financed by domestic revenues and aid inflows in approximately equal proportions. The Government is thus heavily reliant on aid flows.

A key expenditure target established by the Government in its first Poverty Reduction Strategy (PARPA I, 2001-2005) was that 65 per cent or more of total expenditure (whether financed by own revenues or aid) should be spent on six "priority sectors", namely education, health, infrastructure (including water), agriculture and rural development, governance and "other" key areas (social action, work and employment and energy and mineral resources).

Figure 2.5: Expenditure in PARPA I priority areas (by Functional Classification)



Note: Expenditures are grouped by their functional classification. Thus, these figures differ from the sectoral expenditures presented in subsequent chapters (which follow the institutional classification).

Sources: Adapted from CGE by MPD/MF

Until 2004, budget execution in these priority sectors was typically a little below PARPA I targets (see Figure 2.5). However, these figures should be regarded only as broadly indicative of overall expenditures, as a large proportion of external funding is "off-budget" and therefore not captured in the Government accounts. This is particularly pronounced in the priority sectors of health and education, where donor support has been concentrated. As Hodges and Tibana (2005, p. 31) concede in a critical review of Government performance: "If the off-budget expenditure was included in the data, it is likely that they would show the official PARPA targets being met or exceeded". The increased amount of aid on-budget in the year 2005 indeed illustrated that the target was surpassed, with 67 per cent of Government expenditure in 2005 made on priority sectors.

Evidence as to what extent these “priority” expenditures are actually targeted towards the poor is limited and the relationship between public expenditures and poverty reduction is notoriously difficult to demonstrate. Support for the broadly progressive nature of expenditures on health and education is provided in Heltberg et al. (2001). The authors found that, amongst services for which data were available, expenditures were broadly progressive, reducing inequality relative to the distribution of consumption. More recently, Arndt et al. (2006) trace some of the mechanisms by which public spending in general and external assistance in particular, have impacted upon the provision of public goods in the areas of health, education, infrastructure and agriculture, concluding that they have been of fundamental importance to growth and poverty reduction.

The reclassification of expenditures in measuring the 65 per cent indicator (for expenditure on priority sectors) is, however, highly subjective. First, the indicator aggregates over geographic areas and different activities.¹⁴ Second, it masks significant inequity in the allocation of public resources within priority sectors. For example, expenditure per capital in the health sector in 2005 was on average US\$ 2 in Zambezia province, where child well-being indicators are amongst the worst in the country, compared to US\$ 5 in Maputo City, where child well-being indicators are far better (see Chapter III).

While this indicator will no longer be used in PARPA II for measuring Government performance in implementing pro-poor policies, its usefulness lay in keeping the key service delivery sectors at the top of the policy and budgetary agenda and in illustrating that the Government was, at a very aggregate level, successful in broadly matching PARPA poverty reduction priorities to public expenditure through the budget. It is now critical that a more accurate and efficient method for tracking expenditures in key sectors for children in relation to PARPA II targets is developed and implemented. In this regard, the budgetary classifiers should be disaggregated so as to facilitate monitoring of sub-sectors and provincial investment for childhood poverty reduction. The Ministries of Planning and Development and Finance should also begin to strengthen Government’s understanding of the link between allocations, expenditures and outcomes by taking on the leadership of the public expenditure review function currently undertaken by the World Bank.

5. Pro-child poverty reduction?

A. National poverty trends

With half of Mozambique’s population being children, child development outcomes are clearly linked to the wealth of all Mozambicans. It is therefore important to develop an overall picture of the extent and depth of poverty. Official national poverty estimates are produced using a consumption-based measure of poverty as opposed to income, as the latter is regarded as a less reliable and more difficult to measure welfare indicator, while the former has a strong basis in economic theory (see methodology and discussion in Box 2.1).

¹⁴ For example, aggregating over activities resulted in the inclusion of items not targeted at poverty (e.g. spending in central hospitals) and the exclusion

Box 2.1: Methodological note on measuring official poverty – the consumption approach

The consumption based measure, from which the national poverty line is derived, is based on the Household Income and Expenditure Survey (IAF), which is conducted by INE every six years. It was first conducted in 1996/97, followed by a second survey in 2002/03. The latter comprised week-long interviews with a random sample of 8,700 households, including detailed questions on expenditure. It is representative both in terms of space and time, with interviews for each sub-group of the population represented spread evenly throughout the survey year so as to capture seasonality in prices and consumption. The data is then analysed by the Ministry of Planning and Development to determine the national poverty situation through the Poverty and Well-Being National Assessment (GoM, 1998 and 2004).

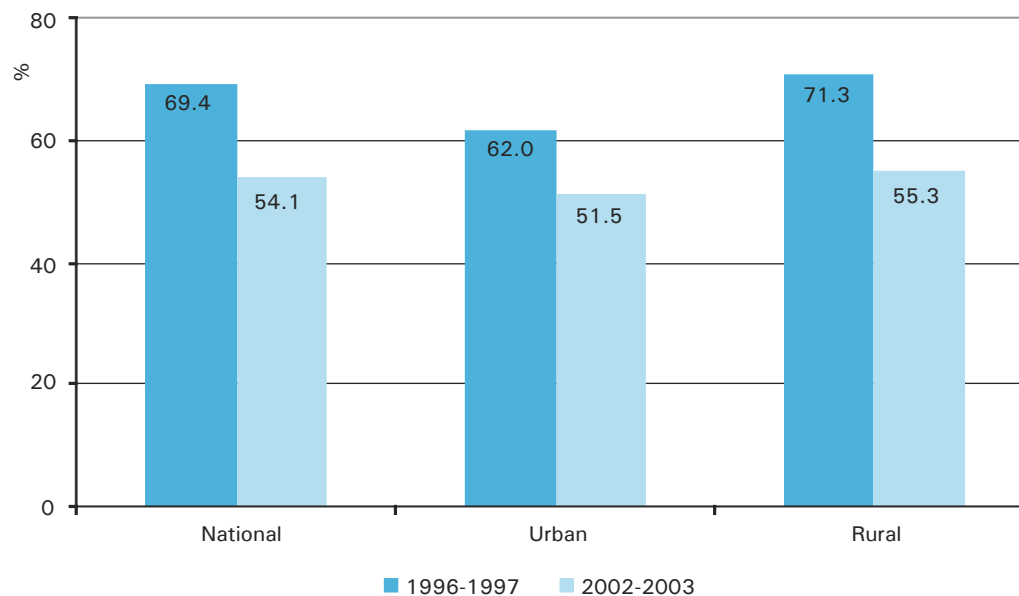
“Consumption” includes both food and non-food items and is adjusted for seasonality of the former, but omits public services and home produced services. A Cost of Basic Needs (CBN) methodology is then applied. This approach consists of the development of a basket of food items consumed by the poor that is judged sufficient for basic calorie needs (the calorie content of each basket depends upon the demographic composition of the region, averaging approximately 2,100 calorie/day). The cost of this basket makes up 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.

The consumption-based measure, however, has important limitations. It produces a measure of ability to satisfy basic needs rather than actual household consumption – to say a household can satisfy its basic needs is not to show that it actually does so. Due to data restrictions, the measure also provides a household average consumption measure and thus does not capture intra-household allocations, so that some members of a non-poor household may in fact be consumption-poor and vice-versa. Finally, in Mozambique, the final consumption measure is produced on a per capita basis, with no compensation made for differences between child and adult expenditure requirements through the use of adult-equivalence weightings (i.e. the average of 2,100 calorie/day to satisfy minimum needs applies equally to both adults and children). At first sight, this implies that the poverty situation for children may be a little better than that portrayed, as a working adult for example requires a higher amount of calories/day, and hence greater expenditure, than a non-working child. However, since children require a higher intake of micronutrients than adults, maintaining the adult calorific requirement may be a reasonable proxy for measuring a child poverty line using the consumption-based measure. In addition, the proportion of children who work is high. As the Second National Assessment observes, “these issues highlight the need for a variety of poverty indicators taken from a variety of perspectives.”

The indicator measuring the percentage of people living below the poverty line is known as the “poverty headcount”. The headcount measure does not convey information regarding improvements in the well-being of those below the poverty line. In order to measure the depth of poverty – how poor the poor are – the “poverty gap index” is used. This indicator is an average percentage distance that examines how far the average poor household is from escaping poverty or rising above the poverty line. In order to measure inequality amongst the poor, the indicator known as the “squared poverty gap index” is also used. This indicator averages the square of the poverty gaps, thereby giving weight to gains made by the poorest of the poor.

The percentage of the population living below the poverty line (“poverty headcount”) reduced by 22 per cent between 1996/97 and 2002/03, falling from 69.4 per cent to 54.1 per cent, exceeding the PARPA I target of 60 per cent by the year 2005. While poverty remains higher in rural areas (55.3 per cent) than urban areas (51.5 per cent), it fell more rapidly in rural areas (decrease of 22.4 per cent) than urban areas (decrease of 19.9 per cent). Poverty also fell in all but three provinces (Maputo City, Maputo Province and Cabo Delgado). The most important reduction occurred in Sofala province, where the incidence of poverty reduced by 59 per cent.

Figure 2.6: Percentage of population living below the poverty line



Source: GoM 1998 and 2004

The poverty gap and squared poverty gap data closely follow the trends in the poverty headcount, showing that, in addition to important reductions in the commonly used poverty headcount between 1996/97 and 2002/03, those who remain poor became better off on average, and inequality amongst the poor was lessened. The overall picture emerging from these data is therefore one of increasing consumption and incomes and falling poverty for a majority of Mozambicans.

Other surveys lend strong support to this finding, producing data consistent with the trend identified. Most recently, estimations based on the IFTRAB 2004/2005 data suggest that the national poverty headcount figure has fallen further, to 50 per cent (see Table 2.2).

Table 2.2: Poverty headcount

	IAF 1996/97	QUIBB 2000/01	IAF 2002/03	IFTRAB QUIBB 2004/05
Predicted Headcount (per cent)	65.5	60.7	55	50
Observed Headcount (per cent)	69.4	n/a	54.1	n/a

Sources: GoM et al. 1998 & 2004; Simler et al. 2004; Mathiassen & Øvansen 2006

Box 2.2: More frequent and cost-effective poverty measurement - the "CWIQ"

Measurement of national poverty rates using large and detailed household surveys such as the IAF is prohibitively expensive and time consuming – hence the six year cycle for the IAF. However, monitoring PARPA implementation and progress towards the MDGs requires more frequent observations. Simler et al. (2004) show that "light" surveys such as the Core Welfare Indicator Questionnaire (CWIQ, known as QUIBB in Portuguese), which collects data on a number of variables that are correlated with poverty but is much less onerous to collect and process than income or expenditure data, can be used to produce relatively accurate predicted national poverty levels. Through the 2000/01 CWIQ, the predicted national poverty headcount stood at 61 per cent. Much more recently, Mathiassen and Øvensesen (2006) applied the same methodology to the 2004/2005 IFTRAB data (which include a CWIQ module), producing a predicted headcount of about 50 per cent, with predicted falls in urban and rural poverty of 5 percentage points and 4 percentage points respectively compared to 2002/03 levels (see Table 2.2).

While poverty reduction trends are encouraging, important geographical disparities and high levels of vulnerability remain, principally as a result of the sheer depth of poverty from which the country is emerging.

Although the northern and central regions of the country enjoyed significant reductions in poverty between 1996/97 and 2002/03, the southern region saw a slight increase in poverty levels, resulting in the highest overall poverty headcount of the three regions in 2002/03. This observed decline in average consumption in the southern region was probably the combined result of drought in the year before the second 2002/3 survey, the devastating floods of 2000 and the substantial depreciation of the Metical in relation to the South African Rand during the period of the survey.

This goes to illustrate a key point, rightly emphasised in the PARPA II poverty analysis. Despite a strong overall positive trend in poverty reduction, the poor and many of those judged to be just above the poverty line remain highly vulnerable to adverse shocks and as a result, there are likely to be large regional fluctuations in quantitative indicators of poverty from year to year. Sofala province in the central region has been subject to particularly dramatic fluctuations, experiencing severe flooding in advance of the 1996/97 IAF survey, which, together with a spike in food prices at the time of the survey, contributed to its very high observed rates of poverty, which fell dramatically in the second 2002/2003 IAF survey (GoM et al., 2004). As a result, the Sofala poverty headcount leapt from last place in 1996/97 (87.9 per cent) to first place in 2002/03 (36.1 per cent). It is therefore not surprising that, when households in Sofala were later questioned in a qualitative survey, their subjective assessments of their own well-being did not fully endorse the quantitative evidence of progress provided in the household surveys (Mate et al., 2005). What initially seems an impressive reduction in poverty can also be interpreted as a recovery from a large adverse shock.¹⁵

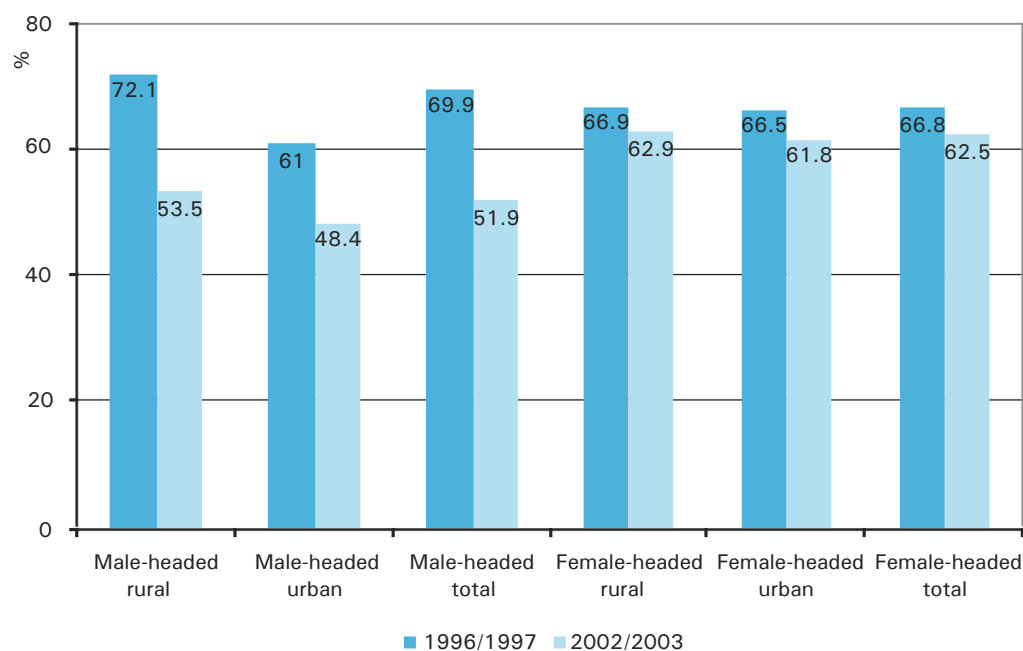
This finding also raised a debate about the correlation between poverty and HIV/AIDS, as Sofala province is by far the most affected by the AIDS pandemic. It should also be noted that the statistical confidence levels associated with the national and regional poverty estimates are tighter than those for the provincial estimates, meaning that there is a greater certainty about the national poverty levels and trends than about provincial ones (Simler and Arndt, 2005).

¹⁵ This vulnerability has led some authors to advocate the inclusion of a measure of the threat of poverty in order to capture this ex-ante risk to households – see for example Calvo and Dercon (2005).

Arndt et al. (2005) show that, on average, there are seasonal variations in household calorie consumption over the course of the agricultural season, and that these are particularly marked in the central region. While the authors find that most households are able to use food stocks, savings or asset sales to maintain consistent consumption, they find that the ability to do so depends upon household income. The poor find it harder to maintain a steady calorific intake over the year.

Another important indicator showing that the overall poverty reduction did not equally benefit all segments of the population is that poverty reduced much more significantly among male-headed households than female households. Female headed households represent about 30 per cent of all households in Mozambique (IFTRAB 2004/2005). While poverty 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 only reduced by 6 per cent in female headed households (from about 67 per cent to 63 per cent between 1996/97 to 2002/03). This is particularly worrying, as orphaned children are largely found in female headed households. The 2004/2005 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.

Figure 2.7: Percentage of household living below the poverty line according to male-headed and female-headed households



Source: GoM et al. (1998) and Chiconela (2004)

Higher poverty among female headed households is the result of their lower levels of education, lack of earning power due to widowhood and associated higher dependency ratios (Bardasi, Fox & Van den Broeck, 2005). It may also be related to the fact that female headed households are disproportionately taking on the burden of caring for orphaned children. These results are supported by Walker et al. (2004) who find that, in rural areas, widow-headed households (45 per cent of all female-headed households) are particularly disadvantaged, with 30 per cent less income than male-headed households.

Of women of active age (aged 15 – 59), overall levels of participation in the workforce (82 per cent) are higher than men’s (78.8 per cent), despite the additional burden of domestic work faced by women. Women’s participation in the labour force is concentrated in subsistence agriculture in rural areas, where women make up 62.1

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 15.1 per cent of men in the workforce having attained upper primary education or better compared with only 4.5 per cent of participating women (GoM, 2006).

Disparities between households nationwide have been examined by James et al. (2005), who measure changes in inequality between the two IAF surveys. The authors note that while all sections of society enjoyed a rapid annual increase in consumption between the sample periods with real per capita growth averaging over 3 per cent annually, the rate of growth in consumption was slightly higher for richer households. This has led to a moderate, though not statistically significant, increase in inequality at the national level while inequality in real consumption between provinces and regions has diminished over time. Ibraimo (2005) supports this result, finding that the coefficient of regional variation for a wide range of socioeconomic indicators has fallen. Simler and Nhate (2005) find that of the total inequality in Mozambique, between 83 per cent and 86 per cent occurs within districts rather than between districts: i.e. poor households typically live alongside non-poor ones, showing that poverty and inequality in Mozambique are widely distributed phenomena and calling into question the feasibility of geographic targeting of anti-poverty efforts at “poor areas.”

Intra-household inequality, though not easily assessed, is also of particular concern in relation to children. A recent study by Nhate et al. (2005) examines potential discrimination in resource allocation within households against children who are not biological descendants of the household head.¹⁶ The rationale behind the study is that the AIDS pandemic is significantly increasing the number of orphaned children and that many will reside in families where the household head is not their biological parent. Government policy is based on the extended family being the first preference in care for orphans and institutionalisation of children being a last resort (GoM, 2004a). The authors’ results point to discrimination within poor households in the intra-household allocation of resources against children who are not the direct biological descendants of the household head. This discrimination is identified at the national, rural, and urban levels. AIDS is likely to aggravate the problem over the next decade by substantially increasing the number of children requiring care from neighbours, friends, and relatives due to the death of one or more of their parents. The authors conclude that assistance should be targeted towards children who are not the biological descendants of the household head, particularly those who are only attending school irregularly, if at all.

Two broad conclusions follow. Firstly, the precarious status of many households implies that the overall objective of poverty reduction should include direct efforts to protect poor households from shocks, particularly female headed households, allowing them to maintain an adequate and relatively stable standard of living (e.g. targeted cash transfers). However, the broad distribution of childhood poverty and inequality and the very low population density in rural areas mean that policies targeting the poorest and most vulnerable children need to be designed very carefully. Secondly, measurement of poverty should not rely on any single indicator or observation; a more pluralistic approach is required, not least because a large adverse regional shock to one of the two most populous provinces – Nampula and Zambezia – in advance of the next household survey could have a big impact on the decline in the national poverty trend.

¹⁶ While it is not normally possible to distinguish between household members using IAF data, the authors manage to do so by examining changes in expenditure on adult-goods following the addition of an extra child to the household – the “outlay equivalence” method (Deaton et al., 1989).

B. Assessing childhood poverty

In addressing childhood poverty, it is vital to analyse whether the above picture in relation to overall poverty in Mozambique reflects the picture for childhood poverty. This is done in two ways. Firstly, estimates of childhood poverty are presented drawn from the IAF using the official consumption-based measure. Secondly, childhood poverty is assessed using the Bristol Indicators, adapted for Mozambique.

(i) Consumption-based measurement

Child poverty headcount estimates were prepared based on the two household surveys. As noted above, the IAF does not measure the allocation of resources within the household directly and therefore measures apply only to an “average” household member. Thus, every child that lives in a household categorised as non-poor is considered to be non-poor.

In line with national trends, the consumption-measure indicates that the level of child poverty decreased significantly between 1996/1997 and 2002/2003. It also indicates, however, that the level of poverty among children remains significantly higher than among adults, with 58 per cent of children living in poverty compared to 49 per cent among adults in 2002/2003. Further, the gap between children and adults did not close between 1996/1997 and 2002/2003, with both groups witnessing a decrease of 22 per cent in poverty level. The decrease in poverty levels was more pronounced in rural areas (decrease by 24 per cent) than in urban areas (decrease by 16 per cent).

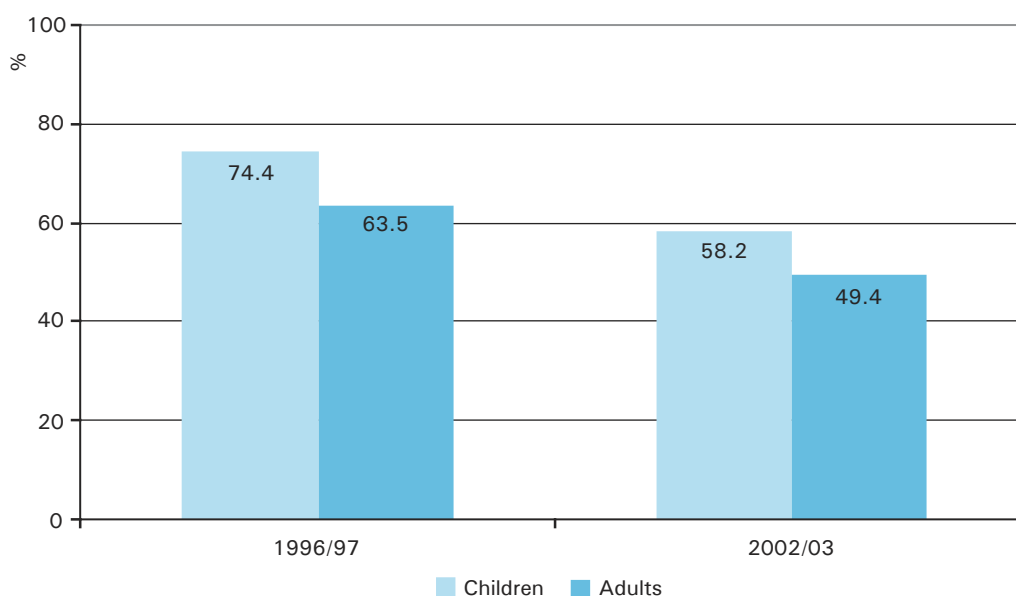
Considerable disparities exist between provinces, with the percentage of children living in poverty increasing over the period 1996/1997 to 2002/2003 in Cabo Delgado province, Maputo province and Maputo City. In these three provinces, poverty among children increased more than among adults. In Maputo province, the gap between children and adults is notable, with the percentage of children living in poverty increasing by 9 per cent compared with only 2 per cent among adults.

Table 2.3: Total, adult and child poverty headcounts, 1996/1997 – 2002/2003

	1996-1997			2002-2003			Decrease in percentage		
	All	Adult	Children	All	Adult	Children	All	Adult	Children
Niassa	70.6	65.5	75.0	52.1	47.5	55.6	-26.2	-27.5	-25.9
Cabo Delgado	57.4	50.3	65.4	63.2	54.1	72.8	10.1	7.6	11.3
Nampula	68.9	62.0	75.0	52.6	47.4	57.2	-23.7	-23.5	-23.7
Zambezia	68.1	60.4	75.0	44.6	39.2	48.8	-34.5	-35.1	-34.9
Tete	82.3	77.2	85.7	59.8	55.9	62.8	-27.3	-27.6	-26.7
Manica	62.6	56.8	66.4	43.6	40.0	46.5	-30.4	-29.6	-30.0
Sofala	87.9	85.2	90.2	36.1	32.6	39.2	-58.9	-61.7	-56.5
Inhambane	82.6	78.5	85.6	80.7	76.9	84.3	-2.3	-2.0	-1.5
Gaza	64.6	62.1	66.4	60.1	55.7	64.0	-7.0	-10.3	-3.6
Map. Province	65.6	64.1	67.3	69.3	65.3	73.6	5.6	1.9	9.4
Map. City	47.8	42.9	51.9	53.6	48.5	59.9	12.1	13.1	15.4
Urban	62.0	57.0	65.7	51.5	47.4	55.5	-16.9	-16.8	-15.5
Rural	71.3	65.1	77.6	55.3	50.5	59.4	-22.4	-22.4	-23.5
National	69.4	63.5	74.4	54.1	49.4	58.2	-22.0	-22.2	-21.8

Source: IAF 1996/97, 2002/03.

Figure 2.8: Children and adults living below the poverty line



Source: IAF, 1996/97 and 2002/03

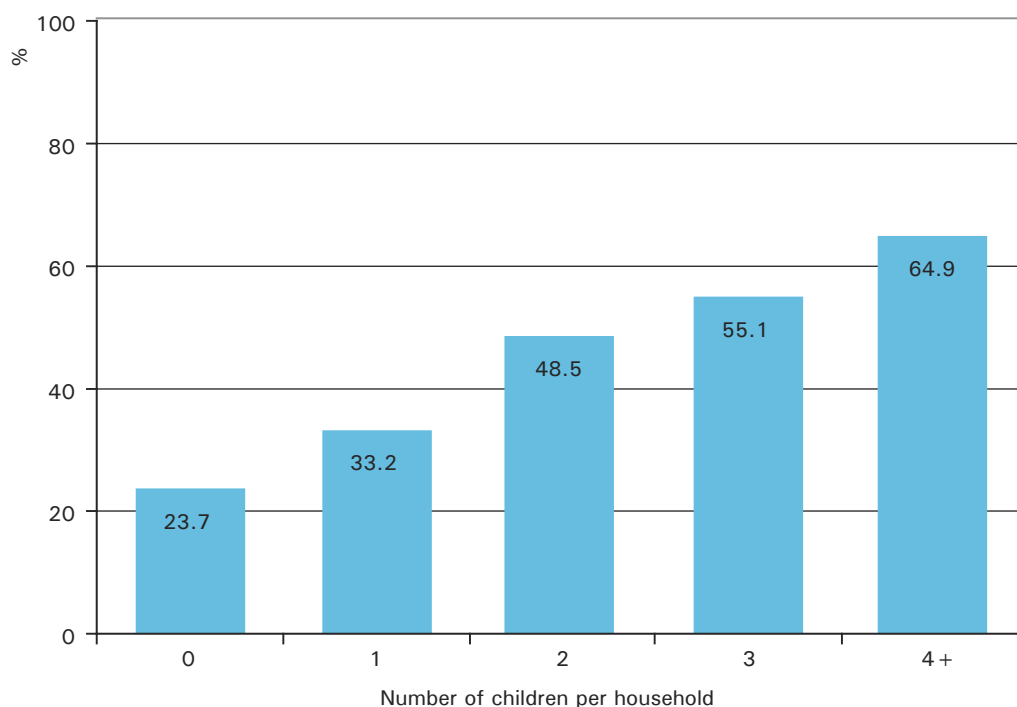
There is a strong negative relationship between the number of children in a household and per capita consumption within the household (see Table 2.4). This is because the greater the number of children in a household, the higher the dependency ratio and the lower the average consumption levels possible for a given household budget. Wealthier households also tend to have fewer children.

Table 2.4: Poverty headcount disaggregated by household size, 1996/1997 – 2002/2003

Number of Children in Household	Poverty Headcount (%)		
	1996/97	2002/03	Difference
0	27.3	23.7	-13.2
1	46.5	33.2	-28.6
2	61.0	48.5	-20.5
3	75.9	55.1	-27.4
4+	81.9	64.9	-20.8

Source: IAF, 1996/97 and 2002/03

Figure 2.9: Households living below the poverty line by number of children in the household



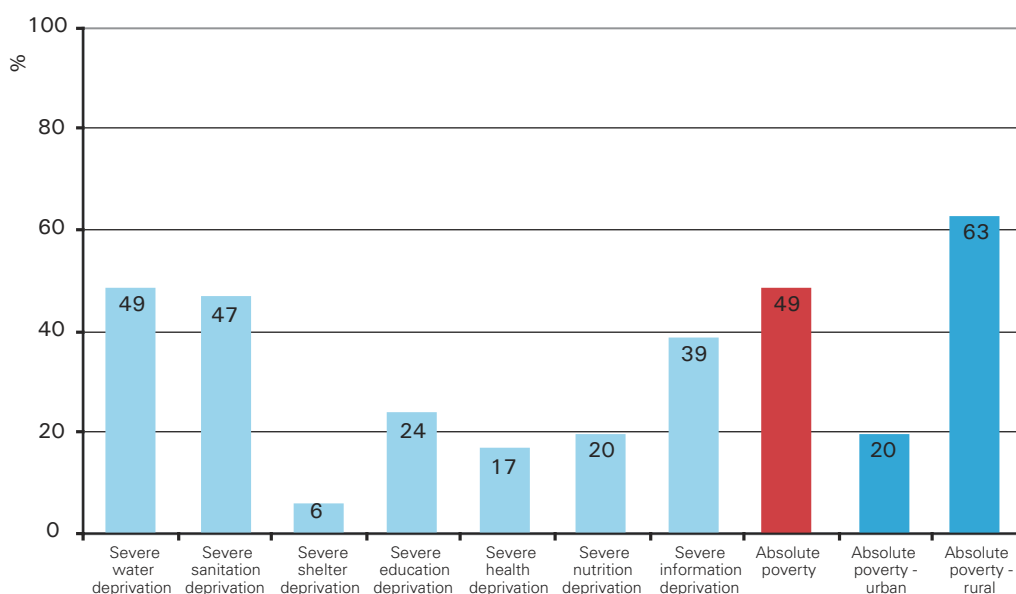
Source: IAF, 1996/97 and 2002/03

(ii) Deprivations-based measurement

Under the standard definition of absolute poverty, children are defined as living in absolute poverty if they face two or more severe deprivations (see Chapter I for definition of indicators and types of deprivation). By this measure, the proportion of Mozambican children living in absolute poverty in 2003 was 49 per cent, with significant disparities between urban (20 per cent) and rural (63 per cent) areas, and between children from the poorest households (i.e. the first wealth index quintile) with 90 per cent absolute poverty, contrasted with 4 per cent among the best-off quintile (fifth wealth index quintile).

Breaking the deprivations measure down by province reveals that the proportion of children living in absolute poverty is highest in Zambezia (75 per cent), followed by Sofala (59 per cent), and Nampula and Tete (55 per cent) (see Figure 2.11). Maputo City emerges as having by far the lowest levels of poverty based on this measure. These results contrast strikingly with those produced by the consumption-based measure. In particular, Maputo City only recorded 3 per cent childhood poverty on the deprivations-based measure, as opposed to 60 per cent under the consumption-based approach. Maputo Province showed a similarly vast gulf between the two estimates. This is explained by the fact that the consumption-based approach does not directly capture the consumption of public services such as health, education, water and sanitation, which are likely to be particularly concentrated in urban areas and in particular around the seat of national Government.

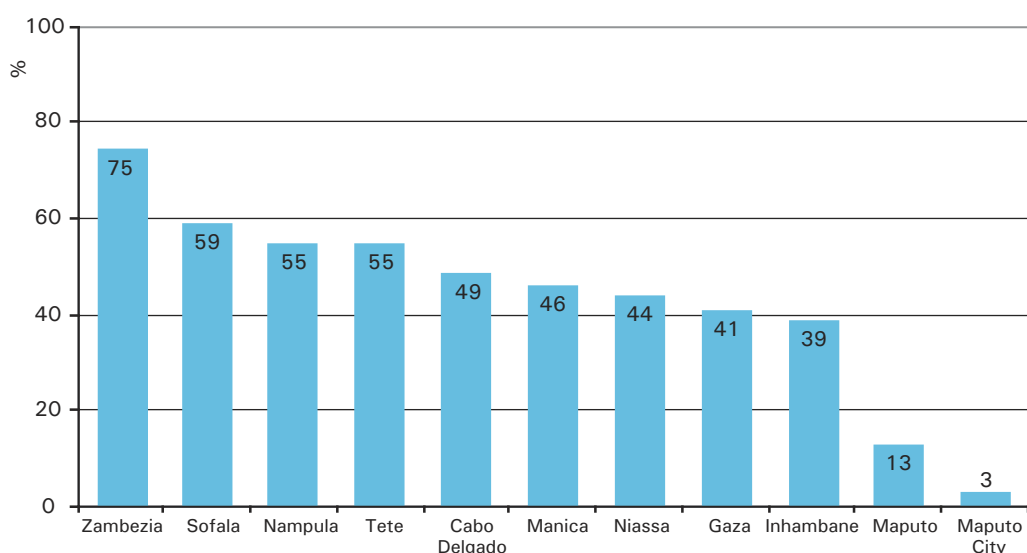
Figure 2.10: Severe deprivation and absolute poverty among children - 2003



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

The deprivations-based measure also indicates that there is no difference between levels of deprivation for girls and boys. However, analysis of specific severe deprivations indicates that girls are more severely deprived than boys in terms of education (see Chapter IV). There is also a correlation between the level of education of the head of the household and the incidence of poverty among children. For example, in households where the head has no education, 68 per cent of children live in absolute poverty compared with 11 per cent in households where the head has secondary or higher education.

Figure 2.11: Absolute poverty among children by province



Source: INE/MPD/UNICEF 2005, additional analysis of the 2003 DHS

Recalculating the absolute measure by three, rather than two deprivations shows that 21 per cent of children at national level (7 per cent in urban areas and 28 per cent in rural areas) are living with three or more deprivations. By this measure, children in Zambezia province are also the most affected, with 39 per cent facing three or more

severe deprivation. In the poorest households (i.e. those in the lowest quintile of the DHS wealth index), more than half of children are facing three or more deprivations (52 per cent) compared to almost none in the best of households. 5 per cent of children are facing four or more types of severe deprivation. Once again, Zambezia is the province worst affected with one in every ten children facing four or more types of severe deprivation (See Table 2.5).

Table 2.5: Children with two, three and four severe deprivations

	Percentage of children living with two or more severe deprivations (absolute poverty)	Percentage of children living with three or more severe deprivations	Percentage of children living with four or more severe deprivations
Province			
Niassa	44	17	3
Cabo Delgado	49	17	2
Nampula	55	24	5
Zambézia	75	39	10
Tete	55	24	6
Manica	46	19	3
Sofala	59	25	5
Inhambane	39	16	3
Gaza	41	14	2
Maputo	13	3	0
Maputo City	3	0	0
Area of Residence			
Urban	20	7	1
Rural	63	28	6
Sex			
Male	49	21	4
Female	49	22	5
Level of education of the household head			
No education	68	33	8
Primary education	45	18	3
Secondary and higher	11	3	0
Wealth index quintile			
Poorest	90	52	13
Second poorest	79	35	7
Middle	44	12	2
Second best-off	25	5	0
Best-off	4	0	0
Total	49	21	5

Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

6. Institutional context

Ensuring improvements in poor children's lives requires crucial capacities in Government to develop policy and planning instruments and processes, ensure appropriate resource allocation, take forward or facilitate implementation and review achievements or gaps in performance.

This section documents the instruments, processes and institutional responsibilities within government for policy and planning, resource allocation, implementation and monitoring and review. It examines the degree to which the Government has been able to link policy and planning with resource allocation, then analyses the links from policy, planning and resource allocation to implementation. This is followed by an examination of government capacity to review its performance. At each stage, the implications for children are highlighted.

The section also addresses questions related to the way in which external aid is provided to Mozambique, describing the significant shift to programme aid, in particular general budget support, that has taken place since 2003. The challenge of achieving long term reform of aid modalities whilst ensuring short term support to the population, especially children, is discussed.

A. Policy and planning mechanisms

The principal Government planning document is the Government Five-Year Plan, which under the Constitution must be produced by each new Government upon entering office.¹⁷ It establishes the Government's priorities and operational agenda until the next General Election. In 2000 and 2005, the Government also produced Mozambique's first and second Poverty Reduction Strategy Papers (PARPA I and PARPA II). The PARPA is an operationalisation of the Government Five-Year Plan, focusing only on key sectors for economic growth and poverty reduction and going into far greater depth with regard to resource allocation and the setting of time bound targets for monitoring and evaluation of performance. On an annual basis, the Government produces an Economic and Social Plan ("PES") outlining priorities for the following year and the Review of the PES, which reviews PES implementation in the previous year. The PES is conceived as the annual embodiment of the Government Five-Year Plan and the PARPA, as well as linking to sectoral plans (see the full planning and budgeting cycle in Annex II).

The Five-Year Plan forms the centrepiece of the medium-term planning structure. However, since the programme is submitted to Parliament for debate in its first session after the elections, the longer PARPA elaboration process allows broader and deeper consultation, clearer prioritisation, projection of a resource envelope, and time-bound targets with associated indicators for monitoring. Thus, while it was initially taken on as a form of conditionality, the PARPA has strengthened the Government's medium-term planning and budgeting for poverty reduction and economic growth.

(i) The PARPA

As the key instrument for the operationalisation of the Five-Year Plan, the PARPA deserves particular attention. The Government produced its first PARPA document for the period 2001 – 2005 in order to qualify for debt relief under the Highly Indebted Poor Countries (HIPC) initiative. The first PARPA was perceived to be a strongly donor driven document, which emphasised macroeconomic stability, rehabilitation of infrastructure and development of human capital, and prioritised, as discussed, expenditures in the six "priority" areas of education, health, infrastructure, agriculture and rural development, governance and "other" activities (including social action).¹⁸

¹⁷ Article 198 of the Constitution mandates that parliament should discuss the Plan (the "Programa Quinquenal do Governo" in Portuguese) at the initiation of the legislature (Government of Mozambique, 2004).

¹⁸ For a children's rights focused review of PARPA I see Robinson, 2003 (pp. 48 - 65).

The second PARPA for the period 2006 to 2009 was developed in 2005 and approved by the Council of Ministers in May 2006. The elaboration process for PARPA II was considerably more broad-based and consultative than for PARPA I. It was developed within the overall structure of the national vision document “Agenda 2025” (Conselheiros, 2003) comprising four pillars: Macro Economy and Poverty, Governance, Economic Development and Human Capital. “Cross-cutting” issues such as gender, HIV/AIDS, environment, food and nutritional security and disasters were mainstreamed throughout the document. PARPA II is considerably more child-friendly than PARPA I, setting out time-bound and quantifiable targets for the further realisation of child rights, many of which contribute directly towards attaining the MDGs (see Table 2.6).

However, while PARPA II reaffirms its commitment to the provision of social services, it explicitly prioritises 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.¹⁹ This is borne out of recognition that one cannot assume that the high growth rates enjoyed in recent years – an important condition for poverty reduction – will continue indefinitely, particularly given the evidence that returns to investment in the social sectors may be diminishing (Arndt et al., 2006). In the short-term, this strategy may mean increasing budget allocations to “pro-growth” activities that do not explicitly target the poorest sections of the population – for example targeting those on the boundary between the formal and the informal sector or commercial agriculture – and this may well result in reductions in the proportions of “internal” funds (comprising revenues and GBS) allocated to some of the traditional PARPA “priority areas” (Ernst and Young, 2006). This highlights the need for a challenging and thorough debate amongst stakeholders regarding Mozambique’s long-term developmental priorities, and how to channel scarce resources so as to deliver lasting benefits for children.

¹⁹ Bolnick (2001) sets out an agenda for a Government growth strategy along these lines. The MPD currently plans to develop a “Growth Strategy” in order to better coordinate Government’s efforts to sustain economic growth.

Table 2.6: Relationship of selected PARPA II targets for children with the CRC and the MDGs

PARPA II	CRC	MDG
<p>Child Survival specific targets</p> <ul style="list-style-type: none"> - Reduce the under-five mortality rate to 140 per 1,000 live births - Reduce underweight prevalence to 17 per cent - Reduce the maternal mortality ratio to 340 per 100,000 live births - 22 per cent of HIV positive mothers receive prophylaxis to prevent vertical transmission - 30 per cent of HIV positive children who are eligible for anti-retroviral therapy are receiving it - Increase the coverage of water (60 per cent urban and 55 per cent rural) and sanitation (55 per cent urban and 40 per cent rural) 	<p>Article 24 (1): ... States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health ...</p> <p>Article 24 (1) (c): To combat disease and malnutrition ... through the provision of adequate nutritious foods and clean drinking-water ...</p>	<p>Goal 1: Eradicate extreme poverty and hunger</p> <p>Goal 4: Reduce child mortality</p> <p>Goal 5: Improve maternal health</p> <p>Goal 6: Combat HIV/AIDS, malaria and other diseases</p> <p>Goal 7: Ensure environmental sustainability</p>
<p>Education specific targets</p> <ul style="list-style-type: none"> - Increase primary school completion rate to 59 per cent (55 per cent for girls) 	<p>Article 28 (1): ... States Parties recognize the right of the child to education ...</p>	<p>Goal 2: Achieve universal primary education</p> <p>Goal 3: Promote gender equality and empower women</p>
<p>Protection specific targets</p> <ul style="list-style-type: none"> - Improve the legal and institutional framework for the protection of children - Develop and consolidate social safety nets for the most disadvantaged citizens, including orphaned children - Ensure that the ratio of school attendance among maternal orphans is the same as non-orphaned children - Ensure that the ratio of malnutrition among orphaned children is the same as non-orphaned children 	<p>Preamble: ... The child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth ...</p> <p>Article 3 (2): ... States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures ...</p>	<p>Millennium Declaration VI</p> <p>Goal 6: Combat HIV/AIDS, malaria and other diseases</p>
<p>Participation specific targets</p> <ul style="list-style-type: none"> - Promote the strengthening of the youth association movement as a strategy for organising and increasing participation by young people in society 	<p>Article 12 (1): ... States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child ...</p>	<p>Goal 8: Develop a global partnership for development</p>

Box 2.3: Civil society engagement in the PARPA: the Poverty Observatory and the RAP

The Poverty Observatory (known in Portuguese as Observatorio da Pobreza, or 'OP') is a consultative and participatory forum for monitoring PARPA implementation, considering Government and civil society evaluations and producing recommendations for improvement. First held in 2003, the OP is coordinated by Government (lead by a Technical Secretariat in MPD) and brings together high-level delegations of Government, civil society and donors, comprising around 20 delegates each. In 2005, the national OP met twice to discuss and contribute to the PARPA II elaboration process, and Provincial Poverty Observatories were also held in all but one of the provinces to provide genuinely national consultation for PARPA II. Young people and children also participated in four of the provincial Poverty Observatories. A fifth national PO was held in June 2006 in order to launch the PARPA II following its approval by the Council of Ministers in May 2006.

Civil Society involvement in the PO process has been coordinated through the "G20" group of NGOs which was formed in 2003 in order to organise more effectively the civil society input into the second national Poverty Observatory. The group – now comprising over 20 organisations – represents religious groups, trade unions, private and financial sector groups and other NGOs, including those concerned with gender, HIV/AIDS and the environment.

In preparation for the second national OP in 2004, the G20 resolved to produce an annual participatory review of progress in poverty reduction, the Annual Poverty Report (known in Portuguese as Relatório Anual da Pobreza, or 'RAP'), to serve as the core civil society input into the OP process. The first RAP, produced in 2004, involved the participation of some 10,000 people and around 100 organisations in an opinion survey whose relevance, "rests with the fact that it incorporated the voice of the common people, integrated into a participatory dynamic at provincial level. Therefore, it is not meant to be seen as a confrontation with official figures, but rather as a contribution that is rooted in the opinions of thousands of people" (G20, 2004).

A second RAP was produced in May 2006, with, among its objectives, "to check on the evolution of increased participation by citizens/civil society in decision making processes" and evaluate the progress made by the Government in implementing the seven recommendations emanating from the 2004 RAP. The 2005 RAP also highlights concerns about the proliferation of national plans with similar objectives (i.e. poverty reduction) but with limited linkages between them, such as the Five-year Plan and PARPA. It notes that the "time and material waste in human and financial resources [for producing these plans] is enormous" and calls for the development of a single and unified medium term National Development Plan.

The 2004 and 2005 RAP place a strong emphasis on child-related issues, including the implementation of special programmes for children who do not have access to schools, the promotion of girls' involvement in the education system, the provision of legal support to young people who are detained and the need for concrete actions to prevent violence against children.

The national RAP is also complemented by provincial versions, developed by autonomous provincial bodies of the G20, which play a similar role to the provincial Poverty Observatories (OP). The provincial RAP 2004 for the province of Maputo presents an interesting case study, with a clear aim of assessing the performance of the provincial government against commitments made at the initial provincial OP and increasing demand for accountability, as shown in the table below:

Government OP Commitment

- National OP committed to hold a technical workshop with a view to developing a new definition of poverty
- Inform civil society regarding the development of regulations for the Law on Local State Organs and encourage participation
- Promote increased involvement of civil society in M&E of public policy performance at provincial level

RAP Observation

- Subsequent meetings between the Government and G20 took place at national level, though there was no dialogue at provincial level
 - Community leaders and authorities had not been informed about this process
 - As yet civil society was not contacted. There is no mechanism for disseminating information about the monitoring of public policy in the province
-

Source: G20 Maputo Province, 2005

Overall, the OPs and the associated RAPs have made a particularly positive step towards promoting civil society participation in and scrutiny of Government policy and performance, thereby strengthening the “accountability balance” towards domestic actors and putting children’s issues on the agenda. However, they have also highlighted the need to build analytical capacity amongst the diverse array of civil society groups in order that they better translate their concerns into viable contributions in the OP dialogue (GoM and PAP, 2006).

(ii) Mechanisms for resource allocation

The budget cycle in any given year can be divided into three broad phases: (i) appropriation for the coming year; (ii) execution of funds in the present year and; (iii) reporting, auditing and evaluation for the previous year (and often for earlier years as well) and for the first half of the present year. Appropriation includes the formulation and approval of the State Budget (known in Portuguese as the Orçamento do Estado, or ‘OE’), which is produced on an annual basis, and the nascent Medium-Term Fiscal Framework (known in Portuguese as Cenário Fiscal de Médio Prazo, or ‘CFMP’), which projects the overall resource envelope for the next three years.

At sectoral level, the planning and budgeting process entails participation in the production of the national level plans and budgets as well as specific sector instruments. The latter are particularly important in sectors receiving large amounts of aid and in which donors have adopted a joint Sector Wide Approach (SWAp) with pooling of much of their support in Common or Basket Funds (education, health, agriculture, roads, water and HIV/AIDS). The planning and budgeting process for year $n + 1$ in these sectors is typically conducted later in the year using different methodologies when compared to the national documents that go before the Council of Ministers and Parliament (see the full planning and budgeting cycle in Annex II).

(iii) Analysis of linkages between policy, planning, budgeting and implementation

The figure in Annex III can be thought of as the Government’s ideal single central process for planning and budgeting. While children’s rights are well featured in PARPA II, it should be noted that the linkages between priority actions and the budget envelope foreseen remain weak. For example, the budget envelope for the Ministry of Women and Social Action (responsible for co-ordinating the national response to the orphan crisis created by the HIV/AIDS pandemic) is not expected to increase significantly over the period 2006 to 2009, remaining at below one per cent of budgeted resources in medium-term projections (GoM, 2006a).

A key cause of these weaknesses is the problem of 'double fragmentation' highlighted by de Renzio & Sulemane (2006). The term refers, firstly, to the duplication of planning and budgeting systems between the sectors and the central agencies due to the external financing available at sectoral level (through SWAps, for example), particularly in key child-related areas such as health and education. This undermines the CFMP and the State Budget as instruments for making strategic resource allocation decisions.

Officially, the Ministry of Planning and Development is charged with the coordination of other Government medium- and short-term planning documents (including the Government Five-Year Plan, the PARPA and the CFMP) and conducting overall monitoring of Government performance, with budgeting lead by the Ministry of Finance.²⁰ The sectors, however, retain very strong de facto roles in planning and budgeting. In particular, those that receive a large portion of their funding through external assistance retain a large degree of autonomy from the Government's central agencies. Until recently the majority of these funds were not recorded in the State Budget. A concerted exercise to place the majority of donor funds "on-budget" is presently underway. The shift in sectoral donor funding away from an exclusively project based approach towards SWAps and Common Funds within the key sectors (which has strengthened the role of the sectoral Planning Directorates) has also helped. Additionally, the CFMP had also been limited until recently in the sense that it was a purely technical document for internal planning within the Ministry of Finance and the Ministry of Planning and Development. Importantly however, it was submitted to and approved by the Council of Ministers for the first time in 2006.

The second aspect of 'double fragmentation' is the separation between planning and budgeting institutions (the Ministry of Planning and Development and the Ministry of Finance), which is also reflected in the division between the planning and budgeting instruments (PES and OE, BdPES and REOE). In particular, the State Budget does not relate strongly to the PES as it is formulated in an incremental, input-focused manner. Categories include what each institution can spend on salaries, goods and services, rather than specific outputs as detailed in the PES.

There is also a third level of fragmentation, between planning instruments submitted to parliament and those that comprise the 'contract' between Government and donors. Thus, in the medium-term, the PARPA (unlike the Five-Year Plan) is not submitted for Parliamentary approval. There is therefore a bifurcation of accountability, with the Five-Year Plan being accountable to the Parliament and the PARPA to donors. This is reflected on an annual basis by the division between the PES/BdPES and the donor-government review processes (see Section (v) below). This division of accountability undermines accountability of the executive to the public, and may also reduce the demand for participation (Hodges and Tibana, 2005). Thus, one could say that there exists, in fact, a system with 'treble fragmentation'. To resolve this tension, the Government has decided to merge, starting 2009, the PARPA with the Five-Year Plan, thereby avoiding the production of two distinct medium-term planning instruments that are accountable to separate institutions. This decision also meets the demand of civil society expressed in the 2005 Annual Poverty Report (see Box 2.3: "Civil Society Engagement in the PARPA: The Poverty Observatory and the RAP"). However, this bifurcation of accountability will continue with respect to the annual planning instruments.

²⁰ The two institutions used to be merged within a single Ministry but were divided during 2005 and many of the operational aspects of the division have yet to be worked through. The CFMP, for example, is a highly collaborative effort with significant input from both ministries.

Parliament's capacity to scrutinize planning and budgeting instruments is also weak. Under the 1990 Constitution, the Parliament is responsible for "deliberating on the Plan and the State Budget and the respective Execution Report" (Article 135). By law, the Government has to submit the PES and OE proposals to the Parliament by the end of September, so that they can be debated and approved during the Parliament's second session of the year, which ends in December. Although the Parliament plays the formal role in debating and approving the budget, and can therefore influence resource allocations for children, Hodges and Tibana have noted the many limitations of parliamentarians as a real check on the Executive in the budget process. The authors note: "The deputies generally have neither the academic nor professional background to analyse complex budget issues. Furthermore, Parliament's general secretariat does not have the technical personnel that would be needed to provide research services to the commissions and deputies. Apart from their own salaries and benefits, deputies are interested mainly in micro issues, such as individual projects in their constituencies, and sensitive political issues such as delays in the payment of salaries, rather than broader fiscal questions or major expenditure allocation issues" (Hodges and Tibana 2005). This capacity gap is a key constraint for ensuring that budget allocations are allocated in an equitable manner for childhood poverty reduction.

In terms of execution, funds are released on a monthly basis and then reported and replenished (an "imprest" system). Liquidity constraints and bureaucratic hold-ups often lead to delays in releasing funds. It is also worth noting that there is substantial scope for reallocation of funds, so that what is executed often bears little resemblance to what was agreed by the Parliament. Whilst allocations do target "priority sectors" that are favourable to children's needs, there are insufficient guarantees that the details of planning and resource allocation within a sector will adequately guarantee that all areas within the sector are covered. This may arise due to gaps between policies within a sector, as for example is the case for newborn infants, whose health needs were not covered in either maternal health care policy (to point of delivery) or in Integrated Management of Childhood Illnesses (IMCI), which until recently targeted children of over seven days old.

Secondly, sectors lack the capacity to carry out detailed costings of the different policies and plans. Thus, policies and plans are developed with no detailed reference to the resources needed for implementation. For example, as will be discussed in Chapter 4, until very recently the Ministry of Education and Culture's report on teacher needs requirements to meet sectoral targets lacked a sound analytical basis. Mechanisms for prioritisation between various areas within a sector are unclear and may be inconsistent. This in turn impedes allocation of sufficient resources to implement child-friendly policies.

(iv) Integrated service delivery for children: coordination and decentralisation

The existing planning and resource allocation mechanisms are strongly sector-driven. This raises challenges, as in every country, for Government when tackling multi-sectoral issues. Children's lives, by their very nature, are multi-sectoral and all good practice policy addresses children's needs in a holistic manner. The difficulties that the Government has in acting across sectors have a clear impact on children in Mozambique. For example, the national nutrition policy depends on action across many sectors. The Plan of Action for Orphaned and Vulnerable Children and the National Strategic Plan for the Combat of HIV/AIDS require action and interaction from all sectors of Government.

One possible way forward in tackling the challenges of multi sectoral implementation that benefits children is to support multi-sectoral coordination bodies, such as the Technical Working Group for Orphaned and Vulnerable Children. Another way forward is to increase focus at local level, where the integrated nature of children's needs are more apparent and local inter-sectoral action is in many ways easier to achieve than at national level. Sub-national levels of Government are critical for matching public services to local needs. Given the inter-regional disparities identified in the foregoing analysis, this role is of central importance for childhood poverty reduction. Local-level state institutions have, however, traditionally been very weak in Mozambique, conceived of primarily as local implementing agencies for central ministries.

While the early 1990s saw steps taken towards "democratic" decentralisation with the passing of legislation providing for autonomous urban and rural municipalities headed by elected officials, the relatively close result of the first national democratic elections in the same year contributed to the dramatic watering down of these provisions (Fozzard, 2002). Subsequent reforms have focused on decentralisation of administrative functions (often termed "deconcentration") and some fiscal elements of the public sector. In particular, the planning and budgeting process has undergone substantial changes at provincial and district level in recent years.

Of particular note has been a pilot Decentralised Planning and Finance Programme in Nampula province. The pilot was originally distinctive vis-à-vis other donor-financed decentralisation programmes due to three core elements: (i) a strong institutional link to the then Ministry of Planning and Finance; (ii) provision of guaranteed funds for implementation of plans, and; (iii) a strong participatory element at district level. This "Nampula pilot" proved highly successful and has led to similar programmes being developed in Cabo Delgado (beginning in 2003) and in the four central provinces (beginning in 2004). It has also provided a model for reforms at national level, with the introduction of an integrated district level PES and Budget (PESOD).

As well as leading the way in decentralisation, the Nampula pilot highlighted key constraints to the process. First, the legal basis for the district remained ambiguous, limiting the impact of District Plans on actual sectoral expenditures. Second, the scheme's dependence on donor grants raised doubts about its financial sustainability. The former concern was addressed in 2003 and 2005 with the passing of the Law for Local State Organs (LOLE) and associated Regulations respectively. LOLE establishes the district as the base unit for planning in Mozambique, and gives it the status of a "budgetary unit" within the State Budget. The District Development Plan is legally recognised as the principal instrument for planning and budgeting. The Provincial Governor is awarded power to authorise district level investment in health and education. Finally, community consultation and participation is strengthened through District Consultative Councils which are given a role in the preparation, approval and implementation of the planning instruments at district level.

Concerns regarding district planning's financial sustainability were eased with the decision to make discretionary investment funds of around \$300,000 available to each district in 2006 for physical infrastructure projects. This decision effectively mainstreamed the Nampula pilot at national level. However, there remains great variation in the capacity at district level to comply with the new legal and budgetary framework and for many these reforms have come too soon. The challenge ahead is to rapidly build district capacity throughout the country and ensure that districts plans prioritise action for the provision of social services to children and for the reduction of existing disparities. The current development by the Ministry of Planning and Development of a national strategy to coordinate the various decentralised planning and finance projects should be crucial in this regard.²¹

Overall vertical sector/Ministry linkages still predominate over the horizontal territorial dimension of the State. 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 through elections.

As resource allocation and planning become closer to citizens' lives, people are more likely to perceive that they can influence power-holders, more likely to be aware of instances of corruption and thus more likely to become active in demanding a reduction in levels of corruption (see Box 2.4).

²¹ A recent inventory exercise concluded that there were 23 projects and programmes operating in the area of decentralised planning and finance in Mozambique in 2005 (MPD, 2005; p.24).

Box 2.4: Corruption and its impact on children

There are no comprehensive data describing the impact of corruption on children. A national study on corruption conducted for the Government in 2004, however, identified areas in which corruption could constitute an obstacle to poverty reduction for children (Austral 2004).²² Respondents perceived corruption as one of the main problems facing Mozambique, and considered that it had increased between 1999 and 2004 (ibid: 7). The study also found that:

- 51 per cent of families reported paying a bribe during the previous year, including 16 per cent who paid more than 10 per cent of their total income in bribes. Families living in urban areas were 1.5 times more likely to have paid a bribe than those living in rural areas (ibid: 19-20);
- The cost of corruption was perceived to impede a family's access to basic public services (ibid: 14). It also undermined confidence in public services and, therefore, reduced the likelihood that the population would use such services. For example, the majority of family and private sector respondents believed that court decisions were influenced by corruption and expressed low confidence in the justice system;
- The institutions perceived to be the least honest were the police, the transit police, the National Water Directorate (DNA), political parties, Electricity Mozambique (EDM) and the judicial tribunals (ibid: 61);
- 90 per cent of respondents did not know how to denounce an act of corruption. 62 per cent of public servants and 48 per cent of families said they would not denounce an act of corruption as they believed they would be afforded no protection from retribution (ibid 21).
- Available evidence suggests, therefore, that corruption is a problem in the lives of Mozambican children and impedes the development of a protective environment.

Corruption undermines the confidence of children and their carers in the State, influences how they perceive the legitimacy of institutions responsible for their protection and shapes their ideas of appropriate behaviour. It is a factor in limiting children's access to public services, in addition to limiting the effectiveness of the institutions charged with the protection of children. The cost of petty corruption is often borne by the poor, making it an obstacle to economic development. Households are less able to escape poverty when part of their income is diverted into paying bribes, or when they are denied opportunities because they have inadequate resources to buy influence.

Fighting corruption is one of six core objectives identified in the Government's Five Year Plan 2005-2009 (GoM, 2005a: 5; 59-60) and one of the main objectives under the Governance pillar of PARPA II (PARPA II: 79). Initiatives to this end are an integral part of both public sector and security sector reform. In 2006, the Government adopted an Anti-Corruption Strategy (2006-2010), which recognised the high levels of corruption in sectors key for the well-being of children, including education, health and water. The strategy identified some of the main causes of corruption - including weak law enforcement, weak control and supervisory mechanisms, the high prevalence of nepotism and the weak participation of civil society in the fight against corruption - and set out measures to address these causes (GoM, 2006a).

²² The study was based on interviews with families, companies and public sector employees throughout the national territory.

(v) Monitoring and reviewing of plans, resource allocation and implementation

A robust national Monitoring and Evaluation (M&E) system is necessary for monitoring and evaluating progress made to deliver results for children set out in PARPA II and other planning documents, providing feedback into the planning process as to whether institutions are achieving their expected objectives and helping to ensure that budget allocations are tailored to maximise their impact.

The need to monitor PARPA I has necessitated the development of an associated Government-wide M&E framework. A reduced form version of this framework (the Performance Assessment Framework - PAF) was adopted as an annual M&E tool and was integrated into the PES and the PES Review report. Changes in the modalities and organisation of external assistance have also contributed to the improvement. At the sector level, the shift away from project specific planning towards a more Sector Wide Approach (SWAp) together with pooled financing has enhanced the importance of sector Planning Directorates and led to the development of improved sector M&E systems. Overall, General Budget Support (GBS) flows and the associated harmonisation and alignment of international partners have created increased demand for a Government-wide M&E system in the form of the PAF, which has been adopted by the Programme Aid Partners (PAPs) as a form of conditionality for GBS disbursements.

The Budget is monitored internally by the Ministry of Finance through the State Budget Execution Report (known in Portuguese as Relatório de Execução do Orçamento do Estado, or 'REOE') and externally via an audit of the Consolidated State Accounts (known in Portuguese as Conta Geral do Estado, or 'CGE') by the Administrative Tribunal. Evaluations of the budget are conducted by international partners, particularly in sectors with SWAps (Hodges and Tibana, 2004).

The Government also participates in biannual reviews with the group of donors providing General Budget Support (GBS) – the Programme Aid Partners (PAPs).²³ Their relations with Government are broadly summarised in a Memorandum of Understanding (MoU), which sets out what the review processes should entail (GoM and PAPs, 2004). The first of these, the Joint Review of Government and donor performance, takes place in April each year and reviews performance in the previous year. The Mid-Year Review takes place in September and is meant to focus almost exclusively on Government and donor performance with respect to key indicators in the Performance Assessment Framework (PAF). The PAF is a matrix of not more than 50 key indicators that contains indicators and targets to measure performance on key PARPA targets.

The PARPA II M&E Strategy aims to develop an integrated national M&E system, operating as a routine part of the planning process. It establishes a Strategic Matrix of indicators to be reported on in the PES and the PES Review Report, which is more extensive than the PAF matrix. It also introduces a distinction between medium-term results-based indicators and annually measured product-based indicators. The former will be measured in 2009, while the latter will measure progress against targets for annual actions aimed at achieving the medium-term objectives and associated results.

²³ In 2006 this group comprised 18 donors (the "G-18"): the EU, World Bank, African Development Bank and fifteen bilateral donors. The IMF, UNDP, Japan and the United States have "observer" status.

(vi) Analysis of monitoring and review mechanisms

Existing monitoring and evaluation systems, however, remain weak, fragmented and strongly donor driven. There are thus concerns regarding the quality of much of the annual data produced in key sectors (Holms and Martínez, 2005), its timing and the proliferation of conflicting methodologies, indicators and targets. Relatedly, the direct conditioning of GBS disbursements on performance relative to PAF indicators has created perverse incentives for the M&E system, with sectors seeking to set conservative, easily attainable targets.

A case study of HIV/AIDS targets in the health sector shows how the production of conflicting targets and associated incentive problems can directly impact on programming for children. The Ministry of Health has a programme to deliver prophylaxis to prevent the mother-to-child transmission of HIV and monitoring of this activity has been selected for inclusion in the PAF matrix.²⁴ The second National Strategic Plan to Fight HIV/AIDS for the period 2005 to 2009 (PEN II) sets out a target of PMTCT coverage of 90 per cent by the year 2009, building on the target established by the Ministry of Health in its HIV/AIDS Strategic Plan of 60 per cent by the year 2008. Following a period of reflection within the health sector in early 2006, the PARPA II target approved by the Council of Ministers aimed to reach a much lower target of 22 per cent by the year 2009. This reduction is partly due to the difficulties encountered in rolling out PMTCT prophylaxis in the health system.²⁵ It is also due, at least in part, to a generally held view in Government that it is better to exceed a conservative target than narrowly fail to meet an ambitious one.

It is hoped that the distinction between the new Strategic Matrix and the smaller list of forty PAF indicators will reduce the downward pressure on the targets associated with the non-PAF indicators. However, it is not sufficient to have one-off efforts to promote M&E activities within the sectors at the time of PARPA/Five Year Plan drafting. The key to the sustainability of the new M&E Strategy will be a coherent and thoroughgoing effort to build capacity to manage a Government-wide M&E system (not simply focusing on “priority” areas) within the Ministry of Planning and Development, integrating the existing sectoral instruments into a coherent whole and building capacity where monitoring and evaluation is particularly weak.

The quality of financial monitoring could be markedly strengthened by the integration of public expenditure reviews (PERs) into the planning, budgeting and monitoring process. At present the Government rarely undertakes such reviews (PERs in education and health were undertaken by consultancy teams and published in 2003 and 2004 respectively) and the linkages between those that do exist and the budget process are weak. Integration of PERs should help to ensure that budget allocations are tailored to maximise their impact on PARPA objectives and provide lessons and recommendations arising from experience in implementing programmes and policies.

B. External development assistance

(i) The new “aid architecture”

As the deprivations-based approach to poverty measurement emphasises, spending in areas such as health, education and water is essential to reducing childhood poverty. These are areas where external assistance is heavily concentrated. Since

²⁴ The indicator addresses the “number of HIV+ pregnant women and neonates receiving PMTCT prophylaxis.” Note that this indicator has added importance within the PAF. For example, it is one of the European Commission’s 11 core output conditionality indicators and determines €1.25 million of the “variable tranche” of its GBS disbursements (European Commission, 2006).

²⁵ In 2005, the PAF reported that 7,297 pregnant women and neonates received treatment in 2005 against the targeted 15,000.

Mozambique is Africa's single biggest recipient of international development assistance, receiving more than other post-conflict countries such as Uganda and Ethiopia (IMF, 2005), external aid flows have a substantial bearing on child development outcomes. The way this assistance is delivered is now changing, with a clear and concerted move towards increased harmonisation and alignment of donor activity centred around the PARPA process (See Box 2.5) together with an interrelated move towards more flexible aid modalities such as sector Common Funds and Government-wide General Budget Support (GBS). Understanding these changes is therefore central to child development because it is intimately linked with not just how much will be spent on children but also how effective and sustainable those interventions are likely to be and therefore how successful the Government and its partners will be in sustaining the broadly positive child development trends observed since 1992.

The Paris Declaration on Aid Effectiveness in 2005 formalised many of the changes in an agreement signed by all Mozambique's major bilateral and multilateral donors that included quantitative time-bound targets (High Level Forum, 2005). These targets include commitments to channel an increasing proportion of funds through national budgets, use national public finance management (PFM) systems, provide capacity development support in a more coordinated manner, increase the predictability of aid flows and reduce the use of parallel project implementation units (High Level Forum, 2005a). The move towards harmonisation, alignment and more flexible aid modalities has been led in Mozambique by the Programme Aid Partners (PAPs), a group of 18 bilateral and multilateral donors providing GBS to the State Budget. Flexible modalities such as GBS and common funds now comprise around 40 per cent of gross aid commitments (Table 2.7). Moreover, PARPA II is clearly in favour of this move, and GBS in particular, stating that: "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" (GoM, 2006, p. 147).

Box 2.5: Harmonisation and alignment

"Harmonisation" (also known as coordination) refers to horizontal coordination among donors, comprising:

- The development of common agreements for planning, managing and delivering aid. This includes increased use of joint reviews, collaboration and joint strategies, joint operations and joint financing arrangements.
- The gradual simplification of procedures and specific requirements in order to reduce their burden on partner Governments. This includes streamlining conditionality, reducing the number of field missions, reducing donor reporting requirements, harmonising financial management and procurement procedures and delegated cooperation.
- The sharing of information to promote transparency and improved coordination.

"Alignment" refers to convergence between Government and donor priorities through:

- Donor actions such as basing country strategies on partners' national development strategies and results frameworks.
- Partner country actions, such as basing national development strategies on sound macroeconomic and poverty diagnoses and translating these national strategies into operational, results-oriented frameworks.

Source: Balogun (2005)

There are two principal drivers behind the profound changes underway in how external development assistance is provided to Mozambique and other recipient countries. Firstly, it is recognised that Government ownership and leadership – for example in making strategic resource allocation decisions – is essential for the sustainability of the development process. Overall assessment of performance coupled with measures to improve the universality of the Government’s planning and budgeting instruments addresses some of the difficulties of fragmentation and gaps in coverage. At the policy level, greater harmonisation and alignment should also reduce the tendency to subject Government to a vast and often competing array of recommendations, thereby producing ‘reform fatigue’.²⁶

Secondly, current changes in how external development assistance is provided are a direct result of the dramatic development progress realised. The drive to expand in the service delivery sectors – where much aid is concentrated and which have direct impacts on children’s lives – is increasingly competing with the need to increase or at least maintain the quality of existing services such as health, education and water and sanitation (GoM and PAP, 2006). As a result, current budgets for salaries and goods and services are straining under the conflict between the need to finance the operation of expanding systems and the need to respect the fiscal constraints required to maintain hard-won macroeconomic stability (i.e. balancing investment and recurrent costs – see discussion on State Budget Recurrent and Investment Expenditures in Annex IV).

Table 2.7: External funding in the 2005 State Budget by modality

Modality	Number of Donors	Funding (million US\$)*	% Total
Grants	89	500.7	57.1
Budget support	16	172.2	19.6
Common Funds (SWAPs)**	8	97.9	10.0
Project Aid	65	240.6	27.4
Credits	18	376.9	42.9
Budget Support	1	57.7	6.6
Lending to parastatals	5	73.7	8.4
Project aid	12	245.5	28.0
Total	107	877.6	100.0

Note: *Exchange rate of 23,061 MZM/USD used.

**Number of donors refers to number of different funds only.

Source: 2005 State Budget, cited in Arndt et al. (2006)

(ii) Analysis of implications for children

a. Longer term implications

Knowing the totality of available resources is a key precondition for genuine policy-driven allocation of public funds for children. Funding fully or partially outside the budget process is termed “off-budget.” In Mozambique such funds are comprised mainly of external assistance flows, although sector own-revenues (often lacking a legal basis) are also problematic. Off-budget funds undermine Government’s efforts to prioritise, plan, budget, monitor and evaluate effectively, damaging the credibility

²⁶ For example, the 2004 Fiduciary Risk Assessment noted that, in the field of public finance management alone, donors and funding agencies had made no less than 280 recommendations in various studies and reports between 2000 and 2003 (Scanteam, 2004). The common practice of referring to the need for second and “third-generation” reforms is indicative of this problem too.

and importance of the budget process, creating costly duplication of reporting mechanisms and weakening the executive's accountability to Parliament. This phenomenon also imposes more direct costs on Government, which has to issue expensive and unnecessary domestic debt because there are unused project balances sitting idle outside the Treasury mechanism which could be used to temporarily strengthen the Government financial position (Lawson et al., 2006).

This problem is most severe in the social services and infrastructure sectors since they are the largest recipients of external aid. The health sector was therefore chosen to pilot a study aimed at classifying and quantifying off-budget funds, seeking to outline the factors leading to their creation and recommend ways to progressively integrate them into the State Budget cycle (Cabral et al., 2005). The study distinguished between entirely off-budget funds and three categories of partially off-budget funding: (i) off-plan funds that are not inscribed into the State Budget; (ii) off-Treasury funds that are not transferred via the Treasury in their execution, and; (iii) off-report funds, which are neither captured in internal audit instruments (budget execution reports) nor external audit instruments (CGE). In the health sector in 2003 it was estimated that 29 per cent, 60 per cent and 44 per cent of funds fell into these categories respectively. Within the off-plan category, the proportion of external funds was estimated to be 87 per cent, with sector revenues comprising the remaining 13 per cent.

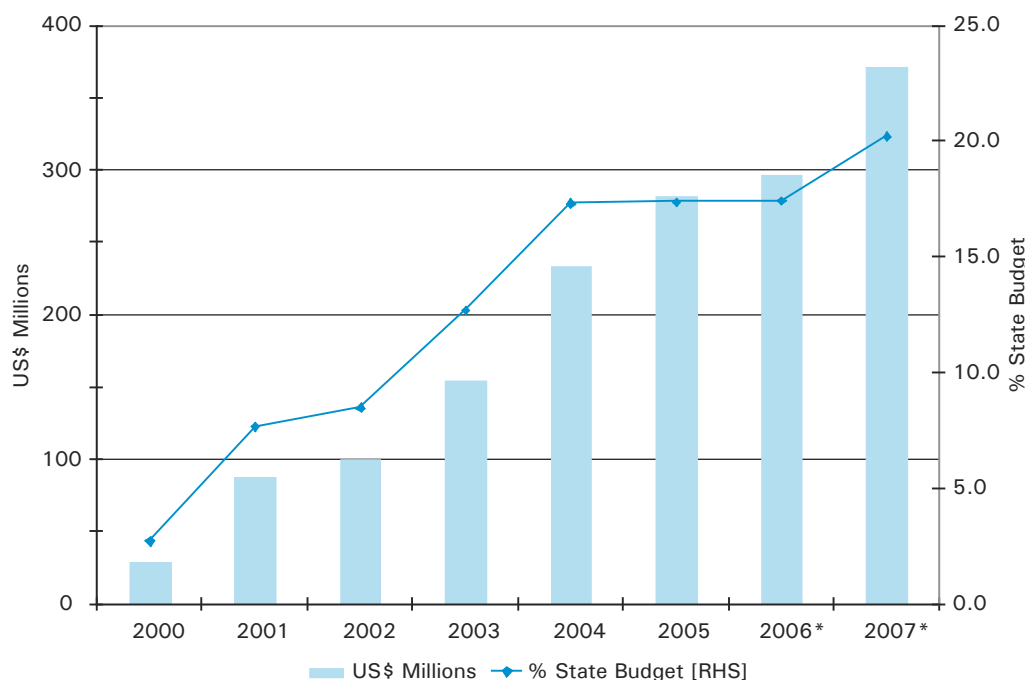
In 2006, the Ministry of Finance produced guidelines to support donors in the integration of external funds into the budget cycle (Ministry of Finance, 2006) and efforts are ongoing to increase this integration. However, key barriers still remain, including: (i) weak incentives for sectors to cede direct control of financial allocation and management decisions; (ii) limited institutional capacity in central agencies and sectors to sustain the necessary changes, and; (iii) continued use of diverse donor financed programmes and projects throughout the sector.

Faltering progress in aligning with Government processes may also be prejudicing child development outcomes. For example, many international partners require that aid for infrastructure projects be exempted from VAT payments, and that these be met by Government. However, the difficulties faced by the Government in budgeting for unpredictable VAT payments have hampered project implementation and led to accumulation of debts by Government agencies – a particularly big problem in the water sector, where it leads to delays in and higher costs for water infrastructure projects (see Chapter III for a more detailed discussion). The World Bank has demonstrated a potential solution to the problem – all its new agreements now acknowledge that credits may be used to pay fiscal charges and the Bank does not necessarily require state co-financing of projects. However further change in this regard is likely to be slow as the rules are written into the domestic laws and procedures of international partners (Orlowski, 2006). Clearly though, a more vigorous approach is needed than a commitment to “discussing, and contributing to a solution to this problem” (GoM and PAP, 2006).

Even amongst the PAPs, a substantial share of project finance has been retained in portfolios, with a concomitant flat-lining of GBS in recent years as a proportion of the budget (though indicative commitments for 2007 suggest this situation may improve – see Figure 2.12). The proportion of project aid in PAP assistance actually increased from 36.9 per cent to an estimated 42.3 per cent between 2004 and 2006 (Ernst and Young, 2006). There is therefore a danger that, overall, the increased focus on global implementation and performance that has accompanied harmonisation and alignment will simply add to the total burden of conditionality, rather than being accompanied by a reduction in the more intrusive micro-management of project aid.

This has troubling implications for the “accountability balance,” weakening domestic institutions such as the Parliament.

Figure 2.12: PAP general budget and balance of payment support, 2000-2007



Note: *Data for 2006 and 2007 gives commitments only.

Source: PAP Secretariat and CFMP

Finally, capacity development is a key area that has so far been neglected in harmonisation and alignment reforms. The State has been the subject of radical reform in the short period since independence, undergoing a particularly rapid transformation and expansion since 1992, notably in the social services area. This has left little capacity available to actually manage the new arrangements. The emphasis on system expansion is increasingly tempered by the need to maintain quality levels, and improved institutional capacity is central to achieving this aim. Better coordinated and targeted capacity development is needed in order to address this, promoting long-term and often intangible outcomes such as improved management, planning and financial capacity within Government. A recent assessment concluded that donor provision of capacity development is incoherent and inadequate at present, and may well be hindered by short-term donor career incentives. In turn, Government also faces challenging incentive problems and needs to define more clearly its capacity development priorities and establish a framework through which they can be supported (Scanteam, 2006).

b. Short and medium term implications

The longer term benefits of these profound reforms in how external development assistance is delivered worldwide are widely accepted, with 91 countries signing the Paris Declaration on Aid Effectiveness in March 2005. However, the process of moving from existing bilateral arrangements, with substantial components of “off budget” and project based funding and the process of developing capacity and experience in recipient country governments is likely to be long.

There is therefore a short and medium term imperative to ensure that, for children in poverty, they do not suffer deprivations in their critical childhood years that shape

their development and impact on the rest of their lives (in terms of growth, mental impairment, ill health or other lifetime effects of childhood poverty). The current generation of children in poverty cannot wait for the longer term benefits of new aid modalities, increased government ownership and capacity to be realised.

The Government and development assistance partners are addressing this challenge in several ways that have direct positive impacts in addressing childhood poverty in Mozambique. Firstly, PARPA II identifies that certain types of interventions are particularly suited to “project type” funding modalities, enabling government to absorb offers of large amounts of external funding and reap the benefits for development, without undermining the basic principles of aid effectiveness (see Box 2.6).

Box 2.6: Scaling-up of aid and child-development

There is a clear role for external financing of specific one-off programmes that deliver a rapid “step-change” in development outcomes. PARPA II explicitly recognises the key role such programmes can play, proposing that the potential increases in aid flows resulting from the scaling-up of external assistance in the coming years should be used for specific investments that require significant resources to initiate but that can be sustained by fewer resources in later years or that stimulate the productive sector of the national economy (GoM 2006; p44). Such programmes often have strong direct benefits for children’s lives. Examples include a comprehensive scaling-up of efforts to eradicate malaria in Mozambique, vaccination programmes, birth registration campaigns, or the recently initiated Millennium Challenge Account programme to provide access to clean water in smaller towns and cities in the north of the country. In such cases, ensuring the long-term sustainability of interventions through the simultaneous development of Government institutional capacity will be crucial.

Secondly, development partners have already made substantial shifts towards financing Government through “Common Funds”, i.e. mechanisms through which a number of donors coordinate in providing funding to a specific sector or area of activity within a sector. In the education sector, a common fund provides finance through which the sector can purchase and distribute text books free of charge of all primary students. In the health sector, essential drugs are funded through a common fund, with the sector responsible for purchasing, distribution and monitoring of costs and use.

Thirdly, various sectors are innovating with regard to how they implement their activities, by adopting new mechanisms for contracting non-government service providers. The accelerated school construction programme is one such example, as is “outsourcing” by competitive tender.

CHAPTER III

CHILD SURVIVAL AND DEVELOPMENT



1. Introduction

Every child has the right to the best possible start in life. The conditions of a child's birth and the environment in which the child spends the first few years of its life are critical in determining the survival, healthy growth and development of the child. Within this context, access to health, nutrition, water and sanitation services are vital to children's survival and development. It is in the first few years of a child's life that most brain development occurs and children learn to sense, walk, think, play and communicate. For these reasons the choices made and actions taken on behalf of children during this critical period affect not only how the child develops but also how a country progresses (UNICEF, 2001).

Significant progress has been made in recent years in improving child and maternal well-being in Mozambique, giving hope that the country has the potential of reaching the MDG targets of reducing child and maternal mortality. However, gains in child and maternal well being have been uneven across the country and large numbers of Mozambican children and women have not benefited equally from the overall economic growth and poverty reduction. In addition, as the impact of the AIDS pandemic is increasingly taking its toll on children's lives, previous positive trends will not necessarily continue. Mozambique has the 23rd highest under five mortality rate in the world, with one in every six children dying before reaching their fifth birthday, often from diseases that can be both prevented and treated (UNICEF, 2006).

Box 3.1: Convention on the Rights of the Child (CRC), Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
 - (a) To diminish infant and child mortality;
 - (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
 - (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
 - (d) To ensure appropriate pre-natal and post-natal health care for mothers;
 - (e) To 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;
 - (f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

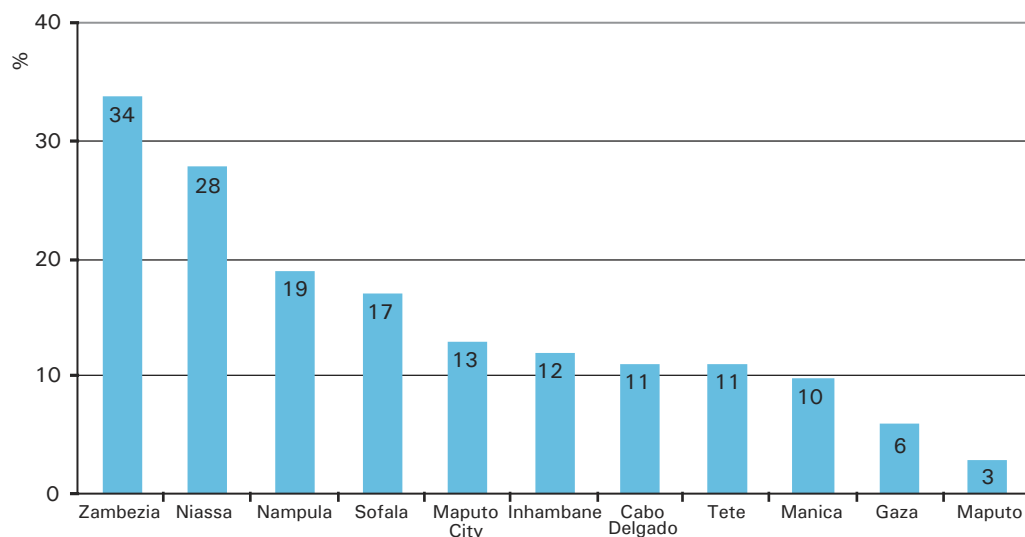
This chapter discusses the situation of children from pre-birth (maternal survival, antenatal and obstetric care) to the early years of childhood (0 to 5 years) from the perspective of their right to survival, healthy growth and development. It is divided into four sections. The first section reviews the situation of maternal survival, health and nutrition; child survival; childhood illnesses; malnutrition; HIV/AIDS; and water and sanitation and analyses the immediate causes of the situation. The second section analyses the underlying causes of the high level of mortality and the barriers to child survival and development. The third section discusses the financing of the health and water sectors, while the last section reviews the policy environment.

2. Overview of children’s deprivations in relation to health, nutrition and water and sanitation

A. Severe health deprivation among children

The deprivation indicator is the proportion of children under 5 years of age who have never been immunised against any diseases or young children who have had a recent severe episode of acute respiratory infection (ARI) and did not receive any medical advice or treatment. Overall, 17 per cent of Mozambican children under five years of age are experiencing severe health deprivation.²⁷ Severe health deprivation is four times higher among children in the poorest households than among children in the best-off households (31 per cent versus 7 per cent). In Zambezia province, more than one third of all children under-five years of age suffer from severe health deprivation (34 per cent) and in Niassa province the proportion is 28 per cent, as compared with only 3 per cent in Maputo Province. Children in households headed by a person with no education are three times more likely to face severe health deprivation than children in households headed by a person with secondary level or higher education.

Figure 3.1: Percentage of children with severe health deprivation by province



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

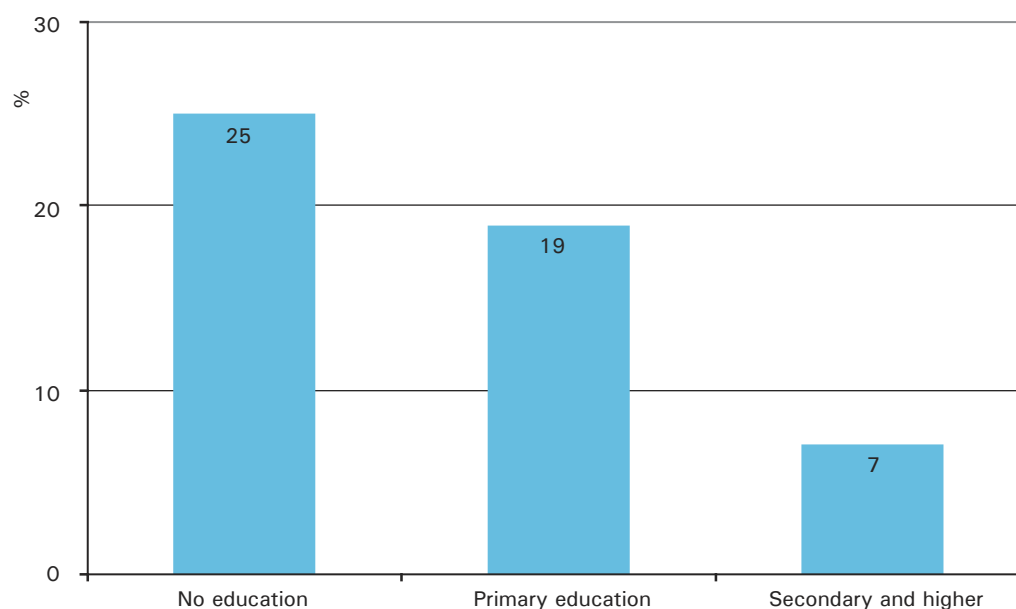
²⁷ This indicator is a composite measure of children under five years of age who have never been immunised or who have suffered from a severe episode of ARI that was not treated.

B. Severe nutrition deprivation among children

The deprivation indicator is the proportion of children under five years of age whose heights and weights for their age are more than -3 standard deviations below the median of the international reference population, i.e. severe anthropometric failure. One in every five Mozambican children under five years of age is severely nutritionally deprived (INE/MPD/UNICEF 2005)²⁸. In 2003, the under-five child population was 3.1 million, meaning that there were approximately 620,000 Mozambican children under five years of age who were suffering from severe nutritional deprivation. Severe nutritional deprivation among children is largely influenced by factors such as where the child lives, the education level of his or her mother and the socio-economic characteristics of the household of which he or she is a member.

Severe nutrition deprivation is almost four times higher among children from the poorest households (27 per cent) than among children from the best-off households (7 per cent). Severe nutrition deprivation is twice as high among rural children as among urban children (23 per cent versus 11 per cent). Levels of severe nutrition deprivation are seven times higher among children living in Cabo Delgado province than among children living in Maputo Province. In Zambezia province more than one in four children is experiencing severe anthropometric failure. Children who live in households where the heads have no formal education are three times more likely to experience severe nutrition deprivation than children who live in households where the heads have secondary level education or higher (25 per cent and 7 per cent respectively).

Figure 3.2: Percentage of children with severe nutrition deprivation by level of education of household head



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

²⁸ This indicator is a composite measure of anthropometric failure which includes all children who are more than -3 standard deviations from the reference median in terms of being wasted, stunted and underweight and all possible combinations of these failures (e.g. severely underweight and severely stunted).

Table 3.1: Percentage of children with severe health and nutrition deprivations

	Percentage of children with severe health deprivation	Percentage of children with severe nutrition deprivation
Province		
Niassa	28	22
Cabo Delgado	11	32
Nampula	19	22
Zambezia	34	26
Tete	11	20
Manica	10	18
Sofala	17	21
Inhambane	12	12
Gaza	6	14
Maputo	3	4
Maputo City	13	6
Area of Residence		
Urban	8	11
Rural	21	23
Level of education of the household head		
No education	24	25
Primary education	15	19
Secondary and higher	7	7
Wealth index quintile		
Poorest	31	27
Second poorest	19	23
Middle	14	22
Second best-off	6	14
Best-off	7	7
Total	17	20

Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

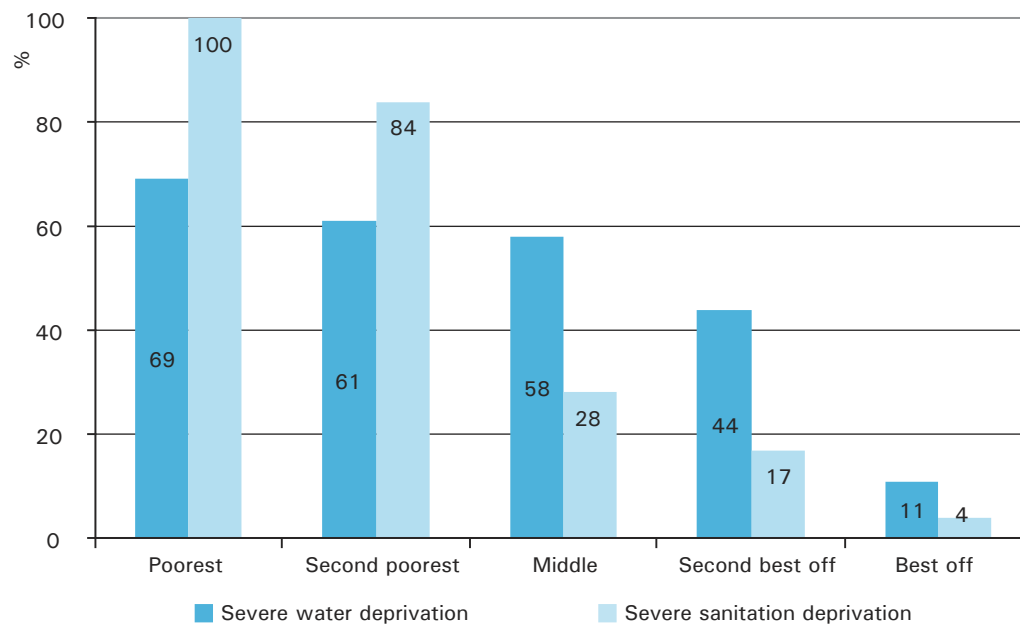
C. Severe deprivation of water and sanitation among children

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 households where the nearest source of water is more than 30 minutes away. 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.

Overall, 49 per cent of children face severe water deprivation and 47 per cent face severe sanitation deprivation, making water and sanitation the most widespread deprivations faced by children in Mozambique. 69 per cent of households with children in the poorest wealth quintile face severe water deprivation, as compared with only 11 per cent in the best off quintile. Most strikingly, 100 per cent of children in the poorest quintile face severe sanitation deprivation compared to only 4 per cent in the best-off households. In urban areas, 25 per cent of children face severe water deprivation and 18 per cent face severe sanitation deprivation. In rural areas, severe water and sanitation deprivation among children reaches 61 per cent. Severe water deprivation varies from 3 per cent in Maputo City to over 60 per cent in Gaza,

Zambezia and Tete provinces. Severe deprivation of sanitation varies from 0.2 per cent in Maputo City to 79 per cent in Zambezia province. 59 per cent of households with children in which the household head has no education experience severe water deprivation, compared with 21 per cent among children in households in which the head has a secondary level or higher education. 63 per cent of children in households in which the head has no education face severe sanitation deprivation, as compared to only 10 per cent in households in which the head has secondary education or higher.

Figure 3.3: Severe water and sanitation deprivation among children by wealth quintile



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

Table 3.2: Percentage of children with severe water and sanitation deprivations

	Percentage of children with severe water deprivation	Percentage of children with severe sanitation deprivation
Province		
Niassa	46	21
Cabo Delgado	52	39
Nampula	48	58
Zambezia	62	79
Tete	63	46
Manica	50	49
Sofala	46	71
Inhambane	55	35
Gaza	63	31
Maputo	24	8
Maputo City	3	0
Areas of Residence		
Urban	25	18
Rural	61	61
Sex		
Male	49	47
Female	49	47
Level of education of the household head		
No education	59	63
Primary education	48	45
Secondary and higher	21	10
Wealth index quintile		
Poorest	69	100
Second poorest	61	84
Middle	58	28
Second best-off	44	17
Best-off	11	4
Total	49	47

Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

3. Maternal survival, health and nutrition

Given the absence of complete and accurate demographic data it is difficult to determine the maternal mortality ratio (MMR), i.e. the annual number of deaths among women from pregnancy-related causes per 100,000 live births. However, MMR appears to have 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 2003.²⁹ The institutional maternal mortality ratio (IMMR) has also declined in recent years.³⁰ This reduction has been largely attributed to improved access to health services, particularly family planning and antenatal care, and improvements in the acquisition and distribution of equipment, communications material, and transport.

²⁹ 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. This method has wide margins of error, meaning that the MMR may fluctuate between 200 and 600 maternal deaths per 100,000 live births.

³⁰ 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 IMMR estimated at 291 per 100,000 live births in Cabo Delgado province compared to 26.5 per 100,000 live births Maputo province in 2003.

If this downward trend continues, Mozambique has the potential to reach the MDG goal of reducing the MMR to 250 per 1,000 live births in 2015 (MDG national Progress Report, 2005). As a first step towards meeting the MDG target, the Government indicated in PARPA II that it aims to achieve a reduction in MMR to 340 maternal deaths per 100,000 live births by the year 2009.

The main immediate causes of maternal deaths include anaemia, haemorrhage, and rupture of the uterus, eclampsia and sepsis. Maternal deaths may also be due to complications from HIV/AIDS, malaria, and tuberculosis. Nutritional deficiencies, when concurrent with other medical conditions and anaemia, also contribute to maternal death.

One of the most important factors affecting women's health is good nutrition. The most critical factor affecting women's nutrition is their workload. Women, especially rural women, consistently work long, hard hours. Their energy intake is not commensurate with their work output. In Mozambique, about 9 per cent of women suffer from malnutrition.³¹ The prevalence of malnutrition is greater among women in rural areas than in urban areas and is twice as high among the poorest women (10 per cent) than amongst the most well off women (5 per cent) (2003 DHS).

Anaemia and vitamin A deficiency are among the major nutritional problems affecting women, particularly those who are pregnant and lactating. Anaemia in association with iron deficiency in pregnant women is linked with increased maternal morbidity and mortality. Anaemia in pregnancy is also associated with low birth-weight babies (Kramer, 1987). The causes of anaemia in Mozambique are multiple and include diets low in iron, frequent bouts of malaria, intestinal worm infestation, in particular hookworm, genetic disorders, deficiencies of folic acid and Vitamin B 12, chronic infections such as TB, as well as HIV/AIDS.

The 2002 National Survey on Vitamin A deficiency and Anaemia indicated that 70 per cent of pregnant women suffered from anaemia, against 48 per cent among non-pregnant women. It also indicated that iron deficiency was strongly associated with anaemia, with 81 per cent of iron deficient mothers being anaemic, against 44 per cent for those without iron deficiency. A positive correlation between vitamin A deficiency and anaemia was also established, with 67 per cent of vitamin A deficient mothers being anaemic, compared with 46 per cent for those without vitamin A deficiency. Despite the high level of anaemia among pregnant women, 39 per cent of pregnant women are not receiving iron and folic acid supplementation during pregnancy, with significant variation by area of residence (49 per cent in rural areas versus 19 per cent in urban areas) and provinces (up to 68 per cent in Zambezia province compared to 4 per cent in Maputo City) (DHS 2003). These findings illustrate low levels of compliance with existing national policy on supplementation of iron and folic acid among pregnant women.

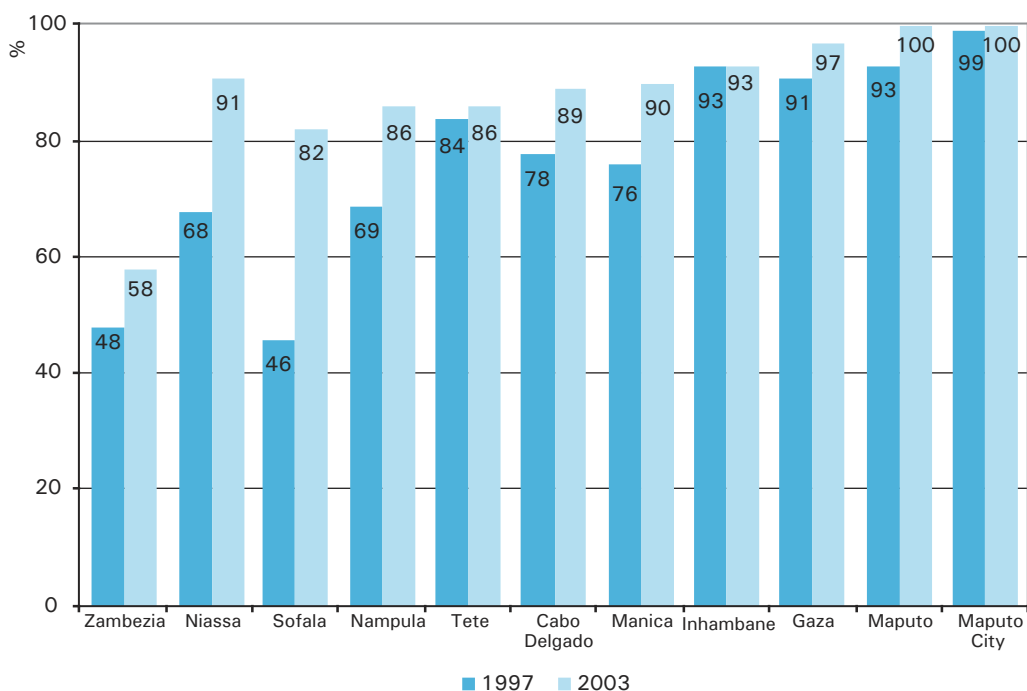
Antenatal care and childbirth care provide good indicators of maternal health care in Mozambique. Antenatal care indicates the proportion of women attended at least once during pregnancy by skilled health personnel (doctors, nurses, and midwives). Regular contact with skilled health personnel during pregnancy is critical as it allows women to identify and possibly correct potential health problems, in addition to receiving general health advice on tetanus immunisation, good nutrition, HIV/AIDS, malaria and hygiene. The Ministry of Health recommends that pregnant women should be checked five times during every pregnancy, with the first consultation during the third month of pregnancy.

³¹ When the ratio of the height and weight of a woman, used to derive the body mass index (BMI), is less than 18.5, then a woman is regarded as being malnourished.

The coverage of antenatal care has improved significantly in recent years, with the proportion of women attended at least once by skilled health personnel during pregnancy increasing from 71 per cent in 1997 to 85 per cent in 2003. As a result of increased coverage of health services, most gains in antenatal care were recorded in rural areas, where antenatal care increased from 65 per cent in 1997 to 79 per cent in 2003. Antenatal care in urban areas remained almost universal, with a slight increase from 96 per cent in 1997 to 97 per cent in 2003. The vast majority of ante-natal care is provided by nurses and midwives, with doctors accounting for only 2 per cent of antenatal care provided (6.2 per cent in urban areas and 0.6 per cent in rural areas).

With the exception of Zambezia province, where antenatal care was only 58 per cent, all provinces in which antenatal care was less than 80 per cent in 1997 succeeded in reaching rates over 80 per cent in 2003, with some remarkable results achieved in Sofala province, where antenatal care improved from 46 per cent to 82 per cent. Antenatal care varies according to the socio-economic status of women, from 67 per cent among the poorest women to 98 per cent among the best-off women.

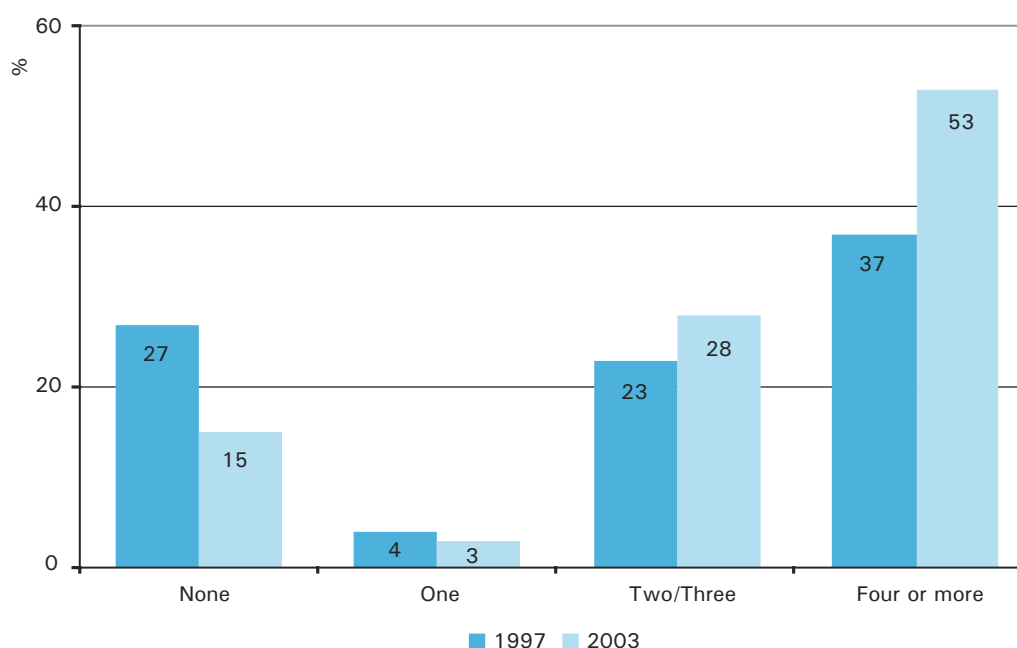
Figure 3.4: Women attended at least once by a skilled health personnel during pregnancy: comparison between 1997 and 2003



Source: DHS 2003

The number of antenatal consultations increased between 1997 and 2003, as shown by the decline in the proportion of women that were never attended during pregnancy (from 27 per cent to 15 per cent) and the increase in the proportion of women attended four times or more during pregnancy, from 37 per cent in 1997 to 53 per cent in 2003. However, only 18 per cent of women received their first consultation before the fourth month of their pregnancy. The majority of initial consultations occurred during the fourth or fifth months of pregnancy (44 per cent), while 22 per cent of first consultations occurred during the sixth or seventh month of pregnancy.

Figure 3.5: Percentage of women receiving antenatal care according to the number of consultation received during pregnancy: comparison between 1997 and 2003



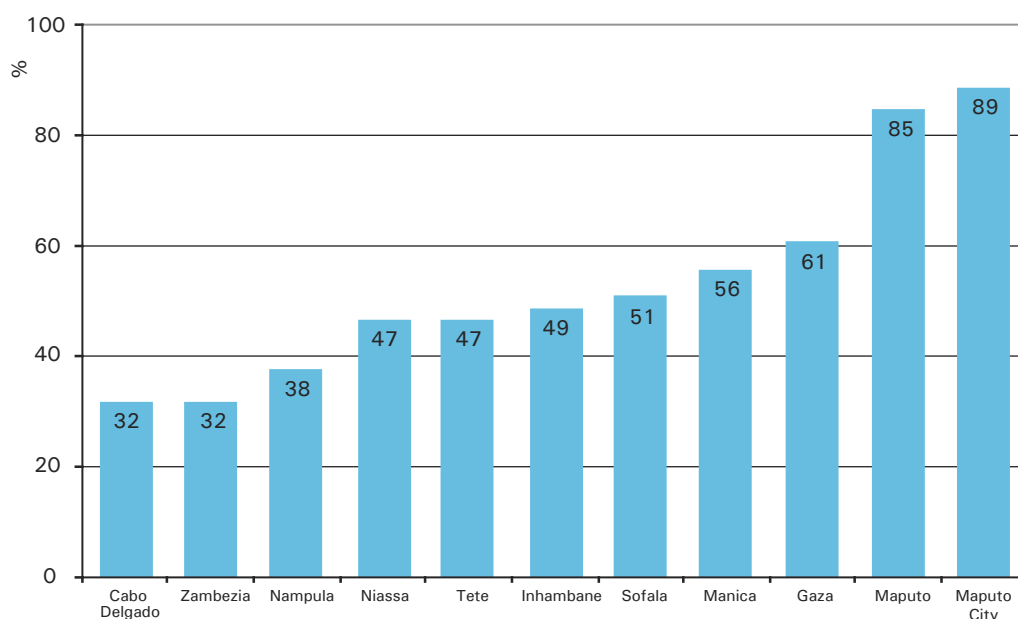
Source: DHS 2003

The norms established in the national antenatal care programme recommend that all pregnant women receiving antenatal consultation should be weighed, have their height measured, have their blood pressure taken and be tested for syphilis, in addition to receiving information on the possible health problems during pregnancy, HIV/AIDS and the risk of HIV transmission to the child. However, there appears to be little compliance with these norms. 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 50 per cent had their blood taken for testing. In addition, only approximately half of the women were counselled about HIV/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.

Childbirth care shows little improvement. Childbirth care measures the proportion of births attended by skilled health personnel (doctors, nurses, and midwives). In 2003, the DHS indicated that only 48 per cent of births were attended by skilled health personnel compared to 44 per cent in 1997, with a substantial difference between rural and urban areas (34.2 and 80.7 per cent respectively in 2003). This is an important factor impacting on the uptake of prevention of mother-to-child interventions (PMTCT) as there is therefore no system in place to ensure that those who do not have institutional deliveries comply with, and therefore benefit from this intervention. Also, the lack of supervision of labour and deliveries by skilled health personnel contributes to the high level of maternal mortality in Mozambique.³²

Disparities in childbirth care remain acute in terms of women's socio-economic status, area of residence and geographical location. Approximately two-thirds of women in rural areas are giving birth without the assistance of skilled health personnel, compared with about one fifth of women in urban areas (34 per cent versus 81 per cent). In Cabo Delgado and Zambezia provinces, childbirth care is only 32 per cent compared to almost 90 per cent in Maputo City.

Figure 3.6: Percentage of women attended by a skilled health personnel at delivery



Source: DHS 2003

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 2 days after delivery and only 8 per cent do so 3 to 6 days after their delivery. Care of the newborn falls through the cracks – it is neither prioritised in maternal health programmes nor in Integrated Management of Childhood Illness (IMCI) programme, which until recently only addressed the child from the seventh day onwards. Children of HIV positive women are not only at risk of HIV infection. Stillbirths, low birthweight, and prematurity are more common in children born to HIV positive women (Duerr, 2005). Therefore, HIV positive women need to be counselled about these facts in addition to the follow-up needed for PMTCT, and should therefore be encouraged to attend for postnatal care as much as for antenatal care and delivery.

4. Child survival

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 (U5MR). The rate of under-five mortality is the result of a wide variety of factors: the nutritional health and the health knowledge of mothers, 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 measures one end result of the development process and therefore presents a good overall picture of the health status of Mozambican children and of Mozambican society as a whole.

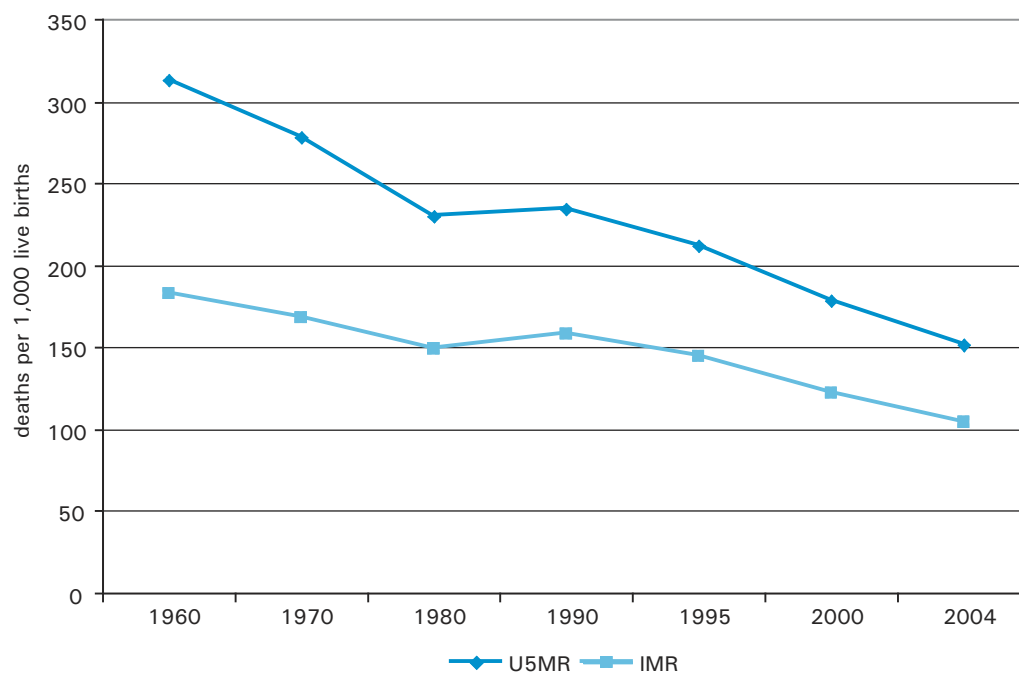
Measuring the rates of neonatal (under one month) and infant (under one year) mortality is also critical, as these rates acknowledge the particular vulnerability of newborn children and children in their first year of life. Neonatal mortality in particular is a reflection of the circumstances surrounding the birth of the child, such as the mother's health, the circumstances in which the child is delivered and the care the newborn received in the first few days of life.

³² The 2003 DHS also indicated that more than half of women deliver at home.

Mozambique has achieved a continual decrease in the rates of child mortality. The 1997 and 2003 DHS data indicate that during the period 1987-1997 and 1993-2003, the under-five mortality rate decreased by around 19 per cent, from 219 to 178 per 1,000 live births, while the infant mortality rate decreased by about 16 per cent, from 147 to 124 per 1,000 live births.³³ The country achieved the targets set out in the first PARPA of reducing infant and under-five mortality rates to 130 and 190 respectively by 2005.³⁴ The 2005 National MDG Progress report found that if this trend continues the country has the potential to reach the MDG relating to child mortality by 2015.

Current child mortality rates, however, remain high, with about one in every six children born in Mozambique dying before he or she reaches their fifth birthday. In the year 2004, it was estimated that the total number of deaths among children under the age of five was 117,000. This is about 320 child deaths every day and represents an under-five mortality rate of 152 per 1,000 live births (UNICEF 2006). A child's risk of dying is much higher in the first month of his or her life (the neonatal period), during which more than a quarter of all under-five deaths occur (48 per 1,000 live births in the 2003 DHS). The growing AIDS pandemic is threatening the gain recorded in terms of child mortality reduction. The probability of meeting the MDG target will therefore depend, amongst other things, on the capacity to accelerate PMTCT and Paediatric AIDS treatment.

Figure 3.7: Estimated infant and under-five mortality rates in given years



Source: UNICEF 2006

Note: for calculation methodology, see <http://www.childinfo.org/areas/childmortality/methodology.php>

The estimated average under-five mortality rate in Sub-Saharan Africa in 2004 was higher than in Mozambique (171 per 1,000 live births compared to 152 per 1,000), while the estimated average infant mortality rate in Sub-Saharan Africa was slightly

³³ Infant and under-five mortality rates are measured by the DHS for a 10-year reference period. Mortality rates measured in 2003 therefore refer to the period 1993 to 2003. While the DHS also measure rates for a 5-year reference period, this measure is considered less accurate. In the year 2004, UNICEF estimated that under-five mortality rate was 152 per 1,000 live births and infant mortality was 104 per 1,000 live births (see *State of the World's Children 2006*).

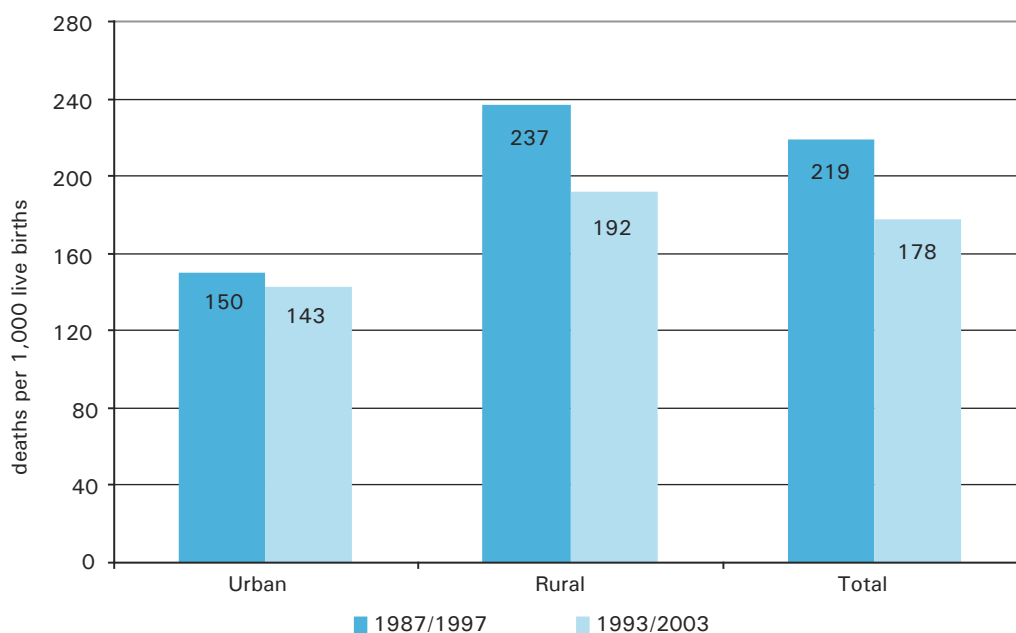
³⁴ Mortality reduction targets for a given year, such as the PARPA I target of reducing U5MR to 190 per 1,000 live births by 2005, refers to a reference period and not to a given year. This is due to the methodology used for calculating U5MR. As shown in the graph, the under-five mortality rate was in fact already less than 190 per 1,000 live births at the beginning of the PARPA I in the year 2001.

lower than in Mozambique in 2004 (102 per 1,000 live births compared to 104 per 1,000 live births) (UNICEF 2006). In the world, the average under-five and infant mortality rates were estimated at 79 per 1,000 live births and 54 per 1,000 live births respectively in 2004.

The emerging trends in relation to under-five mortality reflect the trends in relation to other indicators of children’s well-being in Mozambique, i.e. persisting geographical and residential disparities, with the northern part of the country and rural areas still far behind the southern parts of the country and urban areas (despite marked improvements in rural areas), and improvement in all segments of the population but little reduction of the gaps between the poorest and the best-off. This reflects the prevalence and depth of child poverty at the end of the civil war.

During the period 1987-1997 and 1993-2003, the under-five mortality rate decreased more in rural areas than urban areas, falling by about 20 per cent in rural areas (from 237 to 192) compared with a reduction of approximately 5 per cent in urban areas (from 150 to 143). The marked improvement in rural areas can be attributed to a poor initial base, increased security in rural areas (after the end of the civil war in 1993) and improved access to health facilities over the reference period. Children in rural areas remain more likely to die before reaching the age of five than those living in urban areas. Geographical disparities also 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.

Figure 3.8: Under-five mortality rate: comparison between 1987/1997 and 1993/2003



Source: DHS 2003

All of the available evidence shows that malaria and acute respiratory infection (ARI) are the two major immediate causes of mortality among young children in Mozambique. AIDS is also emerging as a major killer. Malnutrition is a major underlying cause of child mortality, as are diarrhoeal illnesses and measles. Many of these conditions are preventable by either vaccination or other simple prophylactic measures. Accurate and comprehensive information on the causes of death among children, however, is scarce. The first reason for this is that most deaths among children occur outside the health system and are therefore not recorded.

The second reason is that deaths occurring within the health system are not captured comprehensively by the national health information system (HIS), which records less than 5 per cent of all deaths among children in Mozambique.

Box 3.2: A look at three information sources on causes of child mortality

The Health Information System (HIS)

The HIS records deaths among children under 8 years of age in 29 paediatric wards of rural and general hospitals in the country, capturing about two thirds of the rural and general hospitals in the country. Deaths that occur in other health facilities, such as health centres and health posts are not captured by the HIS (there were more than 1,200 such sites throughout the country in 2005). While most health facilities maintain records on the causes of child mortality, the information does not flow regularly to the central level and is therefore not systematically consolidated into the HIS. In addition, the national HIS records deaths among the age group 0 to 8, without further disaggregation of the figures for the age groups 0 to 1 or 0 to 5, thus making it impossible to report on the causes of infant and under-five mortality.

In 2004, the national HIS recorded 2,746 deaths among children aged 0 to 8 years of age, which, according to the current mortality estimates, represents less than 5 per cent of all deaths among children in Mozambique. Among deaths recorded in 2004, malaria was by far the first cause of mortality (39 per cent), followed by malnutrition (16 per cent) and pneumonia (8 per cent). Data for all available years in the system (since 1999) indicate similar findings and consistently show that malaria ranked as the first cause of mortality, followed by malnutrition and pneumonia. An important proportion of all deaths registered by the HIS record the cause of death as "other" (16 per cent in 2004).

While AIDS is emerging as a major killer of children, it does not yet appear in the HIS on a scale commensurate with the scale of the epidemic. Among all deaths recorded, 131, or 5 per cent, were attributed to AIDS related causes. In 2004, it was estimated, however, that more than 17,500 children under the age of five died as a result of AIDS related causes, accounting therefore for about 14 per cent of all deaths among under-five children that year (estimated at 122,000, SOWC, UNICEF 2005). The low reporting of AIDS-related deaths is due to the lack of means of detection, high level of stigma among health workers who tend not to record AIDS as a cause of mortality and the fact that many AIDS-related deaths may be recorded in the HIS as either malaria, pneumonia, malnutrition, tuberculosis or anaemia, all of which can be caused and aggravated by AIDS.

Maputo Central Hospital data

An analysis of child mortality data recorded by the paediatric ward of Maputo Central Hospital, which are not included in the HIS, indicates that the hospital's own monitoring system disaggregates data by age (i.e. 0-1; 1-4; and over 59 months). In 2004, the Maputo Central Hospital recorded 1,012 deaths among children under 5 years of age, which is equivalent to over one third of all deaths recorded by the entire HIS in the same year. The first cause of mortality was acute respiratory infections (19 per cent), followed by malaria (16 per cent) and AIDS (14 per cent). Similarly to the HIS, an important proportion of child deaths recorded by the Maputo Central Hospital reported the cause as "other" (25 per cent).

Zambezia Mortality Study

Conducted in 2001 in Mocuba district, Zambezia province, the study findings provided detailed insight into the causes of neo-natal, infant and under-five mortality in a rural area of Mozambique. Malaria was found to be the major killer among children under the age of five, accounting for more than a quarter of all deaths (27 per cent). The second most common cause of death among under-five children was pneumonia (18 per cent) and the third cause was meningitis (10 per cent). The relatively high incidence of meningitis probably related to a particular epidemic of meningitis in the rural district of Mocuba. In this study, AIDS accounted for 3 per cent of all deaths. The study indicated three major causes of mortality among newborns (less than 1 month old), i.e. septicaemia (35 per cent), prematurity (18 per cent) and pneumonia (15 per cent). The high proportion of neo-natal deaths due to septicemia was most probably related to unhygienic delivery conditions.

5. Childhood illnesses

A major public health intervention to address childhood illness has been the development of the Integrated Management of Childhood Illness (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 and now reaches 130 districts in 2005.

In health facilities, IMCI promotes an integrated holistic approach to the case management of the sick child, looking at the top causes of child mortality (malaria, pneumonia, diarrhoea, malnutrition, measles). The programme was updated in 2006 to include neo-natal and HIV/AIDS components. At community level, the programme is essentially implemented by NGOs and focuses on preventive and promotive care. However, it does not at present involve community-based treatment. The strengthening and expansion of the programme is a key strategy of the Government outlined in PARPA II for further reducing child mortality and morbidity, with a target set for 80 per cent of health facilities to be implementing IMCI by the year 2009, compared with an estimated 60 per cent in 2005 (GoM 2006).

An evaluation of IMCI conducted in 2005 showed that the programme had improved performance levels of health facilities and led to better health services for children since the IMCI baseline survey conducted in 2001, but that in general management of childhood illnesses by health workers remained poor (MISAU 2005).³⁵ 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.

A. Malaria

Malaria is the leading killer of children in Mozambique despite the fact that it is both preventable and can be treated. Due to the poor health information system, it is difficult to quantify the exact proportion of deaths among children due to malaria. It is estimated, however, that more than one in four deaths among under-five children is due to malaria. The disease accounts for 40 per cent of all out-patient consultations and up to 60 per cent of in-patients in paediatric wards as a result of severe malaria illness (MISAU, PNCM). The 2002 National Survey on Vitamin A deficiency and Anaemia indicated that 42 per cent of children were infected with the malaria parasite *Plasmodium falciparum*, with a much higher prevalence in rural areas (58 per cent) than urban areas (21 per cent) (MISAU 2002).

The Ministry of Health has made malaria a high priority in terms of control and prevention, adopting the principles of the global Roll Back Malaria (RBM) initiative in 1999. As part of the RBM inception process, Mozambique signed up to the Abuja Declaration targets in 2000. While progress has been recorded in the fight against malaria, particularly on the side of prevention, the country is seriously off-track for meeting the Abuja targets.

One of the key malaria-related treatment targets agreed at the Abuja RBM summit was to ensure that by 2005 60 per cent of those suffering from malaria should be able to access and use correct, affordable and appropriate treatment within 24 hours of

³⁵ For example, the evaluation indicated that less than half of children in need of oral antibiotics or antimalarials were correctly prescribed medication.

the onset of symptoms. In areas where malaria is common, such as Mozambique, it is recommended that any fever in a child is treated as if it were malaria and that the child be given a full course of anti-malarial tablets. In 2003, the DHS indicated a very high prevalence of fever among children, with 27 per cent of all children under-five years of age reported to have had fever in the two weeks prior to the survey. Among children with fever, only 15 per cent were given anti-malaria drugs and only 8 per cent were given the drugs within 24 hours.

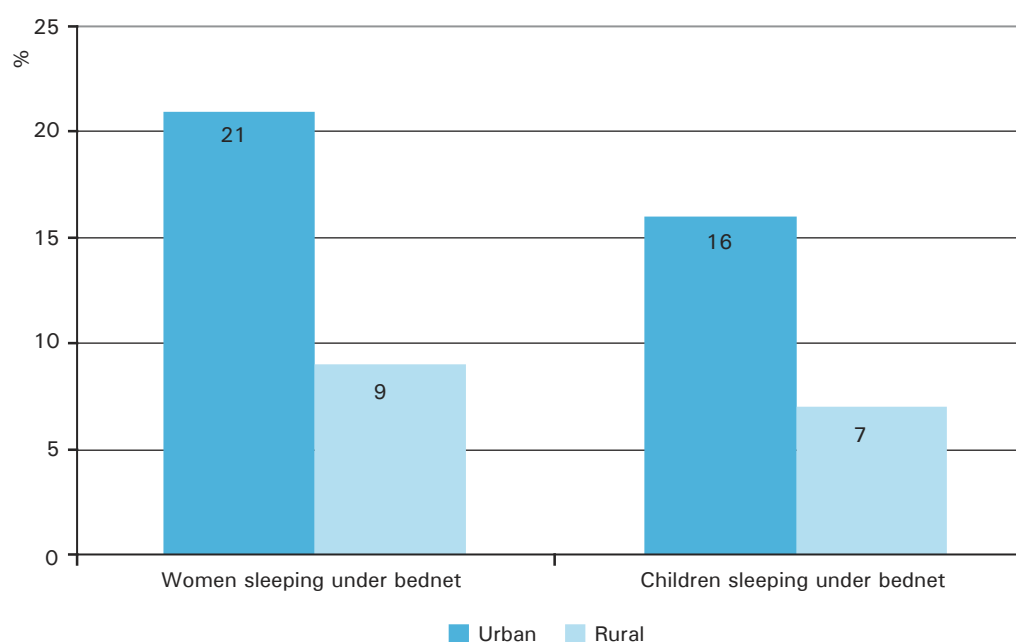
These low rates of appropriate treatment indicate, on the one hand, low awareness and demand among care-givers for treatment (only about half of children with fever were taken to a health facility), and on the other hand low access to health facilities and low availability of drugs. Outside the formal health system, only registered pharmacies and a few specially registered shops can supply antimalarial drugs. As approximately one million pregnancies every year are thought to be complicated by co-infection with malaria and HIV in sub-Saharan Africa, particular attention needs to be given to this issue. 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 incidence may exceed 35 per cent (Brentlinger, 2006). The WHO now recommends the use of intermittent presumptive therapy (IPT) and insecticide treated nets (ITNs) for all pregnant women living in high risk malaria areas. In accordance with this, the Ministry of Health in Mozambique also strengthened preventive treatment and introduced IPT in 2006, which involves the provision of at least two treatment doses of Sulphadoxine Pyramethamine (SP) during routine antenatal clinic visits.

The situation regarding prevention and control of malaria is more positive. There are two major control tools promoted by Mozambique for malaria control, i.e. Indoor Residual Spraying (IRS) using long lasting insecticides and the use of ITNs, which are considerably more effective than un-treated nets. The Government in PARPA II identified IRS as a key strategy for malaria control and prevention, establishing a target of 50 per cent IRS coverage by the year 2009, compared with about 18 per cent in 2005.

Together with IRS, the other effective means of malaria control is the use of ITNs, particularly Long Lasting Insecticide Nets (LLINs). More than 40 field trials in Africa in the past two decades have shown that ITNs reduced overall child mortality by 20 per cent and malaria episodes by 50 per cent. Furthermore, it has also been found that the protective efficacy of ITNs in pregnant women of unknown HIV status was approximately 42 per cent (Brentlinger, 2006). In 2000, two major ITN programmes were initiated in Zambézia and Gaza provinces. These initiatives have expanded over time and by the end of 2005 there were ITN programmes in nine of the eleven provinces of Mozambique. Until 2006, the major thrust of these programmes was the provision through the health system of highly subsidised ITNs (costing about US\$1.25) to pregnant women and children under five years of age. Starting in 2006, the Ministry of Health announced that all ITNs distributed through health facilities will be distributed free of charge.

In 2003, around 18 per cent of mothers aged 15-49 with children under five years of age owned a mosquito bednet (treated or not). The percentage of mothers with bednets was over twice as high in urban areas as in rural, at 28 per cent and 12 per cent respectively. Coverage of bednets varied considerably between provinces, ranging from 9 per cent of mothers with bednets in Manica province to 40 per cent in Gaza province. Of those women owning bednets, 42 per cent had treated nets.

Figure 3.9: Malaria prevention: use of bednet



Source: DHS 2003

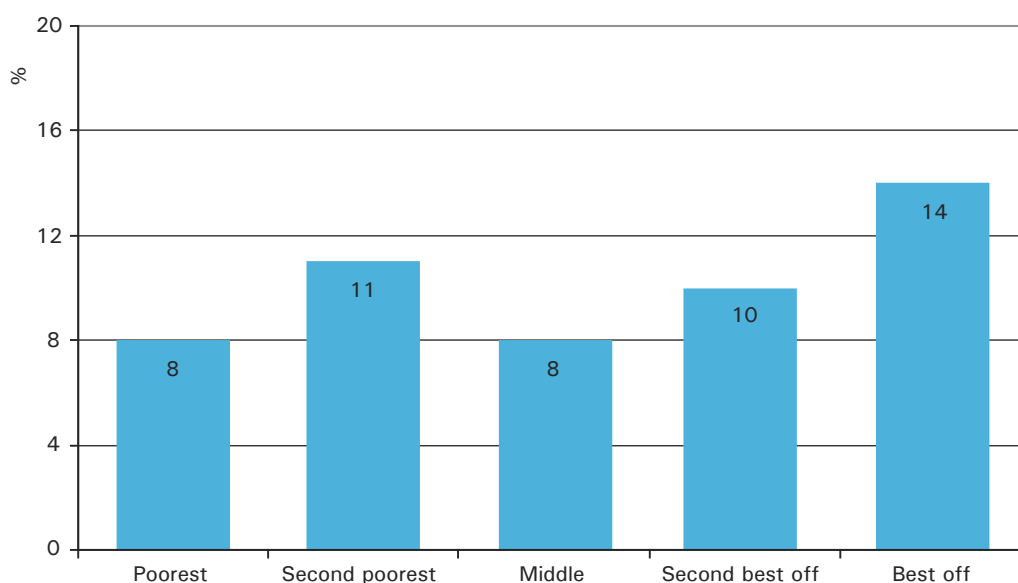
However, the use of bednets remains very low. The 2003 DHS indicated that while 18 per cent of women with children owned a bednet, only 13 per cent of women and 10 per cent of children were using the net (i.e. were reportedly sleeping under the net the night prior to the survey). Disparities between provinces and areas of residence were significant. In rural areas, only 7 per cent of children were using a bednet compared to 16 per cent in urban areas. Use of bednets varied from 22 per cent in Gaza province to only 4 per cent in Sofala province. It is very likely that ITN coverage has significantly increased since the DHS was conducted, as over one million ITNs were distributed across the country in 2004-5.

B. Acute respiratory infection (ARI)

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

According to the 2003 DHS, about 10 per cent of Mozambican children under five years of age had shown symptoms of ARI in the two weeks preceding the survey, with children aged between 6-11 months being the most affected (39 per cent). In contrast to other indicators of child well-being, children from poorer households and those whose mothers had no education were less likely to suffer from the symptoms of ARI than those from better off households and with well-educated mothers. The prevalence of ARI symptoms was 8.4 per cent among children of mothers with no education and 14.6 per cent among children of mothers with secondary level education or higher.

Figure 3.10: Prevalence of ARI among children under five by wealth quintile



Source: DHS 2003

In addition, the level of ARI symptoms among children living in urban areas was higher than among those living in rural areas (12.1 per cent and 8.8 per cent respectively). The percentage of children with ARI symptoms in Maputo City was five times the percentage in Tete. This could be explained by the higher population density in urban areas, as ARI are likely to be spread or aggravated by over-crowded housing, poor quality living environments or pollution. The lower prevalence among children from poorer or less well educated families could therefore be explained by the fact that the majority of more highly educated people are located in urban areas. Children living in urban areas, 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. Children of mothers with secondary level education, for example, were almost 70 per cent more likely to receive treatment than children of mothers with no education.

C. Diarrhoea

Diarrhoea is another major cause of child morbidity and mortality in Mozambique. The problem becomes more frequent in children six months and older, when they begin to crawl and eat complementary food. According to the 2003 DHS, 14 per cent of children under the age of five had experienced diarrhoea in the two weeks preceding the survey. Children 6-11 months were most likely to have had diarrhoea (27 per cent), followed by children in the 12-23 month group (23 per cent). Both boys and girls are affected.

Among children with diarrhoea, only 49 per cent were taken to a health facility for treatment, where 71 per cent were given oral rehydration therapy (ORT) solution, an effective means of treating the dehydration resulting from diarrhoea. 65 per cent of children whose mothers had no formal education were given ORT compared with 97 per cent of children whose mother had secondary or higher education.

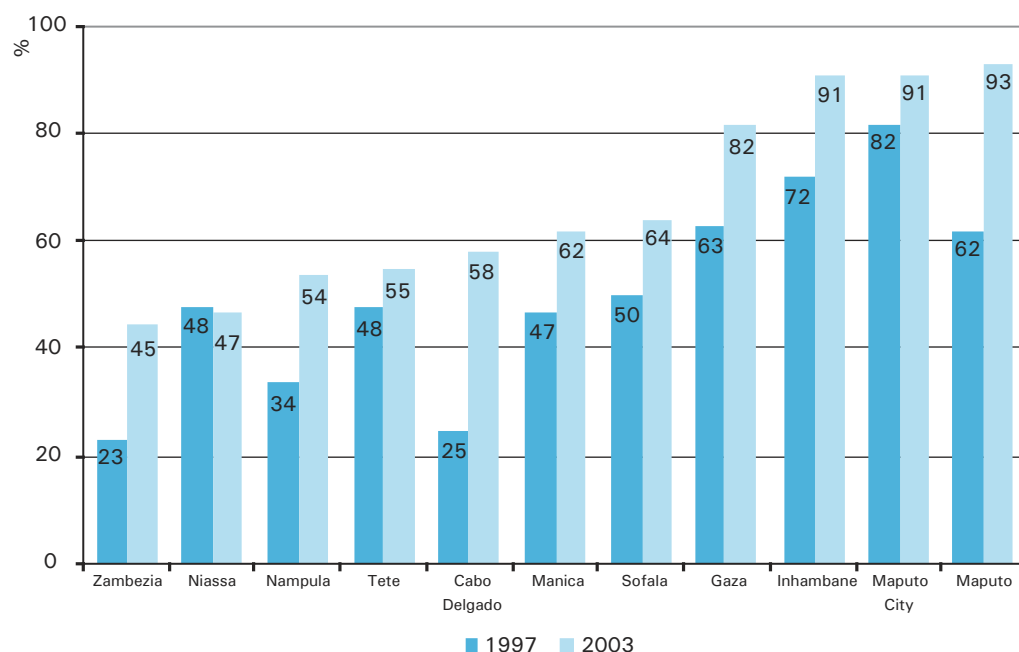
The 2005 Nutrition Survey conducted among 6-59 month-old children in 54 drought affected districts indicated a much higher prevalence than the 2003 DHS, with 37 per cent of children experiencing diarrhoea in the two weeks preceding the survey. As in the DHS, the prevalence of diarrhoea was highest among children aged 6-11 months, at 53 per cent, dropping to 20 per cent amongst children aged 48-59 months in these highest food insecurity districts.

The higher prevalence of diarrhoea found in these districts shows the correlation between drought and diarrhoea. Children living in drought-affected areas are much more likely to experience water-related illnesses, such as diarrhoea, due to increased reliance on unsafe water sources when regular water sources have dried up, as well as an increased likelihood of malnutrition, which increases susceptibility to diarrhoeal diseases. Children suffering from malnutrition (stunting) showed an increased susceptibility to water-borne illnesses, with 51 per cent of children identified as being malnourished experiencing diarrhoea in the two weeks prior to the survey, compared with 37 per cent of non-malnourished children.

D. Vaccine preventable diseases and immunisation

The national Expanded Programme of Immunisation (EPI) for improving immunisation coverage among children against vaccine preventable diseases has made substantial progress in recent years. The proportion of one-year old children fully immunised against the six main vaccine preventable diseases (diphtheria, pertussis, tetanus, polio, measles and TB) has increased from 47 per cent in 1997 to 63 per cent in 2003. With the exception of Niassa province, all provinces show substantially higher coverage than in 1997. The overall improvement noted is attributed to the expansion of static and outreach services, a major increase in the availability of equipment, commodities and vaccines, the strengthening of health staff capacity and case management, and social mobilisation. In terms of individual antigens, the highest coverage is BCG (87 per cent), followed by measles (77 per cent), DPT (72 per cent) and polio (70 per cent).

Figure 3.11: Full immunisation coverage among 1-year old children: comparison between 1997 and 2003



Source: DHS 2003

In general, however, coverage remains low and highly unequal. The 2003 DHS indicated that full immunisation coverage among one-year-old children was 81 per cent in urban areas compared to only 56 per cent in rural areas. As for most child well-being indicators, children in Zambezia province are the most disadvantaged, with coverage of only 45 per cent. Coverage among children of mothers with no education was 49 per cent compared to 98 per cent among children of mothers with secondary education. Children from the poorest households had 45 per cent coverage compared with 90 per cent coverage among children from the best-off households. Among the poorest households, up to 20 per cent of children had never been immunised. In order to correct these striking inequities, the Ministry of Health is planning in 2006 to introduce the Reach Every District approach, which aims at providing immunisation services to children in hard-to-reach and underserved areas through outreach activities and strengthening of routine EPI services in selected districts with low coverage.

The coverage of vaccination against measles and polio substantially improved in 2005 following the implementation of the national immunisation campaign, reaching 95 per cent for each antigen. As a result of the campaign, the number of measles cases reported in the country substantially decreased. It will be essential in the future to strengthen surveillance of measles cases and conduct a follow-up national campaign in 2008 in order to ensure measles control (see Box 3.3: "Combating measles and polio in Mozambique").

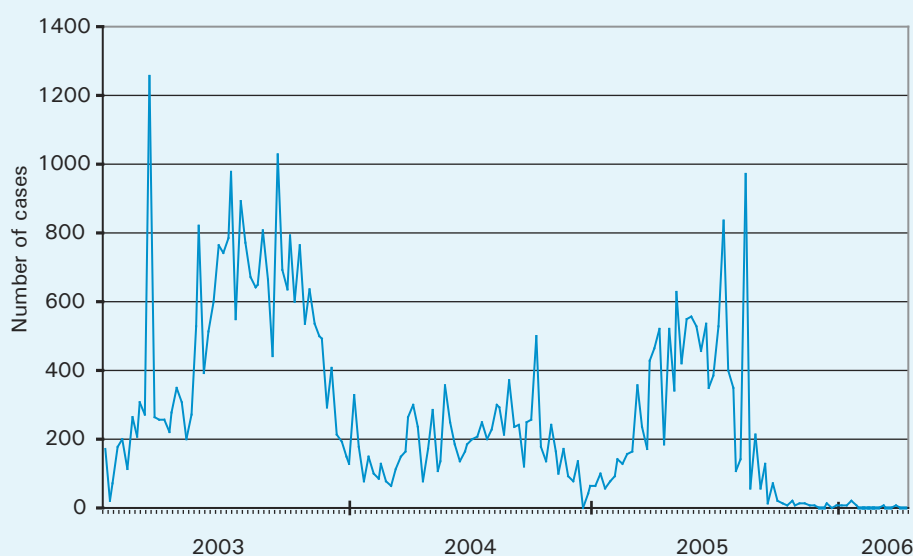
Box 3.3: Combating measles and polio in Mozambique

Measles remains an important cause of mortality and morbidity among children. Mozambique experienced a large epidemic in 2002/2004, with about 45,000 measles cases reported, particularly among children above five years of age. In response to the epidemic and the global measles elimination initiative, in 2005 the Ministry of Health implemented the largest ever nation-wide vaccination campaign. In addition to the immunisation against measles of all children between 9 months and 14 years of age, the campaign also aimed at boosting polio immunisation coverage among under-five children in order to bring Mozambique a step closer to being certified polio free.

The cornerstone of the polio eradication strategy is the maintenance of high levels of routine immunisation coverage with at least 3 doses of oral polio vaccine (OPV) among children under 1 year of age in addition to surveillance and supplementary immunisation activities such as the 2005 vaccination campaign. Routine immunisation rates of less than 90 per cent leave a population at substantial risk of an outbreak in the event of a re-introduction of polio. Even with high routine immunisation coverage, pockets of non-immunized children accumulate, favouring the spread of polioviruses and an eventual polio outbreak. It is therefore essential to ensure that all segments of the population are immunised. In this regard, the administration of polio vaccine as part of the 2005 national vaccination campaign was a key strategy for reaching the many existing pockets of unvaccinated children, particularly in provinces such as Zambezia and Niassa, which in 2003 recorded only 50 per cent and 52 per cent coverage respectively.

The nation-wide vaccination campaign mobilised 40,130 persons, including 4,750 vaccinators working in 2,300 vaccination teams, 800 team supervisors and 14,000 volunteers. Vaccinations were handled at fixed vaccination sites and by mobile teams. In order to ensure that children received two doses of polio vaccination, two rounds were conducted in each of the eleven provinces of the country. During the campaign over 8.1 million children were immunised against measles (9 month-14 years old), over 4.3 million were vaccinated against polio during each round (0-59 months old), and 3.4 million children received vitamin A supplementation (6-59 months). Polio and measles vaccination coverage was 95 per cent among the target population. The campaign also had an immediate impact on reducing morbidity with the number of measles cases sharply decreasing after the end of the campaign in week 37 of 2005 (see graph below).

Figure 3.12: Number of measles cases by weeks for period January 2003 to April 2006



Source: MISAU, 2006

6. Malnutrition

Malnutrition is the main underlying cause contributing to the high level of child mortality in Mozambique. It is also closely linked to future educational outcomes, as malnutrition seriously impacts on the immediate and future cognitive development of the child.

1997 to 2003 represents a period during which Mozambique experienced rapid poverty reduction by both income and non-income measures. Average economic growth was 8 per cent per year, the poverty headcount ratio fell from 69 per cent to 54 per cent and the under-five mortality rate was reduced by 19 per cent. However, over the same period, there was no significant change in the nutritional status of children.

The causes of malnutrition amongst children are interrelated and complex. The immediate causes are related to inadequate dietary intake and diseases. The interaction between the two leads to increased morbidity and mortality. Inadequate dietary intake and diseases in turn are caused by insufficient access to food, inadequate maternal and child caring practices (particularly poor breastfeeding practices), insufficient access to safe water and sanitation and poor health care. HIV infection is also a major cause of failure to grow and of malnutrition among children.

On an individual level, malnutrition places the child at risk of entering a downward spiral of malnutrition and infection. Insufficient dietary intake leads to an immunodeficiency similar to that of HIV and an increased susceptibility to infections. Infections lead to a further reduction in nutrient intake. As a consequence, the child suffers from frequent infections that become progressively more severe and longer lasting. The child fails to regain weight lost during one infection before the onset of the next. This downward spiral increases the child's chances of dying.

The major manifestations of malnutrition are macronutrient deficiencies and micronutrient deficiencies. In order to measure macronutrient deficiencies among children, three standard anthropometric indicators from the 2003 DHS are used: stunting (height-for-age), wasting (weight-for-height) and underweight (weight-for-age). In order to measure selected micronutrient deficiencies (vitamin A, iodine and iron), the results of various studies conducted by the Ministry of Health are used. Poor breastfeeding practices in Mozambique contribute to both macronutrient and micronutrient deficiencies in the young child.

A. Macronutrient deficiencies

(i) Severity level of malnutrition among mozambican children

In order to determine the severity of malnutrition within a population, WHO has established international standards on malnutrition, expressed as the percentage of malnutrition prevalence. The severity of malnutrition has been classified in four levels, from low to very high. When using this classification as a reference, it appears that stunting prevalence among Mozambican children is very high (41 per cent), underweight prevalence is high (24 per cent), and wasting prevalence is low (4 per cent). In rural areas, where about 70 per cent of children live, malnutrition levels are substantially higher than in urban areas, reaching 46 per cent for stunting and 27 per cent for underweight. The high prevalence of stunting and underweight malnutrition have enormous social and economic implications and constitute one of the main challenges for public health interventions in Mozambique.

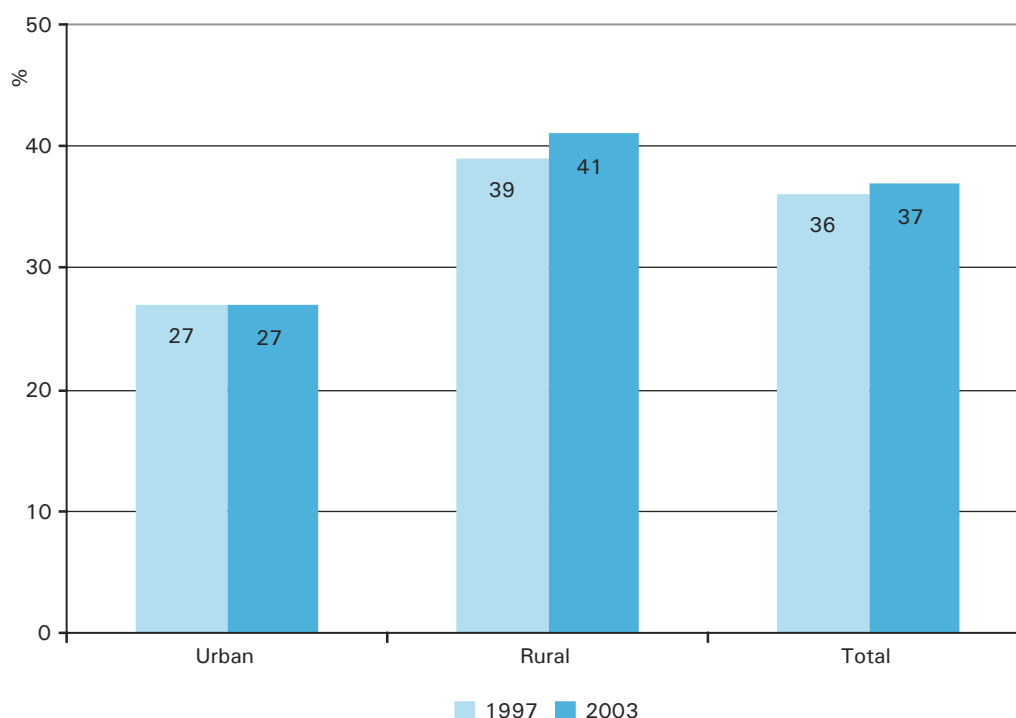
(ii) Stunting prevalence (chronic malnutrition)

Stunting, or chronic malnutrition, defined on the basis of the height to age ratio, shows malnutrition resulting from 'cumulative inadequacies' in the child's nutritional status. Stunting is a good indicator for the general well being of a population, as it reflects the structural context surrounding malnutrition. It is difficult for a child who is stunted at some stage in his or her growth cycle to make up their lost growth and almost impossible for them to catch up completely, as this would need substantial improvement in the child's quality of life. Stunting is also closely linked to impaired mental development.

The national stunting prevalence for Mozambique in 2003 (DHS) was 41 per cent among children aged 0-59 months. This is slightly higher than the average estimated for that year in sub-Saharan Africa (38 per cent, UNICEF 2005). The prevalence of severe stunting was 18 per cent.

Stunting prevalence among children under 3 years of age (0-36 months) has to be used to measure trends over time, as the 1997 DHS only measured malnutrition levels among children in that age group. Comparison between 1997 and 2003 data indicates that the stunting prevalence among children under 3 years of age did not improve and actually slightly worsened in rural areas.

Figure 3.13: Stunting prevalence among children under 3 years of age: comparison between 1997 and 2003



Source: 1997 and DHS 2003

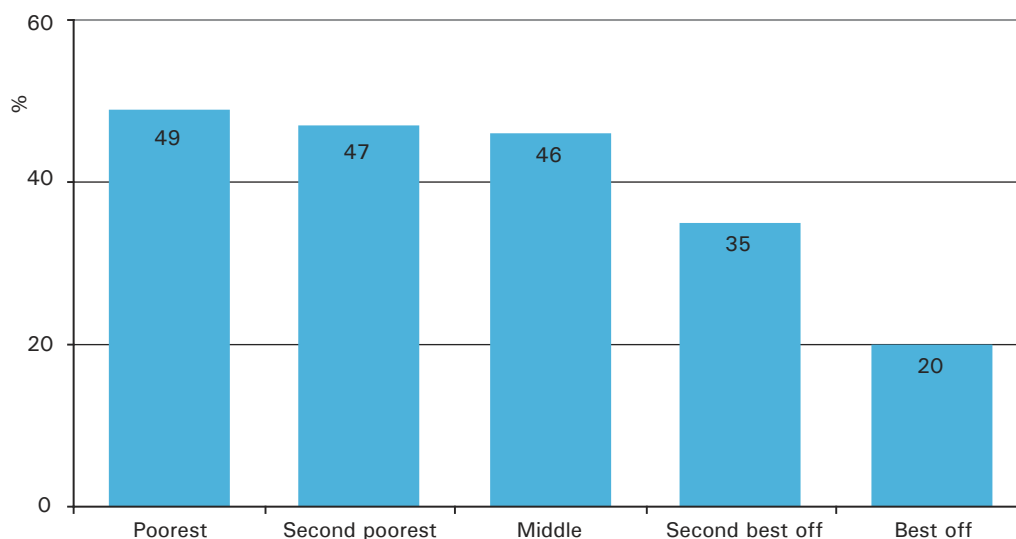
Stunting, both for moderate and severe chronic malnutrition rates, increases with age up to 12-23 months. From the 24th month onwards it remains at stable levels, between 44 per cent and 49 per cent. This is because during the first months of life the nutritional demands of the child can still be met with breast milk. With increasing age, poor quality complementary feeding practices and frequent exposure to illness lead directly to impaired growth. In the absence of adequate feeding and care practices, the accumulation of deficits over an extended period of time will result in children with lower height than expected for their age.

Boys are slightly more stunted than girls (43 per cent versus 39 per cent). This can be partly attributed to the fact that boys have a higher requirement for certain micronutrients such as zinc and are, therefore, more susceptible to these deficiencies. It also suggests that in Mozambique young girls are not discriminated against compared with boys in terms of access to food.

Children living in rural areas show a much higher prevalence of stunting than those living in urban areas, (46 per cent versus 29 per cent). This is largely explained by differences in food availability, monotonous feeds and lower access to health services for rural children. They may also be more likely to experience a reasonably prolonged food deficit at some point in time. Provincial disparities are particularly acute in relation to stunting. Stunting prevalence among under-five children varies from less than 25 per cent in Maputo City and Province to over 55 per cent in Cabo Delgado province. The 1997 DHS recorded rates of stunting for children under 3 years old in Cabo Delgado of 57 per cent, making this the most affected province in the country.

The prevalence of stunting declines as a child's social status and level of schooling increase. However, it is only for the best off children (fifth quintile) that stunting prevalence is significantly lower than national averages. Stunting prevalence among under-five children in the three poorest quintiles varies from 46 per cent to 49 per cent, decreasing to 35 per cent in the fourth quintile and 20 per cent in the fifth quintile. This shows that children have poor nutrition in the overwhelming majority of Mozambican households. The same patterns are observed in relation to education levels. Stunting prevalence varies from 47 per cent among children of mothers with no schooling to 42 per cent among children of mothers with primary level education, but drops sharply to 15 per cent among children of mothers with secondary education.

Figure 3.14: Stunting prevalence by wealth index quintile

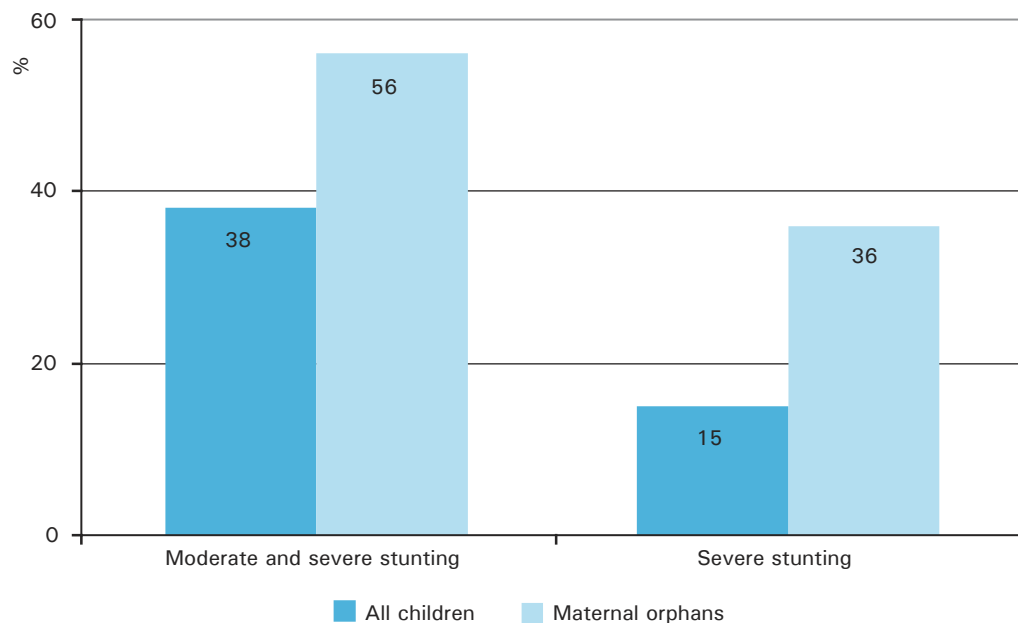


Source: DHS 2003

The persisting high stunting prevalence and the lack of progress made in improving the nutritional status of children highlights the underlying chronic vulnerability to which Mozambican children are exposed. Vulnerability to malnutrition is further exacerbated by the AIDS pandemic and the recurrent droughts that regularly affect areas in the southern and central regions of the country.

Alarming high levels of stunting were found among children whose mother had died (maternal orphans) in the third multi-sectoral Vulnerability Assessment carried out in 2003 in 29 selected districts with high levels of food insecurity and high HIV/AIDS prevalence (SETSAN, UNICEF, Pierre Martel, 2003). The assessment revealed that maternal orphans were 50 per cent more likely to be chronically malnourished than the general child population. Levels of severe stunting were more than double for maternal orphans compared with other children (36 per cent versus 15 per cent). Children whose father had died (paternal orphans), on the other hand, did not appear to be more vulnerable than other children with regard to levels of stunting. Unfortunately, the DHS of 2003 only measured the nutritional status of children whose mothers were alive, therefore preventing further confirmation of the pattern observed in the 2003 vulnerability assessment.

Figure 3.15: Vulnerability to chronic malnutrition among maternal orphans



Source: SETSAN/UNICEF/Martel 2003

(iii) Wasting prevalence (acute malnutrition)

Wasting or acute malnutrition, defined on the basis of weight to height, shows malnutrition resulting from excessive loss of weight that occurred in a recent period due to severe illness or lack of food. This indicator is particularly dynamic, as it is very sensitive to seasonal variations and changes in the child’s environment. In 2003, the DHS indicated that wasting prevalence among children under the age of five was 4 per cent. There were no differences between wasting prevalence in boys and girls and little difference according to area of residence (3.1 per cent in urban area versus 4.3 per cent in rural areas). Wasting was significantly higher among children in the poorest households (5.6 per cent) than among children in the best off households (2.5 per cent). Provincial variations were important, with wasting prevalence as high as 7.6 per cent in Sofala province and as low as 0.5 per cent in Maputo province.

The prevalence of acute malnutrition increases steadily during the first two years of life and only decreases after 24 months of age. This is explained by poor breastfeeding and feeding practices in Mozambique. Breast milk is complemented, or even replaced by foods of inadequate nutrient content, usually at far too early an age.

The prevalence of wasting does not reach the proportions of stunting and underweight, but, given its close association with morbidity and mortality, is elevated enough to be a public health concern. For example, acutely malnourished children are 20 to 40 times more likely to die during an episode of persistent diarrhoea, and 4 to 10 times more likely to die during an episode of acute diarrhoea. Wasting prevalence found by other nutritional surveys conducted by SETSAN as part of the Vulnerability Assessment in drought affected areas all indicated moderate or low levels of wasting (6.4 per cent in November-December 2002 in six provinces, 4.3 per cent in May-June 2003 in six provinces and 4.7 per cent in October 2005 in ten provinces). However, all the evidence shows that there are pockets of the country with a high prevalence of wasting, particularly at the time of the pre-harvest season.

The October 2005 nutrition survey in drought-affected areas indicated that the highest wasting prevalence was in Zambezia province (6.9 per cent). High wasting prevalence was strongly linked to dietary intake and the prevalence of diarrhoea. The survey indicated an overall wasting prevalence of 8.8 per cent among children who had not had any food during the 24 hours prior to the survey compared to 3.8 per cent among children who had food made up from three different nutritional groups.³⁶ Furthermore, wasting prevalence among children who had experienced a recent episode of diarrhoea was 6.5 per cent compared to 3.7 per cent among children without a recent episode of diarrhoea (MISAU/SETSAN 2005).

As with other forms of severe malnutrition, wasting is also strongly associated with AIDS and is a common clinical manifestation of HIV/AIDS in children. For example, screening of 573 malnourished children hospitalised in Beira in Sofala province between January-June 2005, which has the highest HIV prevalence in the country, found that 55 per cent of the children were HIV-positive.

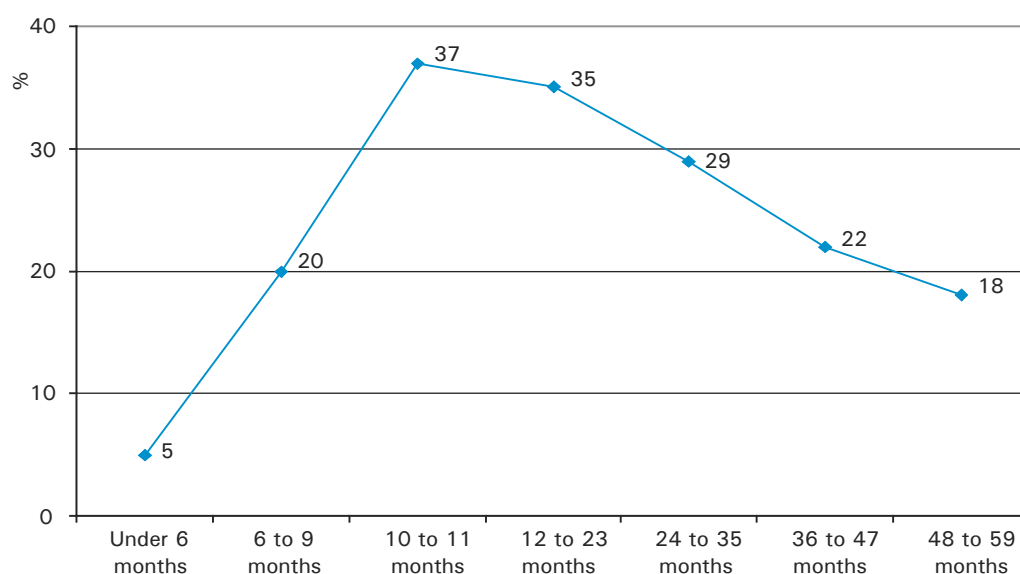
(iv) Underweight prevalence

Being underweight, defined on the basis of weight for age, shows past nutritional or health deficits experienced by a child, in a similar way to stunting. Comparison between 1997 and 2003 indicates that the underweight prevalence among children under 3 years of age remained stagnant at 26 per cent, with an improvement in urban areas (from 20 per cent to 16 per cent) and a slight worsening in rural areas (from 28 per cent to 30 per cent). The lack of progress in reducing underweight prevalence led the Government in its 2005 Report on the Millennium Development Goals to report that it was unlikely that Mozambique will meet the MDG target of reducing underweight prevalence by half (GoM/UN 2005).

Underweight levels by age group are highest at ages 10-23 months, slowly decreasing after that age. However, similarly to stunting and wasting, underweight prevalence indicates high levels of malnutrition amongst Mozambican children. Boys are slightly more underweight than girls. Children living in rural areas are almost twice as likely to be underweight as those living in urban areas (27 per cent against 15 per cent among under-five children), and children in the poorest households are more than three times as likely to be underweight as children in the best off households (31 per cent against 9 per cent among under-five children). Provincial disparities in terms of underweight prevalence are particularly acute, with children in Cabo Delgado being four times more malnourished than children in Maputo City.

³⁶ Nutritional groups are carbohydrates, fats and sugars, proteins, vitamins and minerals.

Figure 3.16: Underweight prevalence by age-group



Source: DHS 2003

Box 3.4: Comparing children's nutritional status over time

In comparing children's nutritional status over space and time it is essential to compare like with like. In Mozambique this is complicated by subtle differences in demographics and survey implementation. Simler and Ibrahim (2005) examine four different surveys (1996/97 IAF, 1997 DHS, 2000/01 CWIQ and 2003 DHS) and find three key differences between the samples:

- 1. The age distributions:** The prevalence of stunting (low height-for-age) and underweight (low weight-for-age) are highly correlated with age because they are cumulative processes. This means that if age distributions differ between surveys, they are no longer directly comparable. This is the case between the 1997 DHS, which only collects data for children below 36 months, and the other three surveys, which collected data up to 60 months.
- 2. The correlation of incomplete data with household economic status:** To produce accurate child nutrition data it is crucial to know the child's age to at least the nearest month, usually using a health card or birth certificate. Without this information, stunting cannot be calculated and the child is left out of the analysis. Since poorer and older children are less likely to have adequate documentation of their date of birth, they are underrepresented in the analysis of stunting, thereby tending to underestimate the prevalence of stunting and underweight. If this bias changes over time it undermines inter-survey comparisons.
- 3. Changes in child mortality:** Obviously, measurements are only available for surviving children. Reductions in child mortality therefore make more children eligible for measurement and also probably change the characteristics of those survivors (i.e. there are more "survivors" in the more recent samples, who in the past would not have survived). This effect undermines comparability between surveys.

The authors, controlling for these factors, show that there has been a more positive change in the nutritional status over time than the uncorrected data. Stunting amongst children of 0 – 59 months in particular is adjusted down from 41% to 38% in the DHS 2003 (thereby bringing it into line with the average for sub-Saharan Africa). The adjusted data are presented in Annex V. Overall, the authors still find that changes in child malnutrition are very small in comparison to recent gains in economic growth and poverty reduction.

B. Micronutrient deficiencies

The other major manifestation of malnutrition in Mozambique is micronutrient deficiency. The lack of two minerals (iodine and iron) and one vitamin (vitamin A) plays a particularly important role in these deficiencies.

(i) Iodine deficiency

Iodine deficiency remains the single greatest cause of preventable brain damage and mental retardation worldwide. Iodine Deficiency Disorders (IDDs) can lead to increased rates of stillbirths, congenital abnormalities, cretinism, psychomotor defects and neonatal mortality. In children and adolescents the effects are manifested as goitre, hypothyroidism, impaired mental function, and retarded mental and physical development. In addition, iodine deficiency can lead to a diminished capacity to learn. Milder IDD in a community means that many children without outward signs of disabilities will suffer learning problems and do poorly in school.

All studies conducted in Mozambique indicate that IDD is a serious public health problem. The October 2004 national survey of iodine deficiency among primary school children indicated that the overall prevalence of goitre among children was 15 per cent. Niassa showed the highest rates (36 per cent), followed by Zambézia and Nampula (both 24 per cent), and then Tete (11 per cent). Even the city of Maputo indicated a prevalence of 10 per cent of goitre. While there were no significant differences among boys or girls and areas of residence, the difference between populations living at an altitude of 2000 feet (610 m) or above, in relation to those living at a lower altitude, was highly significant (23 per cent versus 13 per cent, respectively). Soil at high altitude is known to be poor in iodine, which in turn leads to a child's diet being poor in this micronutrient, unless he or she is eating salt enriched with iodine (MISAU 2006).

Measuring urinary iodine provides more reliable information than measuring the prevalence of goitre when estimating the extent of iodine deficiency. The estimated national median of urinary iodine is 60µg/L, which classifies Mozambique overall as mildly deficient in iodine (2004 national study). Among primary school children, the survey indicated that 42 per cent had levels of urinary iodine below 50µg/L (moderately deficiency), while 12 per cent has less than 20µg/L (severe deficiency). Three provinces had average results below 50µg/L: Niassa (37µg/L), Zambézia (47µg/L) and Nampula (47µg/L). Here again, the differences between boys and girls and between age groups are small. However, rural areas show much lower levels of urinary iodine (54µg/L) than the urban areas (90µg/L).

Given that the vast majority of Mozambican households have and use salt (over 90 per cent according to the 2003 DHS), the most cost-effective and efficient way to prevent IDD among the child population is to ensure that the salt children eat contains iodine. In January 2000, the Government passed a ministerial diploma (Diploma Ministerial n.o. 7/2000) making it obligatory for all salt produced, commercialised and imported in Mozambique for human consumption to be iodised with an iodine level of 25 and 55 parts per million (ppm). Furthermore, in order to encourage the production of iodised salt in the country, a decree was adopted by the Government in December 2001 (decree 41/2001) to exempt all iodised salt producers from purchase tax.³⁷ Due to its geographical location with long coastal areas, Mozambique has a salt production capacity estimated at 195,250 tons per year, which is sufficient to meet the internal need and produce salt for exportation.

³⁷ It should be noted that, beside the promotion of iodisation of salt, the Ministry of Health is planning the distribution of iodised oil capsules to children and pregnant women in high IDD prevalence provinces in order to reduce the high level of iodine deficiency.

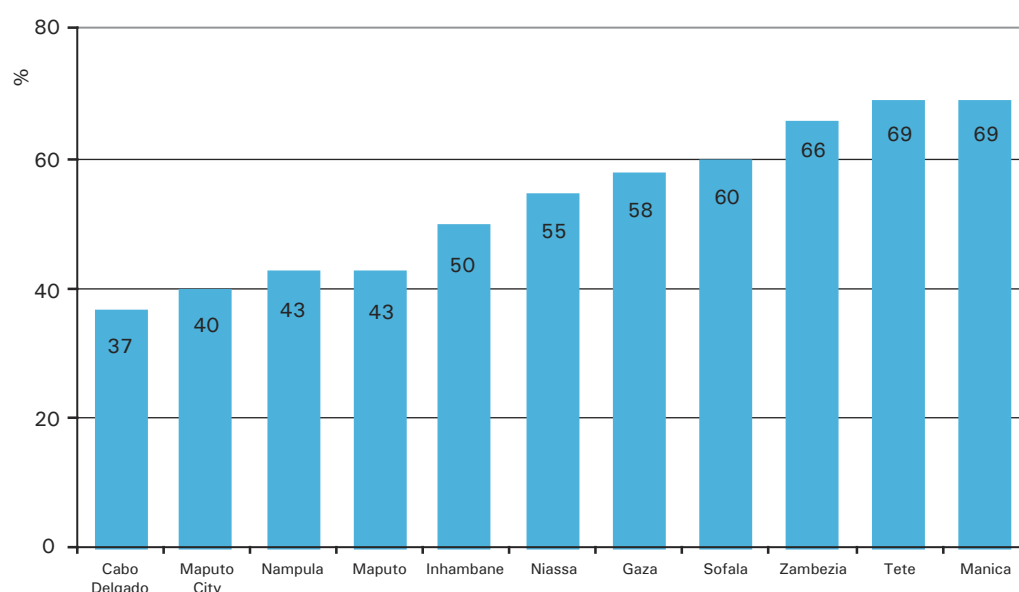
There are 86 known salt producers registered in the country, about half of whom are small scale producers with a capacity less than 1,000 tons per year. The biggest production capacity of individual producers is found in Nampula, Inhambane and Maputo provinces (10,000 tons or more per year per producer). Latest available data for 2005 indicate that Mozambique produced 75,800 tons of salt (just over a third of its capacity) and that iodised salt accounted for only 44 per cent of the total production (or 33,500 tons of iodised salt produced in 2005) (National Programme of Iodised Salt, 2006).

The lack of equipment and poor infrastructure among the salt producing plants is one of the main reasons for this low level of iodised salt production. In addition, despite the 2001 decree on exemption from purchase tax, there are not enough incentives for the salt industry to comply with the 2000 Bill. For example, the import of potassium iodate, which is a necessary product for the iodisation of salt, is still subject to import tax and purchase tax. This discourages many small scale producers from importing potassium iodate. The production costs of washed, refined, packaged and iodised salt are also high in Mozambique. For the Mozambican consumer, price, not presence of iodine, is the main motivating factor in deciding what type of salt is bought in the market.

Data also indicate that in some regions of the country most of the locally-produced iodised salt is exported and therefore not available on the local market for consumption in Mozambican households. For example, one of the biggest producers of iodised salt in the country is located in Nacala, in Nampula province. This plant produces on average 19,000 tons of iodised salt per year, of which 75 per cent, or about 14,000 tons, is exported to Malawi (National Programme of Iodised Salt, 2004).

Thus, universal access to iodised salt has not been achieved in Mozambique. In 2003, the DHS indicated that only 54 per cent of sampled households with salt were using iodised salt.³⁸ In other words, at national level around half of households have salt that if iodised adequately could prevent the occurrence of iodine deficiencies. Mozambique falls below the average iodised salt consumption recorded in Sub-Saharan Africa of 67 per cent in the same period (UNICEF 2005).

Figure 3.17: Households consuming iodised salt



Source: DHS 2003

In general, the coastal provinces make the least use of iodised salt and the interior provinces (with the exception of Niassa) make the most use of iodised salt. The relatively high level of iodised salt consumption in Tete and Manica provinces might be related to the proximity of these provinces to transport corridors bringing imported iodised salt from Botswana and South Africa.

The use of iodised salt is slightly higher among rural households (55 per cent) than urban households (50 per cent). The low use of iodised salt in Maputo City (40 per cent) indicates the lack of awareness among the population about the benefits of iodised salt. The DHS results show very little variations between the poorest and best-off households in terms of use of adequately iodised salt. The probability of encountering adequately iodised salt is only slightly higher among the best-off households (58 per cent) than the poorest households (51 per cent). Non-iodised salt is usually slightly cheaper than iodised salt. However, in Maputo City where 93 per cent of households fall within the best off quintile, it could be expected that households could afford the price difference and would change their salt purchasing habits, if aware of the benefits of iodised salt.

(ii) Vitamin A deficiency

Vitamin A improves children's resistance to infection such as diarrhoeal diseases, ARI, measles and malaria. Severe Vitamin A Deficiency (VAD) can lead to poor eyesight and blindness. In 2002, the National Survey on Vitamin A Deficiency and Anaemia indicated that 69 per cent of children 6-59 months were suffering from vitamin A deficiency, 14 per cent in a severe form. Thus, VAD constitutes a serious public health problem, particularly as it is associated with increased susceptibility to several types of infectious diseases, which in turn impacts on infant mortality (MISAU 2002). For example, the 2002 national survey indicated the prevalence of vitamin A deficiency in anaemic children (75 per cent) was significantly higher than in those without anaemia (50 per cent). These vitamin A deficient children also showed a significantly higher risk of being infected with the malaria parasite.

High-dose vitamin A supplementation is one method of improving the vitamin A status of children and women. Because breastfeeding is critical for the vitamin A status of infants, the provision of vitamin A supplementation to new, breastfeeding mothers (up to 8 weeks post-partum) helps protect the infant during the first months of life, when the risk of mortality is at its highest. Since March 2002, a programme of vitamin A supplementation was introduced as part of the routine child health consultations and in the mobile health teams for EPI. That same year, post-partum Vitamin A supplementation was introduced in Maputo province and was later extended in 2004 to maternity clinics in provincial capitals and to some maternity clinics in rural hospitals. The Mozambican national protocol of high-dose vitamin A supplementation recommends that children from 6 to 59 months receive supplementation of vitamin A every 6 months and women post-partum receive one dose of vitamin A within 6 weeks of delivery.³⁹

In 2003, the DHS reviewed vitamin A supplementation coverage among children and women. It indicated that 50 per cent of children received vitamin A supplementation in the six months prior to the survey.

³⁸ It is not clear from the 2003 DHS report whether the salt tested in households was tested for adequacy level of iodine (i.e. minimum of 25 parts of iodine per million according to the national standards). This analysis therefore uses the expression "use of iodised salt" rather than "use of adequately iodised salt".

³⁹ High-dose of vitamin A for children 6-11 months old is 100,000 IU, while it is 200,000 IU for children 12-59 months old and post-partum women.

Among children, there were no variations in the coverage according to gender but important variations according to area of residence. In urban areas, 65 per cent of children aged 6-59 months had received vitamin A supplementation, compared with only 43 per cent among children in rural areas. Provincial disparities were also acute, with 77 per cent coverage in Maputo City compared to only 37 per cent in Niassa province.

In Mozambique, the significant variations observed by the 2003 DHS between the coverage of Vitamin A supplementation correlate with household wealth levels and with mothers' level of education. Only 39 per cent of children from the poorest households received vitamin A supplementation compared to 70 per cent among children from the best-off households. The immediate cause of this disparity is the lower access among poorer children to health facilities. It is very likely that the national immunisation campaign against measles conducted between August and October 2005 in all provinces of the country, which also included vitamin A supplementation for 6-59 month-old children, substantially reduced the disparities recorded in the 2003 DHS. The October 2005 nutritional survey conducted by the Ministry of Health as part of the Vulnerability Assessment in drought affected districts indicated almost universal coverage with 96 per cent of children reporting having received vitamin A supplementation in the six months prior to the survey. All provinces indicated coverage above 90 per cent (the lowest being Niassa with 92 per cent coverage and the highest being Cabo Delgado with 98 per cent coverage) (MISAU/SETSAN 2005).

The campaign-based approach such as the 2005 nationwide immunisation campaign is therefore a powerful vehicle to addressing issues of disparity and inequity, in addition to ensuring very high coverage. The main limitation, however, is that children need two doses of vitamin A each year. A campaign-based approach is difficult and costly to sustain. In addition, because the causes of vitamin A deficiency are diverse, interventions should also be targeted through channels other than routine services and campaign activities. For example, immediate reasons for a child to be deficient in vitamin A are low vitamin A levels in the mother's breast milk and low consumption of vitamin A rich foods. Food-based approaches such as food fortification with vitamin A, cultivation and consumption of vitamin A-rich foods such as orange sweet potatoes, and nutrition education are the preferred long-term strategies to improve the vitamin A status of children and women.

(iii) Anaemia and iron deficiency

Iron deficiency is the major cause of anaemia (causing 50 per cent of anaemia worldwide), and remains one of the most severe and important nutritional deficiencies in Mozambique today, thus constituting a serious public health problem. The World Health Organisation lists iron deficiency as one of the top risk factors for "lost years of healthy life" in developing countries. Severe iron deficiency causes iron deficiency anaemia, which impairs the cognitive development of children from infancy through to adolescence. Anaemic infants and children grow more slowly than those who are not anaemic and are apathetic, anorexic and without energy. Anaemia has multiple causes, including, in order of importance, iron deficiency caused by poor dietary intake and quality, diarrhoea, malaria, helminth (worm) infections, chronic diseases such as TB, and HIV/AIDS.

Until six months of age, normal weight healthy infants who are born to healthy mothers and are exclusively breastfed receive enough iron from their own stored iron and from breast milk. After six months, a growing 6-14 month old child, who has high iron needs, quickly becomes iron deficient, when their own stored iron is exhausted and if they are fed unfortified and inadequate complementary foods without sufficient iron. Iron supplements provided after 24 months may not correct the cognitive impairment suffered during this crucial early period in life. Low birth weight infants, premature babies, non-exclusively breastfed infants and infants of mothers with anaemia need additional iron from about 2 months of age.

The Ministry of Health 2002 National Survey on Vitamin A Deficiency and Anaemia found that, overall, 75 per cent of children suffer from anaemia, 7 per cent in a severe form. Anaemia is significantly more frequent in younger than in older children ((89 per cent in 6-23 months compared with 67 per cent in 24-59 months). Rural areas are also more affected than urban areas (81 per cent and 67 per cent respectively). As expected, iron deficiency is also strongly associated with anaemia, 90 per cent of iron deficient children being anaemic, compared with 66 per cent for children without iron deficiency. The survey also indicated that 36 per cent of children were suffering from iron deficiency, with a higher prevalence in younger children than older children (50 per cent among 6-23 months compared with 21 per cent among 24-59 months). A clear link between anaemia and iron deficiency was established, with a 14 per cent prevalence of iron deficiency in children without anaemia, against 44 per cent in those with anaemia (MISAU 2002). The study also found that children with anaemia present a much higher prevalence of *Plasmodium falciparum* malaria (50 per cent) than children without anaemia (17 per cent). There are currently no iron supplementation or deworming programmes for the high risk group of children under two years of age in Mozambique.

C. Breastfeeding practices

Mothers' practices related to infant and child feeding have an important bearing on the nutritional status of young children, both in terms of macronutrient and micronutrient deficiencies. Breast milk provides a complete source of nutrition during the first six months of life, fulfils half of the child's nutritional requirements during the second six months of life and one-third of requirements in the second year of life.

Overall, the benefits of breastfeeding, both for the child as well as for the mother, are well known and widely documented. However, breastfeeding is a risk factor for HIV transmission from a sero-positive mother to her child (see Box 3.5 on "Infant feeding in the context of HIV/AIDS"). Among the most important benefits of breastfeeding for infants in developing countries are the reduction of the incidence and severity of diarrhoeal diseases during the first year of life, reduction of the risk of respiratory infections, improved neurological development and improved protection against a number of chronic diseases in later life. Breastfeeding is also important in bonding between mother and child. Infants who are not breastfed at all are at much higher risk of dying, particularly due to diarrhoea, than breastfed children. Optimal infant and young child feeding can reduce child mortality by nearly 20 per cent, according to the Lancet Child Survival series.

Box 3.5: Infant feeding in the context of HIV/AIDS

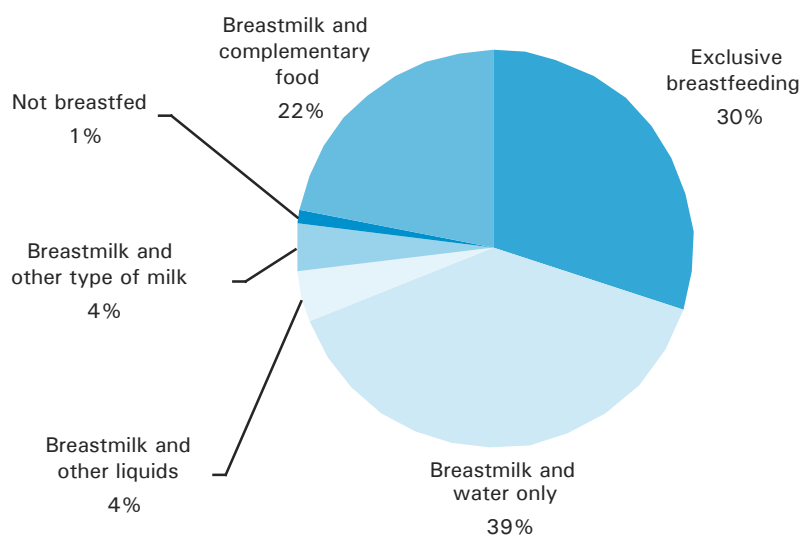
In 2004 - 2005, a revised Policy on Infant and Young Child Feeding in the Context of HIV/AIDS was developed. The new policy is based on a consideration of the balance of risks for a child in the context of Mozambique. Risks of HIV infection, taking into account the national HIV prevalence rate, are weighed against risks of infant mortality in order to design the best approach for the country. The timing and risks of HIV transmission in the absence of interventions are as follows:

Modelling of how the safest infant feeding option changes with level of infant mortality shows that where infant mortality is over 100 per 1,000 live births, such as in Mozambique, replacement feeding from birth gives the worst HIV-free survival. All types of breastfeeding patterns result in higher HIV-free survival, even usual breastfeeding to 24 months with no intervention. Individual risks of HIV transmission of course vary depending on the health status of the mother and related conditions. The PMTCT programme counsels mothers on options for feeding their infant. The Mozambican policy states that only when replacement feeding is acceptable, feasible, affordable, sustainable and safe, should avoidance of all breastfeeding by HIV positive women be recommended. For HIV positive women who choose to breastfeed, exclusive breast-feeding during six months is recommended; then breastfeeding should be discontinued as soon as feasible, to minimise the risk of HIV transmission to the child.

Mixed feeding carries the greatest risk of HIV infection, with early mixed feeding having the worst prognosis – mixed feeding before the age of 3 months in infants born to HIV positive mothers is associated with a fourfold greater risk of postnatal transmission at 6 months compared to exclusive breastfeeding (Ilfiff 2005). This is due to the greater chance of breast milk transmission when breasts are infected with mastitis and abscesses caused by breasts not being completely emptied and to increased risk of morbidity due to diarrhoea. For children exclusively breastfed in the first months of life, the transition period to replacement feeding must be shortened as much as possible to minimize the risk. However, many women in Mozambique may not be able to implement this rapid transition effectively due to socio-economic constraints, including fear of stigma. Exclusive breastfeeding protective effects are still significant at 18 months with approximately 60% reduction in postnatal transmission as compared to mixed feeding (Ilfiff 2005).

In general, international best practice recommends that children begin breastfeeding during the first hour of life, continue to exclusively breastfeed until 6 months of age (thereby protecting them from morbidity and mortality whether or not it is HIV related), start complementary feeding at 6 months while still breastfeeding, and continue to breastfeed up to 2 years of age. The 2003 DHS reveals poor breastfeeding practices among Mozambican women with only 30 per cent of children exclusively breastfed during the first six months of life. Exclusive breastfeeding is higher in rural areas (32 per cent) than in urban areas (25 per cent). Exclusive breastfeeding practices vary to a great extent according to where a woman lives. In Tete and Nampula, only 6 per cent and 7 per cent of children respectively are exclusively breastfed during the first six months of life compared to 55 per cent in Sofala province.

Figure 3.18: Feeding practice among children under six months of age



Source: DHS 2003

Although the vast majority of children are breastfed, with 92 per cent of mothers initiating breastfeeding during the first day of life, the rate of abandoning exclusive breastfeeding is very high. By three months of age, only 38 per cent of infants are exclusively breastfed. Liquids other than breast milk and solid/mushy food are introduced far too early in the feeding of Mozambican children, which, given poor dietary habits, food availability and unhygienic preparation of foods, increases the child's vulnerability to infections and places the child at much greater risk of entering the vicious malnutrition-infection cycle. For example, by three months of age, 42 per cent of children are already given water and 11 per cent already receive solid/mushy food. Many infants also receive various types of traditional medicines. By the age of 6-9 months, three quarters of infants received cereal-based food, around a third received fruits and leafy foods and only 6.1 per cent received vegetables and 10 per cent animal protein. 25.9 per cent were reported to consume vegetables and fruits rich in vitamin A. This indicates that the quality of weaning diet is inadequate for good physical growth and cognitive development of the child and is clearly related to the lack of progress in anthropometric measures such as stunting, despite the recorded reductions in poverty levels.

While breastfeeding should continue up to the age of 23 months, more than one third of children aged 20-23 months are not breastfed, which might result in depleted vitamin A stores. The proportion of children 20-23 months who are still receiving breast milk in addition to family foods (complementary breastfeeding rate at 20-23 months), is only 63 per cent. This rate varies from 45 per cent in urban areas to 70 per cent in rural areas. In Maputo City, mothers stop breastfeeding earliest, with only 37 per cent continuing to breastfeed their children at 20-23 months, compared to over 75 per cent in the three Northern provinces of the country (Niassa, Cabo Delgado and Nampula).

The current nutritional situation of Mozambican children indicates the failure to implement the Food and Nutrition Security Strategy, which was approved by the Council of Ministers on 23rd December 1998 (Council of Minister Internal Resolution No. 16/98). In 2005, the multi-sectoral Technical Secretariat for Food and Nutrition Security (SETSAN) undertook an evaluation of the implementation of the Strategy, which contributed to increasing the focus of the Government on the issue of food security and nutrition (SETSAN 2005). As a result, food security and nutrition featured

highly in PARPA II, which sets a target of reducing underweight prevalence among children to 17 per cent by the year 2009. What remains outstanding, however, is to operationalise and give authority to the multisectoral strategy. The SETSAN evaluation revealed that many sectoral Ministries have not integrated food security and nutrition into their own sectoral strategies.

The stagnation in levels of malnutrition among children led the Ministry of Planning and Development to comment in its June 2005 paper on the subject that, "A key policy question is therefore how to translate the economic gains that are being made into improved nutrition and health. In a multi-country analysis Haddad et al. (2003) found that although economic growth alone would not be sufficient to meet targets for reducing undernutrition, it could be expected to contribute much more than what has been observed with the Mozambican data. This presents two challenges for policy makers and programme managers in Mozambique. First, how can the link between reducing income poverty and reducing undernutrition be strengthened, and second, what are the most cost-effective direct investments that can be made to improve children's nutritional status above and beyond what can be achieved through income growth. A first cut would likely include greater attention to intra-household distribution of resources, promotion of nutrition education programs (particularly for feeding of those less than two years old), accelerated progress in disease control (especially diarrhoea and malaria), and improved access to primary health care" (Simler & Ibrahim, 2005).

7. HIV/AIDS

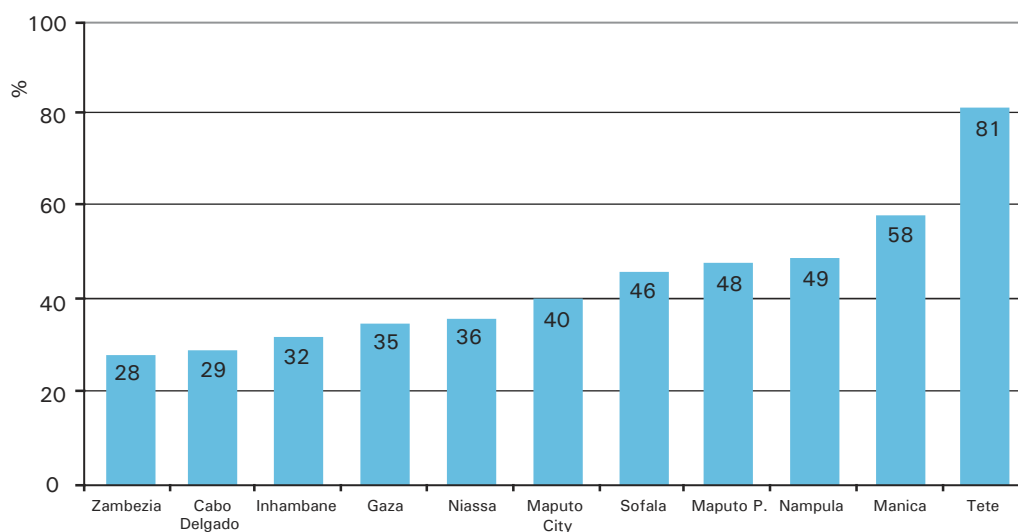
By 2006, over 1.6 million Mozambicans were estimated to live with HIV or AIDS, of whom 58 per cent were women and 5 per cent were children under five years of age. AIDS is fast becoming a major cause of mortality among children, with an estimated 20,000 children under five dying from AIDS in 2006 (Multisectoral Technical Group for the Fight against HIV/AIDS, 2004).

A. Prevention of mother to child transmission (PMTCT)

Globally, each year 700,000 children under 15 years of age are infected with HIV. More than 9 per cent of paediatric HIV infections are due to mother-to-child transmission (Duerr, 2005). It is estimated that there were about 146,000 HIV-positive pregnant women in 2006 in Mozambique, almost half of whom lived in the four central provinces of the country. In the absence of preventive measures, transmission rates are as high as 40 per cent, with up to two-thirds of the infections occurring during labour, birth and pregnancy and one third occurring during breastfeeding.

Level of knowledge among the Mozambican population about mother-to-child transmission of HIV remains low. The 2003 DHS indicated that only 44 per cent of women and 43 per cent of men in the age group 15 to 49 had knowledge that HIV can be transmitted from mother to child during pregnancy, delivery, and breastfeeding. Knowledge among women greatly varied across provinces, from as low as 27 per cent in Cabo Delgado province to as high as 79 per cent in Tete province. Knowledge was significantly lower among women in rural areas, women with no education and women in the poorest households. While knowledge across age groups does not vary significantly, it is the lowest among young women of 15 to 19 years of age (41 per cent). Counselling among pregnant women about HIV/AIDS during ante-natal care visit also remains low at 51 per cent, with acute disparity across provinces, varying from only 27 per cent in Zambezia province to 81 per cent in Maputo City.

Figure 3.19: Knowledge of mother-to-child transmission of HIV among Mozambicans (15-49 years of age)



Source: DHS 2003

A series of interventions are available to prevent HIV transmission from mother to child. In Mozambique, the most commonly used protocol is single dose Nevirapine (sdNVP) given to the mother at the onset of labour, and to the baby no later than 72 hours after birth. This protocol reduces the risk of transmission from mother to child by more than 40 per cent (to 10-15 per cent).

Since the establishment of a national PMTCT programme in 2002, the number of health facilities offering PMTCT services has expanded rapidly, from 8 in 2002 to 113 by mid-2006. However, coverage remains very low and highly unequal. By mid 2006, only about 5 per cent of the total estimated HIV-positive pregnant women in the country received PMTCT prophylaxis (fewer than 6 per cent of pregnant women in sub-Saharan Africa in 2005 were offered services for PMTCT). Most services are still concentrating in and around provincial capitals. Since the start of the national programme until mid 2006, 71 per cent of pregnant women who attended ante-natal care (ANC) in the PMTCT sites accepted counselling and testing for HIV. Of those, 14.5 per cent tested positive. Acceptance of testing is declining. In some provinces, such as Gaza, acceptance of testing was as low as 50 per cent in 2005. This might be explained by a decline in the quality of counselling and the fact that the rapid expansion of sites was not accompanied by a similar expansion in the capacity of the Ministry of Health for close supervision. Another factor which may influence levels of acceptance of counselling and testing is related to high levels of stigma and fear of discrimination. In 2003, the DHS indicated that only 8 per cent of women and 16 per cent of men had an accepting attitude towards those living with HIV.⁴⁰

⁴⁰ "Accepting attitude" is measured as the proportion of respondents who report an accepting or supportive attitude on all the following four component questions: (1) would be willing to care for a family member who became sick with the AIDS virus; (2) would buy fresh vegetables from a vendor whom they knew was HIV-positive; (3) female teacher who is HIV-positive but not sick should be allowed to continue teaching in school; and (4) would not want to keep the HIV-positive status of a family member a secret.

Table 3.3: Overview of PMTCT programme performance between 2002 and 2006

	Total pregnant women attending ANC	Pregnant women counselled and tested	Total pregnant women HIV +	HIV + pregnant women who received ARV prophylaxis	HIV + women who delivered in a health facility	Babies who received ARV prophylaxis
2002	5,685	4,641	951	253	391	328
2003	27,437	24,260	4,273	877	1,428	1,490
2004	65,562	46,583	6,576	3,182	3,002	3,335
2005	158,273	102,116	14,193	7,690	5,754	5,439
2006*	94,916	72,308	10,319	8,728	8,855	5,500
Total	351,873	249,908	36,312	20,730	19,430	16,092

Source: MISAU, 2006

* Data for 2006 are from January to June only

Between the start of the national programme in 2002 and mid-2006, about 54 per cent of the pregnant women that tested HIV positive delivered in a health facility and 57 per cent received ARV prophylaxis, while 44 per cent of their infants received it. The uptake of Nevirapine is improving, from 27 per cent in 2002 to 85 per cent at mid year in 2006. The proportion of children who received Nevirapine in PMTCT programmes and who were subsequently tested at 18 months is only around 8 per cent. Of those, 89 per cent tested negative and 11 per cent tested positive. The status of the vast majority of the children who received PMTCT services is unknown, as the children are lost to follow-up during the 18 months before the HIV antibody test becomes possible.

One of the most important factors associated with increased risk of mother to child transmission is the mode and duration of breastfeeding, together with vaginal delivery and maternal HIV viral load (Lancet, 2006 Feb; Vol 6: 83-90). No data is yet available in Mozambique concerning the percentage of HIV positive mothers who choose replacement feeding over breast milk, or at what point these mothers stop breast feeding. According to health worker reports, however, the vast majority of mothers follow the usual tradition and breastfeed until a child is 18-24 months old, albeit with early cessation of exclusive breastfeeding. Preliminary results of an evaluation of Early Breastfeeding Cessation and Replacement Feeding conducted in 2005 by the Elizabeth Glazer Paediatric AIDS Foundation and Health Alliance International in three provinces of Mozambique indicated that the majority of mothers did not have the means to provide an adequate replacement diet for their babies.

Prioritising access to Highly Active ARV Therapy (HAART) by pregnant women is critical, given the very high risk of post-natal transmission in breastfeeding mothers with low CD4 and high viral load and in the context of the challenges faced by mothers in implementing recommended infant feeding options. Women with CD4 counts less than 200 cells/ μ l are 5 times more likely to transmit HIV during breastfeeding as compared with CD4 counts over 500 cells/ μ l (Iloff, 2005). HAART can further reduce the risk of transmission to approximately 2 per cent, as compared to the more widespread interventions currently used, e.g. single dose Nevirapine (10-15 per cent). Currently, the Ministry of Health policy is that pregnant women with CD4 counts of under 350 are eligible for HAART, as opposed to the standard adult criteria of under 200. However, very few pregnant women are enrolled in treatment centres. In 2005, about 550 pregnant HIV-positive women were enrolled on HAART (out of a total of about 20,000 people on HAART and over 14,000 HIV positive pregnant women tested in PMTCT sites). Increasing enrolment of pregnant and lactating women requires close coordination between PMTCT programmes and ARV treatment sites and the initiation of HAART within PMTCT programmes.

**Box 3.6: PMTCT programme in two cities of Manica and Sofala provinces
(Chimoio and Beira)**

Nine lessons learned from a quantitative and qualitative evaluation

1- Integration of PMTCT services into prenatal and primary care services is crucial. There is no evidence that incorporating PMTCT into normal Maternal and Child Health (MCH) services has diminished the number of mothers seeking prenatal services. On the contrary, the programme has demonstrated increasing programme attendance and adherence over time because women are empowered to make their own choices when PMTCT services are integrated into routine prenatal care.

2- The development of a successful PMTCT programme can be a catalyst to reinforce all components of the MCH programme. Many MCH programme elements are not directly dependant on PMTCT, but because of the increased vulnerability of seropositive mothers, it is imperative that associated services be strengthened. Further integration of PMTCT services should be pursued, including in institutional births, child monitoring, family planning, nutritional counselling, post birth follow-up, and partner counselling.

3- Health facilities and trained health personnel are the single most limiting factor in terms of project expansion. Health facilities and human resources in both cities are insufficient to meet the demands of the population. The shortage is particularly dire for PMTCT services. HIV testing and counselling is a time-consuming procedure. Suggested standards for counselling sessions are 30-60 minutes per patient, with additional duties occurring in prenatal consultations, the maternity clinic and management of positive mothers clubs. Actions must be urgently taken to increase access to services and meet the demand of pregnant women.

4- Ongoing training needs must be regularly addressed. The provision of training is one of the most important functions of national and provincial management. Unless managers, counsellors, MCH nurses, and Day Hospital staff have appropriate knowledge, skills, and attitudes, the PMTCT programme is only partially effective.

5- Information, Education and Communication (IEC) can be a powerful mobilisation tool in increasing uptake of testing and associated PMTCT services. Expansion and standardisation of strategies and messages is needed to support a complete IEC campaign. In order to create motivation to seek follow-up care for mothers and their babies, the programme must develop a communications strategy aimed at developing an accurate perception of risk in men and women. High attendance at positive mothers clubs could be interpreted as evidence of the interest of the population in seeking information, education, and support concerning health care.

6- Stigma and discrimination against seropositive women are important aspects that must be considered in expansion of PMTCT services. Stigma must remain a key issue at all steps of planning and implementation of PMTCT programme. Clear strategies developed in partnership with PLWHA and community-based women's organisations must be explored.

7- Greater partner involvement is essential. The experience of the project demonstrates that the participation of partners is possible; but greater participation must be stimulated through active outreach. A successful partner inclusion strategy must include the involvement of women themselves.

8- Women must be rallied as peer educators and programme advocates. The best mechanism for mobilising women and encouraging adherence to the PMTCT programme is involving women themselves as activists – otherwise the programme runs a great risk of continuing to lose women.

9- Comprehensive monitoring and reporting systems can best illustrate programme successes and ongoing challenges. Identification of programme strengths and weaknesses can only occur with accurate and consistent collection and reporting of data. All project staff, from health workers to supervisors to manager must be included in development and monitoring of data systems

Source: Prevention of Mother-to-Child Transmission of HIV in Manica and Sofala Provinces, A Quantitative and Qualitative Project Evaluation, Sarah Sheldon/DPS Manica and Sofala/HAI/UNICEF, July 2004.

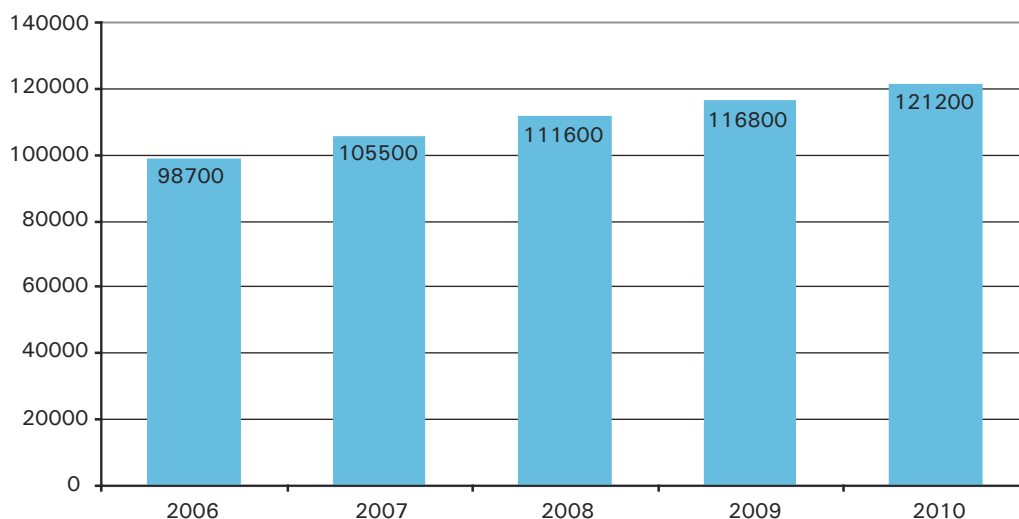
The reduction of mother-to-child transmission of HIV is a key Government priority. The second National Strategic Plan to Fight HIV/AIDS for the period 2005 to 2009 (PEN II) sets out a target of PMTCT coverage of 90 per cent by the year 2009, building on the target established by the Ministry of Health in its HIV/AIDS Strategic Plan of 60 per cent coverage by the year 2008. In PARPA II, the target decreased substantially to 22 per cent by the year 2009, on the grounds that the country did not have the capacity to reach more ambitious targets. This decrease raised many concerns among co-operating partners and civil society organisations, who argued that it was much more cost-effective to accelerate the PMTCT programme and that alternative service delivery systems, notably through NGOs and community based initiatives, could be put in place for reaching more ambitious targets.

However, international experience to date demonstrates that uptake of PMTCT in general averages about 50 per cent, reflecting the need to re-examine the approaches taken and to strengthen links to other health services, in particular reproductive and maternal/child health services. Experience has also shown that the biggest 'point' of drop-out is after counselling and testing, i.e. when it comes to actually taking the intervention. Uniformly, it appears that peripheral health units have a better uptake than larger units, the reasons for this are not very clear. In a country such as Mozambique where less than 50 per cent of women have an institutional delivery, broader health system development, improving access to health care, and access of women to information regarding their health and that of their children, will be imperative to increasing the uptake of an intervention such as PMTCT.

B. Paediatric AIDS

It is estimated that there were about 99,000 children under the age of 15 living with HIV/AIDS in Mozambique in 2006, a number expected to increase to over 121,000 by the year 2010. One in two infected children live in the four central provinces of the country. Among infected children, 80 per cent are children under five years of age. The number of new infections among children has steadily increased over the year, from an estimated 23,400 in 2000 to 37,300 in 2006, representing about 102 new infections every day. Projection indicates that this number will increase to over 40,000 by the year 2010, with 110 children becoming infected each day (Multisectoral Technical Group for the Fight against HIV/AIDS, 2004).

Figure 3.20: Children living with HIV/AIDS: projection until 2010



Source: Multisectoral Technical Group for the Fight against HIV/AIDS, 2004 – figures rounded

More than half of children living with HIV/AIDS in Mozambique probably die before reaching their second birthday. AIDS is fast emerging as a major cause of mortality among children, with an estimated 20,000 child deaths due to AIDS in 2006 (or about 17 per cent of all deaths). In this regard, AIDS is threatening the gains made by Mozambique in recent years for reducing child mortality. It is the single greatest obstacle to meeting the MDG target for child mortality reduction.

While most infection among children occurs through mother-to-child transmission, there are reports from the Paediatric Day Hospital in Maputo that up to 5 per cent of children are infected with HIV through sexual abuse, blood transfusions and contaminated injection equipment.

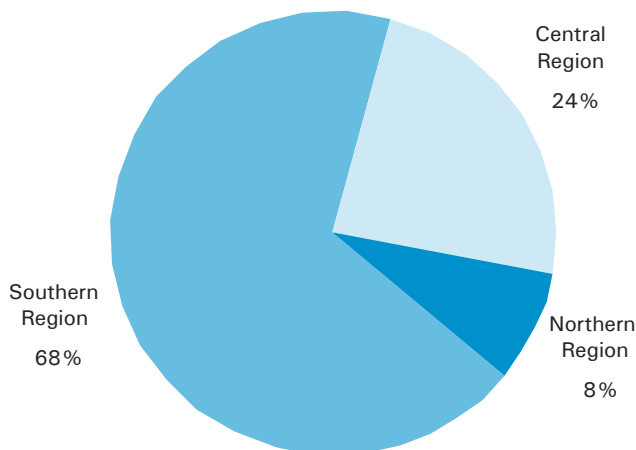
Box 3.7: Making paediatric treatment more affordable

Paediatric formulations have not been a priority of drug companies, as effective family planning and PMTCT programmes in industrialised countries have reduced transmission to negligible levels and the demand for child-oriented drugs in developing countries remains uncertain. Continuing advocacy efforts are underway for greater priority to be given to development of combination paediatric formulations. Mounting public pressure and a series of global consultations have begun to yield results and several companies are developing easy-to-use paediatric three-drug combinations.

Paediatric ARVs have until recently cost up to ten times as much as adult formulas. However, with increasing availability of generic first-line syrups, costs have gone down substantially. The most common first-line paediatric syrups procured by the Mozambican Government, which is suitable for 80 per cent of children, currently cost US\$ 313 per child per annum, compared to an average of US\$ 145 for the most common adult first line treatment. Second line paediatric treatment costs an average of \$2,637 per annum per child. The proportional costs for adult second and third line treatment are similar.

The Ministry of Health estimates that 75 per cent of children under 15 living with HIV/AIDS require ARV treatment, compared to an average of 15 per cent of HIV positive adults. By mid 2006, only about 2,300 children were receiving treatment, representing less than 3 per cent of the need. The distribution of children accessing treatment is highly inequitable, with 68 per cent of all children under treatment in 2005 living in the four southern provinces of the country, and 55 per cent alone living in Maputo City.

Figure 3.21: Access inequity: distribution of children receiving paediatric treatment in 2005 by region



Source: MISAU

It is only recently that paediatric treatment for children living with HIV/AIDS has received increased attention in Mozambique. Paediatric treatment was described as “not urgent” in the Ministry of Health’s original national strategic plan for HIV/AIDS for 2004-2008. This perception of the lack of urgency for paediatric treatment is not unique to Mozambique – globally, paediatric AIDS treatment has not received high priority, perhaps due to the assumption that all infected children will die in early childhood. Policy makers, programme managers and health care providers therefore remain to be convinced that ARV treatment is important and effective in the management of paediatric HIV/AIDS.

It is possible that the lack of a sense of urgency articulated in the strategic plan also filtered down to some of the treatment sites, where health workers may feel that paediatric treatment is very complicated and difficult to implement in the context of ever increasing patient numbers and staff shortages, especially paediatricians. Low numbers of children receiving paediatric ARV treatment may also be due to a lack of follow up of exposed children, routine child health consultation failing to identify or refer children living with HIV/AIDS, mothers failing to attend the Day Hospital, as well as fear of stigma and lack of understanding that children can be infected with HIV.

In 2005, the situation changed dramatically, with the Government making the scale-up of paediatric treatment one of its key priority actions in the fight against HIV/AIDS and poverty. In PARPA II, a target of 30,000 children under treatment by the year 2009 per was established. The number of paediatric treatment sites is planned to increase from 34 sites in 2005 to 150 in 2009, with a particular focus on the centre and northern provinces of the country. This commitment, together with international progress in the area of more affordable and appropriate formulations of paediatric ARVs, is critical in highlighting the need for increased attention to the care and treatment of HIV positive children, and in moving from rhetoric to action.

8. Water and sanitation

Access to clean, safe water and adequate sanitation are 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 and sanitation lowers the risk of water-borne diseases among children weakened by malnutrition and reduces the risk of opportunistic infections among the growing number of children living with HIV/AIDS. These children are not only more susceptible to diseases related to poor water, sanitation and hygiene, but once infected, are more likely to die as a result. In addition, improved management of water resources reduces the transmission of malaria. In Mozambique, the poor situation in the sector is directly responsible for regular outbreaks of cholera. Lack of access to safe water and sanitation also infringes upon other rights. Children, particularly girls, may drop out of school to collect water and may have to travel long distances, which places them at greater risk of abuse.

It is estimated that over 300,000 Mozambican children would need to gain access to an improved water supply and improved sanitation every year if the MDG target of reducing by half the number of people without sustainable access to safe drinking water and adequate sanitation is to be met by 2015⁴¹ (WHO/UNICEF 2005).

⁴¹ A WHO/UNICEF survey in 2005 found that 600,000 Mozambicans would need to gain access to improved water and sanitation if Mozambique is to meet the MDG. The estimate of 300,000 children is based on an estimate that at least half the population are children.

Box 3.8: Water and sanitation are essential for poverty reduction

Water and sanitation are important strategic tools for poverty reduction, because they:

- result in quantifiable benefits with substantial direct economic value;
- are cost-effective, with benefits outweighing costs by a factor of more than ten to one;
- reduce the need for public expenditures in other sectors, such as curative health services, and make in others, such as education, more effective;
- stimulate a chain reaction of economic growth and poverty alleviation; and
- are highly valued by the poor.

Source: The Case for Water and Sanitation, Clarissa Brocklehurst, 2004

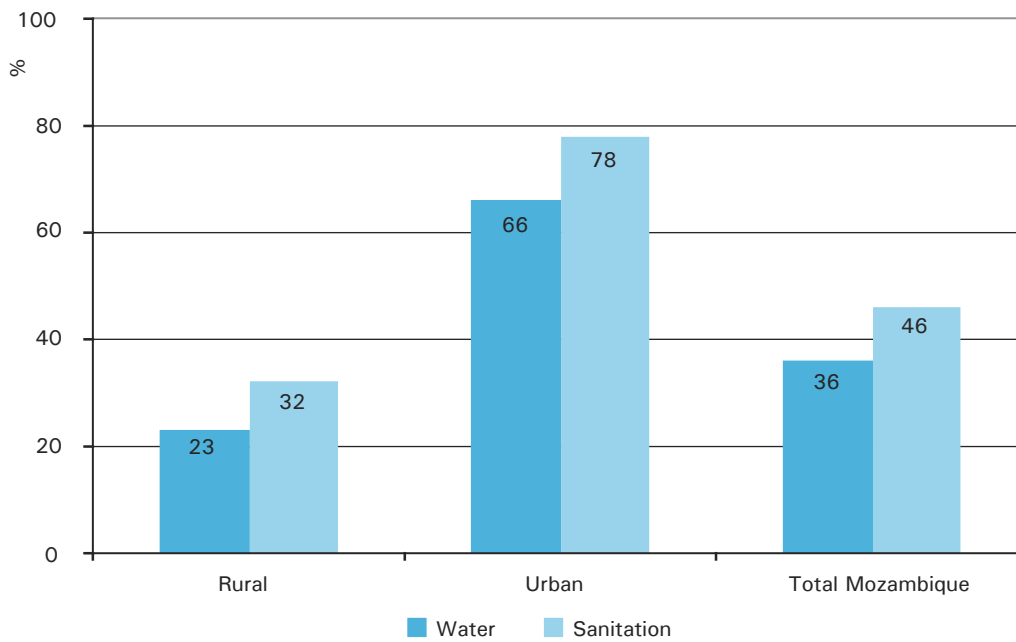
There are two main sources of information on access to and use of water and sanitation: the routine monitoring systems of the National Water Directorate (DNA) and household surveys conducted by the National Institute of Statistics (INE). Both sources measure different type of indicators. While the National Water Directorate focuses on access to safe water and sanitation, household surveys focus on the use of safe water source and sanitary means of excreta disposal. Both sources also use different definitions of urban and rural areas.⁴²

The National Water Directorate measures access to safe water based on the standard that every safe water point should serve 500 people in a radius of not more than 500 metres. Safe water is defined as piped water and water from wells or boreholes with a pump. Protected wells without a pump are not considered safe as contamination of water can occur in the process of fetching the water. According to this measurement, the National Water Directorate calculated in 2004 that 40 per cent of the population had access to safe water, with a slightly smaller proportion in urban areas (36 per cent) than rural areas (41 per cent). The National Water Directorate also estimated in 2004 that 33 per cent of the population had access to good sanitation, with no difference between urban and rural areas.

On the other hand, INE measures the use of safe water source without including the factor of distance to the water point. Use of safe water source is defined as the proportion of households who use any of the following types of water supply for drinking: piped water, public tap and borehole/well with a hand pump. The latest household survey (IFTRAB 2004/2005) indicates that only 36 per cent of the population use a safe drinking water source, with massive disparities between urban areas and rural areas (66 per cent with safe water in urban areas and 23 per cent in rural areas). Data from all household surveys conducted by INE since the year 2000 show no improvement in the use of safe water sources, with measures of 37 per cent in 2000 (QUIBB), 36 per cent in 2002/2003 (IAF) and 37 per cent in 2003 (DHS).

⁴² The water sector considers urban areas to include only 13 major cities, while the definition of urban areas used by INE in the 2003 DHS was 13 cities and 68 secondary towns.

Figure 3.22: Use of safe water source and sanitary means of excreta disposal

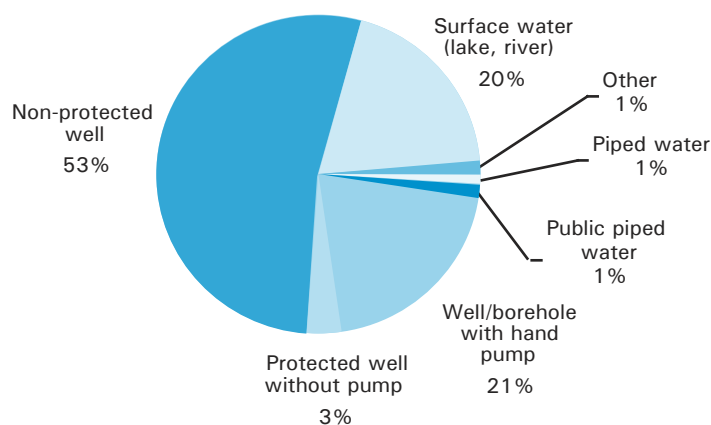


Source: IFTRAB 2004/2005

As for sanitation, household surveys measure the use of sanitary means of excreta disposal, defined as the proportion of population who have, within their dwelling or compound, a toilet connected to a sewage system; any other flush toilet (private or public); an improved latrine or traditional latrine. Sanitation data also indicate little improvement over time. The 2004/2005 IFTRAB survey indicated that the use of sanitary means of excreta disposal is 46 per cent at national level, with significant disparities between urban areas (78 per cent) and rural areas (32 per cent). Sanitation coverage was estimated at 41 per cent in 2000 (QUIBB), 45 per cent in 2002/2003 (IAF) and 48 per cent in 2003 (DHS).

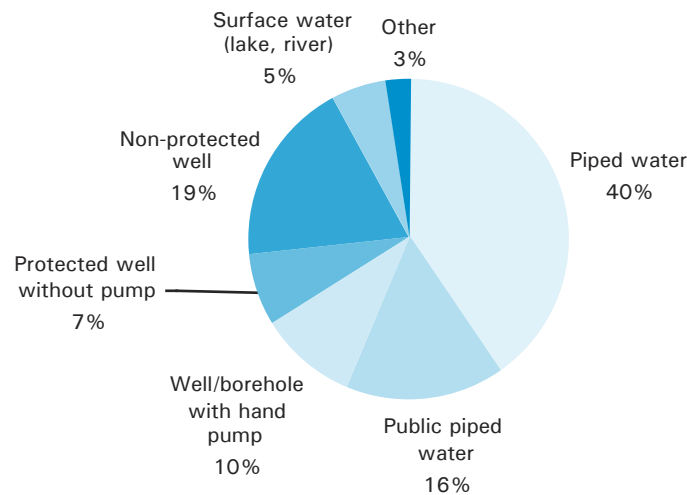
In rural areas, most households use water from non-protected wells (53 per cent), followed by water from well/boreholes with a manual pump (21 per cent) and surface water (20 per cent). Surface water is the most unsafe source of water. In Tete province, the proportion of households using surface water for drinking reaches as high as 32 per cent. In comparison, the main source of drinking water in urban areas is piped water (56 per cent), followed by water from non-protected wells (19 per cent) and water from well/boreholes with a manual pump (10 per cent).

Figure 3.23: Type of water source used in rural areas



Source: IFTRAB 2004/2005

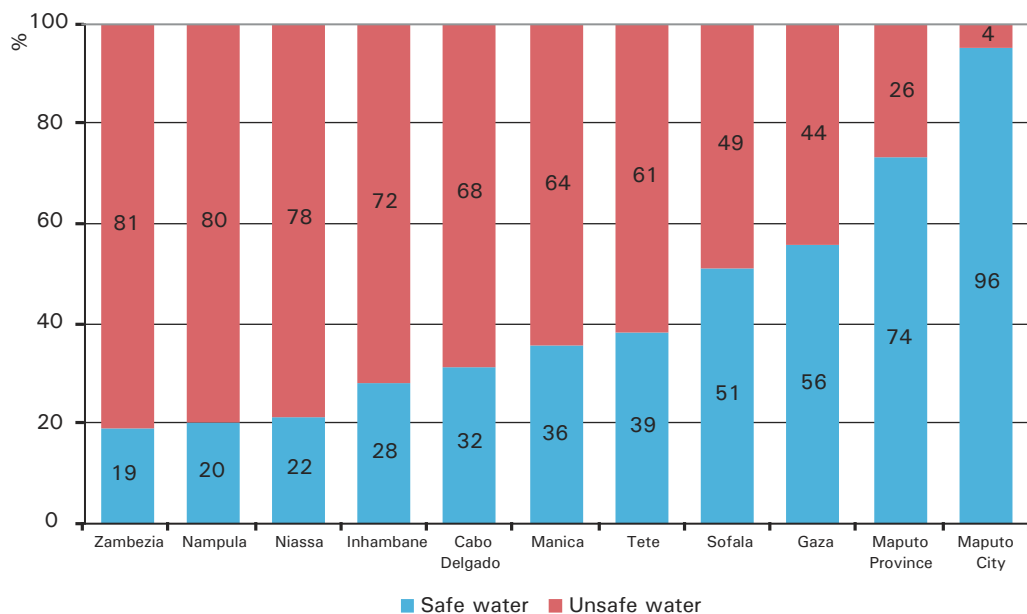
Figure 3.24: Type of water source used in urban areas



Source: IFTRAB 2004/2005

Beside urban/rural disparities, there are massive disparities in the use of safe water sources between provinces. In the two most populated provinces of the country (Zambezia and Nampula), 80 per cent of the population is using an unsafe water source for drinking. In comparison, the use of unsafe water in Maputo is only 4 per cent. Use of sanitary means of excreta disposal also varies significantly according to province, with Zambezia province being the province with the lowest coverage (16 per cent).

Figure 3.25: Use of safe and unsafe water source by province



Source: IFTRAB 2004/2005

9. The underlying causes of challenges to child survival and development

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.

A. Inequitable access to and funding of social services

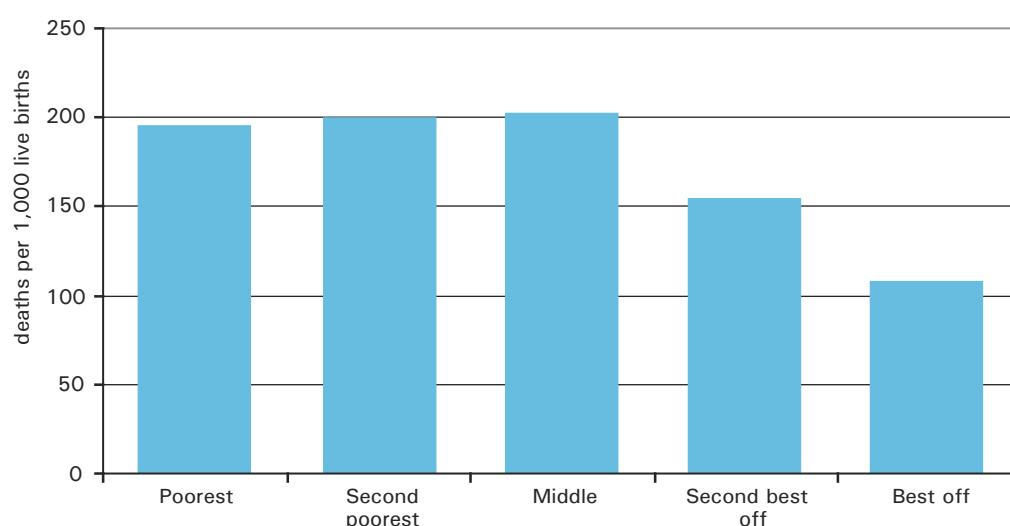
One of the main underlying causes of child morbidity and mortality in Mozambique is the lack of access to public services, both in terms of physical and economic access and the poor quality of these services. Barriers to accessing and using services are particularly acute for poorer households, for people 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 (see section 10 below). The 2002 Expenditure Tracking and Service Delivery Survey, for example, showed that rural districts are relatively underserved by the primary healthcare system, with a lower number of staff and less qualified staff than in urban districts (WB 2004).

(i) Economic accessibility

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 2003 DHS show that child mortality levels start decreasing significantly only in the fourth wealth quintile, with the best off quintile suffering under five mortality rates of half compared with the poorest 60 per cent of households. One in ten children will not reach their fifth birthday in the best off households, compared with one in five under fives in the lower 60 per cent of households. It is important to note that the households in the lower quintiles are overwhelmingly rural (83 per cent of the rural population belong to the first three quintiles in comparison to 21 per cent of the urban population in these quintiles) and worse educated.

Figure 3.26: Under-five mortality rate by wealth index quintile



Source: 2003 DHS

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. The Expenditure Tracking and Service Delivery Survey showed that nearly half (46.4 per cent) of Mozambicans questioned found it 'difficult' or 'very difficult' to find money to pay for healthcare, with 51.5 per cent in rural areas and 31.7 per cent in urban areas finding it so.

The study found that those living in rural areas were five times more likely to have to sell something to pay for healthcare as those living in urban areas (WB 2004). This information on poverty as a leading barrier to healthcare is consistent with the 2003 DHS results, which found that 57 per cent of women considered that the main barrier to accessing health services was finding the money to pay for treatment.

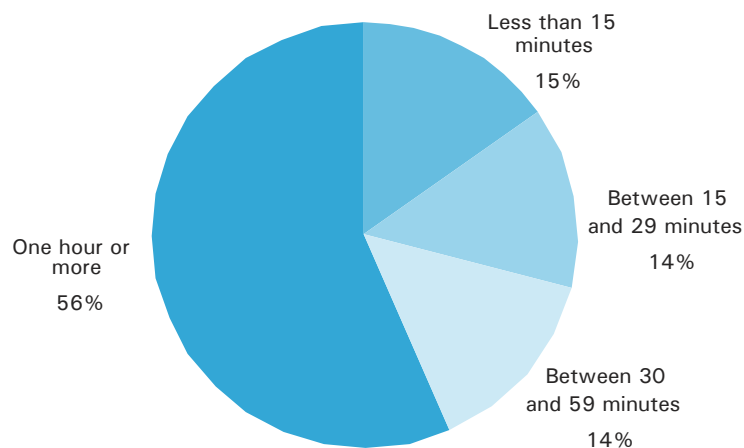
The legislative and policy framework in Mozambique relating to user fees has been revised on many occasions, leading to a lack of clarity regarding basic inpatient drugs, which are in principle free of charge, and non-basic outpatient drugs, for which there is a charge. The application of user fees therefore tends to vary from district to district, leading to inequities. In spite of social protection mechanisms in place for the most vulnerable, such as fee waivers or reduction in fees for specific target populations, such as children under five, pregnant women, the elderly or the poor, the 2002 Expenditure Tracking and Service Delivery Survey found that in a large proportion of district health facilities such mechanisms were not implemented. This was particularly the case with regard to drugs. Among the surveyed facilities, 95 per cent charged full fees to children, 70 per cent charged full fees to retired soldiers, 66 per cent charged full fees to the elderly and retired and 39 per cent charged full fees to the poor (WB 2004).

Corruption is also a problem in the health and water sectors and illegal over-charging, which affects the poorest families disproportionately, is thought to be commonplace. The national Survey on Governance and Corruption, indicated that in a list of 31 public institutions, households considered that the National Water Directorate was the third most dishonest institution, followed by the Ministry of Health in the fourth place (Austral Consultoria e Projectos, Lda 2005).

(ii) Physical accessibility

After lack of money for treatment, the distance from healthcare facilities was the second problem to accessing healthcare cited by women in the 2003 DHS. The 2004/2005 IFTRAB survey indicated that 56 per cent of households were one hour or more on foot from the nearest health facility, with a significant disparity between urban areas and rural areas (18 per cent in urban areas and 72 per cent in rural areas being more than one hour away from a health facility). In Zambezia province the proportion of people more than one hour from a health facility reached almost three quarters (73 per cent) and in Cabo Delgado, Nampula and Tete was about two thirds. This contrasted with Maputo province (one in ten people more than one hour away from a health facility) and Maputo city (only 2 per cent more than one hour away).

Figure 3.27: Access to health facilities: time taken by households to reach the nearest health facilities on foot



Source: IFTRAB 2004/2005

The 2004/2005 IFTRAB survey also suggested a correlation between households whose heads had no education and poor access to health facilities, with 69 per cent of households whose heads had no education one hour or more from the nearest health facility, compared with only 17 per cent of households whose head had secondary or higher education. One must be cautious in interpreting these correlations however, as areas with poor education supply (and hence poor levels of education amongst the population) are also likely to lack other social services. Thus, while it is undoubtedly the case that better educated people are more likely to seek out social services, this effect is probably less pronounced than a first examination of these correlations would suggest.

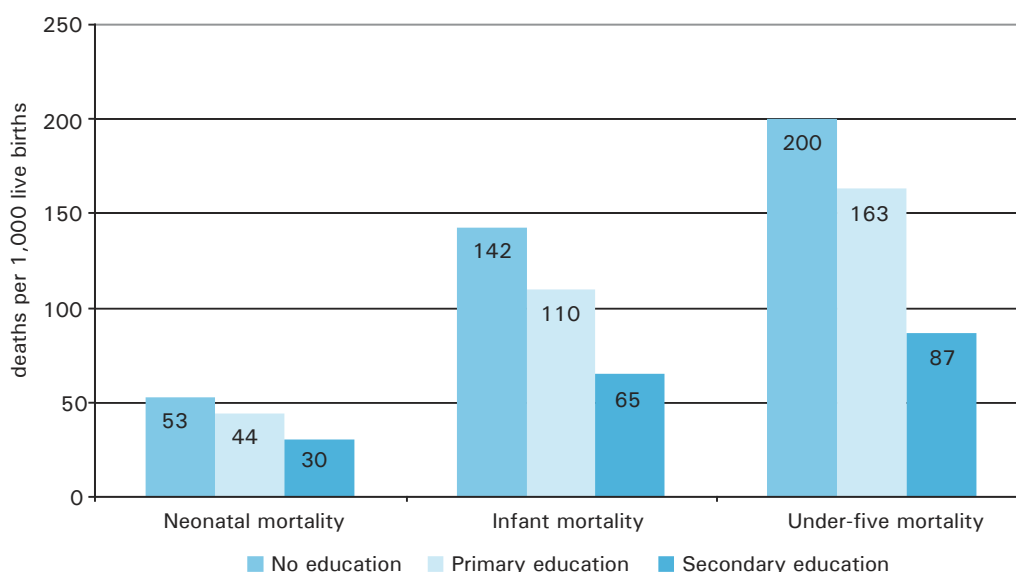
In terms of the distance travelled to collect water, the 2003 DHS found that the average time travelled was about 20 minutes, with people in rural areas needing three times more time than those living in urban areas (29 minutes and 9 minutes respectively).

In 2005, the ratio of inhabitants per health facility (hospitals, health centres and health posts) was on average 15,462, which was worse than in 2004 and 2003 with ratios of 15,154 and 15,018 respectively (MISAU 2006). In 2004, there were on average 421,600 inhabitants per hospital, with a ratio varying from 729,100 in Zambezia province to 214,800 in Maputo City (MISAU, 2005b).

B. Low levels of education among mothers

The education level of mothers is strongly correlated with children's well-being. Mothers with little or no education have less access to information on issues such as nutrition and the prevention, symptoms and treatment of diseases. In the Northern region where the literacy rates among women are the lowest (82 per cent non-literacy rate among women according to the 2004/2005 IFTRAB), mortality levels among children are the highest (above 200 deaths per 1,000 live births among under-five children). The 2003 DHS indicated that children of mothers with no education were 130 per cent more likely to die before reaching the age of five than children of mothers with secondary level education. However, as noted above, education levels will be lower where access to social services in general is lower, suggesting that while education levels are undoubtedly of fundamental importance for child outcomes, this measure is also capturing a general lack of access to services (as opposed to only reflecting the benefits from education). More generally, since poverty and mothers' level of education are strongly correlated, it becomes difficult to assess the relative contribution of each to children's chances of survival. Still, the low access to education and information for women/mothers clearly remains a key constraint to reducing mortality levels among children.

Figure 3.28: Mortality level among children by type of mortality and level of education of the mothers



Source: DHS 2003

C. Family care practices

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. For example, only 30 per cent of Mozambican infants aged under 6 months are exclusively breastfed for 6 months.

D. Weak human resource capacity in the health and water sectors, particularly at sub-national levels

The health sector is faced with an acute shortage of human resources, particularly at the sub-national levels, a situation that is further exacerbated by the AIDS pandemic. In 2005, there were on average 1,638 inhabitants to every qualified health professional in the country. There is currently one doctor per 44,000 inhabitants, compared to the average for sub-Saharan Africa of one doctor per 22,000 inhabitants. Geographic inequalities exist in the distribution of healthcare professionals, with disparities between provinces in the north and south of the country and urban and rural areas. For example, the ratio of qualified health professionals per inhabitant in 2005 was three times lower in Zambezia province (1 per 2,685 inhabitants) than in Maputo City (1 per 737 inhabitants) (MISAU 2006). Maputo City is well served in terms of qualified health workers (1 doctor per 3,500 inhabitants), while Zambezia province is severely disadvantaged (1 doctor per 74,400 inhabitants) (MISAU 2005b).

The scarcity of skilled health workers has been attributed to insufficient funding for training, low production of health workers, the ongoing brain drain to the private sector and loss through HIV/AIDS. As a result, the rate of production of new staff does not keep pace with the rapid expansion of the network of facilities. A recent study to evaluate the approaches to supporting health sector development at the

provincial level reported that only 20-35 medical doctors graduate each year, and only 5-6 specialists are trained annually, with the gaps being filled by expatriate doctors, who account for more than a third of the physician positions in the country (Costa et al 2006). In addition, the study found that the distribution of health workers is uneven due to a lack of sufficient incentives for them to locate to rural areas, particularly at district level. The deployment of staff to rural areas is particularly problematic in the field of maternal and child care. The provinces most adversely affected were Sofala, Zambézia, Nampula, Manica and Inhambane (Costa et al 2006).

There are significantly more unqualified than qualified health workers in the health sector. In 2004, for example, of 20,105 public servants employed in the sector, less than 3 per cent were medical doctors, 15 per cent were mid-level health professionals (tecnicos medios de saude), 29 per cent were health assistants ("assistentes tecnicos de saude"), 11 per cent were health auxiliaries ("auxiliares tecnicos de saude") and 42 per cent were general service staff (carreiras de regime geral) (MISAU 2005b).

Estimates on the number of workers in the water and sanitation sector infected by HIV/AIDS indicate that in 2002, 983 out of 6,618 workers in the sector were living with HIV/AIDS - with 472 workers in the Southern region, 388 in the Central region and 124 in the North (CBE 2005). The rate was higher among women than among men. Such a high prevalence rate has a huge impact on the human resource capacity of the sector and highlights the need to strengthen human resource capacity and skills within the sector, particularly at the sub-national levels, and to establish programmes that strengthen staff knowledge of HIV prevention and promote behaviour change.

E. Poor quality infrastructure

The poor quality of infrastructure is a challenge impeding child survival and development in both the health and water sectors. Many existing health facilities are without electricity, adequate water supplies or basic equipment. In the water sector, although poor coverage remains the main problem, another major barrier to access and use of safe water is the frequency with which existing water points break down. The National Water Directorate estimates that approximately 30 per cent of the water supply facilities that have been constructed in recent years are non-operational. This breakdown of water points can be attributed to various factors, including the lack of means to undertake adequate preventive maintenance (such as accessible spare parts); the poor quality of services delivered; inadequate community empowerment to take action; and insufficient time spent in creating demand for services (through strengthening community/family knowledge and skills in regard to safe hygiene practices and their impact on health).

F. Natural disasters

Mozambique is a country prone to natural disasters, including cyclones, floods and repeated drought, which can have dramatic consequences on the lives of the affected population. In rapid onset emergencies, such as flooding or cyclones, health infrastructure is damaged and roads or paths made inaccessible, reducing people's already limited access to health services. In extreme cases (such as the severe flooding of 2000 and 2001), displaced populations move to temporary accommodation centres, where health facilities vary in quality and coverage, depending on accommodation centre management, the scale of displacement and accessibility to supplies and equipment. The public health risks of epidemic outbreaks are significant for people living in accommodation centres. However, it should be noted that, in some instances, temporary accommodation centres allow wider coverage of some

health services, such as vaccination. In drought affected districts groundwater sources are depleted, resulting in the drying up of a significant number of shallow wells. The increased water demand then places enormous pressure on the fewer functioning deep wells, which often results in their failure. The climatically vulnerable situation of the country also impacts on the implementation of planned activities within the water sector, as it diverts resources (particularly human resources at the sub-national level) and priorities to respond to emergency needs, thus delaying the implementation of regular planned activities.

G. Involving service users

Relatively low levels of satisfaction among health service users have been registered in several surveys. The 2002/2003 IAF survey indicated, for example, that 38 per cent of the population was not satisfied with the health services provided, the first reason being the long waiting time, the second being the lack of treatment and the third being unsuccessful treatment. The 2004/2005 IFTRAB survey confirmed these findings, although the level of dissatisfaction slightly decreased to 31 per cent. The long time waiting was the first reason of dissatisfaction, followed by unsuccessful treatment and the lack of treatment. While the level of dissatisfaction did not vary much between urban and rural areas (28 per cent and 33 per cent respectively), variation by provinces were significant, reaching 46 per cent in Zambezia province and 44 per cent in Nampula province. The main reason for dissatisfaction in Zambezia province was unsuccessful treatment (34 per cent).

The water sector has embarked upon a process of decentralisation, which aims to transfer decision-making processes to the lower (sub-national and community) levels, in order to ensure increased accountability and enhanced ownership of water and sanitation facilities by the users. This process has not been complemented with the necessary strengthening of capacity, particularly at the sub-national level (district and provincial levels), which is negatively affecting the sector's ability for planning, management and absorption of allocated funds.

10. Financing health and water

Developing an accurate picture of financing for the health and water sectors is difficult as data are often inconsistent and incomplete. This situation is the result of incomplete – though dramatically improving – coverage of external funding flows and internal revenues, and differences in planning, budgeting and reporting cycles and systems within the sector and between the sector and the central agencies. The problem is more acute in the water sector.

A. Health sector

While treating the data with caution, the global picture indicates that between 2002 and 2005 total budgeted resources for the Ministry of Health increased by a dramatic 108 per cent, from around US\$165 million to an estimated US\$344 million – a rise from 4.3 to 5.2 per cent of GDP (see Table 3.4). There have thus been consistent annual increases in the total Ministry of Health budget, which has grown by, on average, 21 per cent per year over the period in nominal terms (compared to an average annual rate of inflation of 12.3 per cent). This has been comprised of strong average increases in both the recurrent and investment components of the State Budget (averaging 22 per cent and 37 per cent per annum respectively), although the investment budget has fluctuated a great deal more than the recurrent budget, as one would expect.

Table 3.4: Ministry of Health budget allocations, 2001 – 2005

	2001	2002	2003	2004	2005
Total Ministry of Health Budget (US\$ million)	165	178	209	253	344
Growth Rate (% change on previous year)	n/a	7.6	17.8	20.9	36.0
Inflation (% , annual average)	9.1	16.8	13.5	12.6	6.4
Expressed as a % of GDP					
Total Ministry of Health Budget	4.5	4.3	4.4	4.3	5.2
Ministry of Health funding in the State Budget*	1.9	1.9	1.8	1.6	2.6
Expressed as a % of total State Budget					
Total Ministry of Health Budget	23.6	14.7	17.8	19.2	21.3
Ministry of Health funding in the State Budget	10.0	6.3	7.5	7.3	10.6
Expressed as a % of total Health budget					
State Budget	42.4	43.2	42.3	37.9	49.5
Recurrent Expenditure	37.7	39.1	38.1	34.5	32.0
Common Funds	10.0	11.5	17.7	25.0	44.2

Note: *State Budget funding comprises recurrent and investment expenditures captured in the OE.

Sources: Adapted from Ministry of Health (2005, p. 53), Ministry of Health (2006) & MPD/MF data (inflation & GDP).

As discussed in Chapter II, not all donor financing and internal revenues in the sector are captured in the State Budget – there are many “off-budget” funds. Cabral et al. (2005) have estimated that in 2003, 29 per cent of total sector funding was not recorded in the State Budget, 60 per cent was not registered in the Treasury and 44 per cent was not accounted for in the public accounts. This hampers sectoral planning and has prompted efforts by the sector and the Ministry of Planning and Development / the Ministry of Finance to improve the coverage of external assistance in Government Public Finance Management systems. This initiative may explain part – though by no means all – of the recent recorded rise in external assistance to the sector. Another contributing factor has been the channelling of increasing proportions of vertical funds through Common Funds rather than projects, making these funds easier to capture too.

As a result of the measurement issues surrounding off-budget and vertical funds, measuring the balance between external assistance and government revenue in financing the sector’s budget is not straightforward (see Box 3.9). However, it is undoubtedly the case that the share of external financing in the health sector budget is increasing: growth in internal financing over the period 2002 – 2005 averaged 15 per cent per annum, while external financing increased by 25 per cent on average, with particularly marked increases in levels of budgeted external assistance channelled through the three sector Common Funds (total Common Fund budgets rose from US\$17 million to US\$152 million).⁴³ As a result the proportion of external financing in the total sector budget has increased from around 55 per cent to 63 per cent (see Figure 3.29).

Box 3.9: Health sector funding and the Abuja Declaration

The 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases, to which Mozambique is a signatory, includes a pledge, "...to set a target of allocating at least 15% of our annual budget to the improvement of the health sector" (OAU, 2001). The Health Sector Working Group in the joint government-donor review has observed that the "government" budget allocation for health expenditure as a proportion of overall expenditure has been consistently below this target. The figure was estimated by the sector to be 10.6 per cent in 2005 (GoM & PAP, 2006). Aside from considerations as to the usefulness of such relative targets, it should be noted that the Abuja Declaration makes no distinction between sources of funding. Thus, if the total Ministry of Health funding is considered, the Abuja target has been attained, having been missed once (in 2002) over the past five years (see Table 3.4). In addition, it should be noted that the distinction between "government" and "external" funds used in health sector planning documents is not a distinction between aid and domestic revenues. Much of the "government" component is donor financed for example, being made up of: (i) a recurrent component which is partially financed by General Budget Support, and; (ii) an investment component that is largely funded by external funds (for example, around 71 per cent of the health investment planned in the State Budget for 2005 was to be financed externally). The distinction is arguably more an indication of where the allocation decision over aid is made, which is at present predominantly conducted through negotiations between the sector and donors.

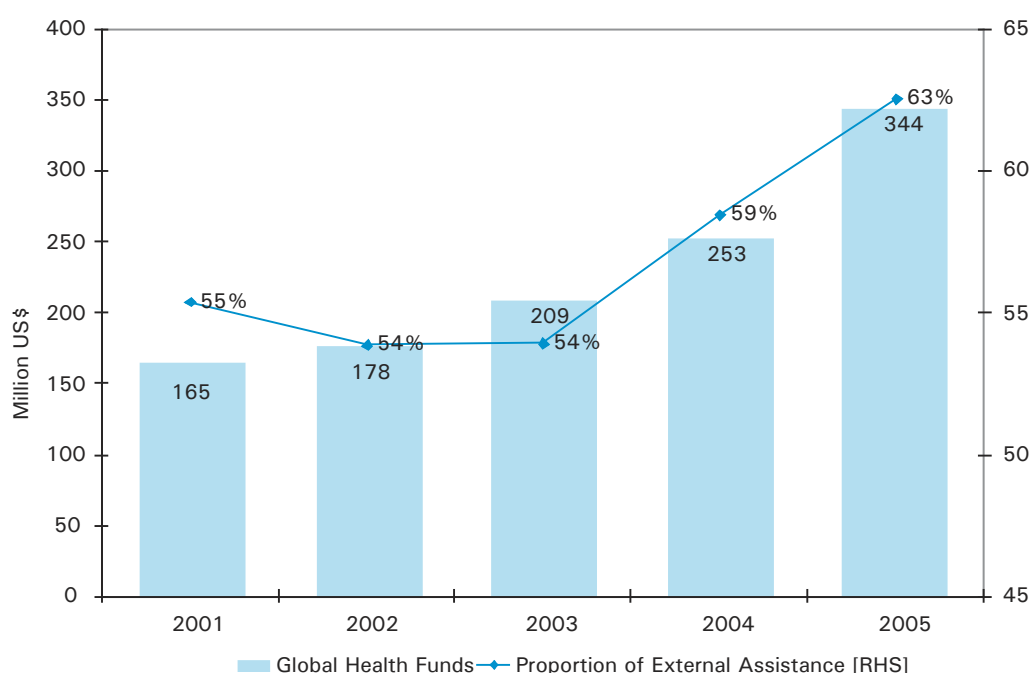
The increased share of donor financing in the sector gives added emphasis to the importance of stable and predictable aid flows. At present, several donors in the sector still find it very difficult to commit to the increasingly important common funds more than one year in advance and, as at mid July 2006, for example, three donors had yet to confirm funds for 2007. The problem is even more pronounced for vertical projects, which often do not provide adequate financial data. This undermines intra-sectoral strategic resource allocation. A key area where this directly impacts upon public health is HIV/AIDS, where the proliferation of projects and the discrepancies between these and official Ministry of Health policy. For example, external funds have been made available – particularly to NGOs – specifically to expand the number of voluntary counselling and testing (VCT) centres, known by their Portuguese acronym as GATVs, in contrast to the Government's policy of incorporating health counselling and testing (ATS) into all health facilities (including, but not exclusively limited to, VCT for HIV).⁴⁴

More flexible aid modalities should also be prioritised in order to protect the sector from fluctuations in allocations of the internal component of the State Budget and give the central agencies (i.e. the Ministry of Planning and Development and the Ministry of Finance) leeway to make strategic resource allocation decisions. As in the education sector, the recent improvements in the information available to the Ministry of Planning and Development and the Ministry of Finance regarding total available resources within the sector (resulting from the move to place funds on-budget) need to be complemented with detailed resource planning between the three Ministries to ensure that required levels of internal funding are reconciled with allocations through the CFMP and the State Budget.

⁴³ The three Common Funds are the "Prosaúde" general fund, the Common Fund for Medicines and the Provincial Common Fund.

⁴⁴ GATV stands for "Gabinete de Aconselhamento e Testagem Voluntária" and ATS for "Aconselhamento e Testagem em Saúde".

Figure 3.29: Total sector resources and share of external financing, 2001 – 2005



Sources: Ministry of Health (2005 & 2006)

The health sector has in recent years experienced difficulties with low execution rates. Sector data indicate that overall budget execution in 2005 was 73 per cent for current expenditure and 22 per cent for investment expenditure (Ministry of Health, 2006). Moreover, budget execution levels vary considerably between provinces and also between central and provincial levels. For example, execution rates varied between 71 – 98 per cent for current expenditure and between 0 – 64 per cent for investment expenditure amongst the provinces in 2005 (Ministry of Health, 2006b).⁴⁵ The problem arises due to slow and unpredictable disbursement of central government funds (which in turn is primarily a result of liquidity constraints), the complex budgetary procedures and schedules for different sources of funds and the difficulties arising from the non-payment of VAT on infrastructure projects by international partners (discussed in more detail in Chapter II and in the following Section). This issue highlights the importance of a coherent and concerted move to build the capacity of the sector, in particular in the area of planning and financial management at provincial and district levels.

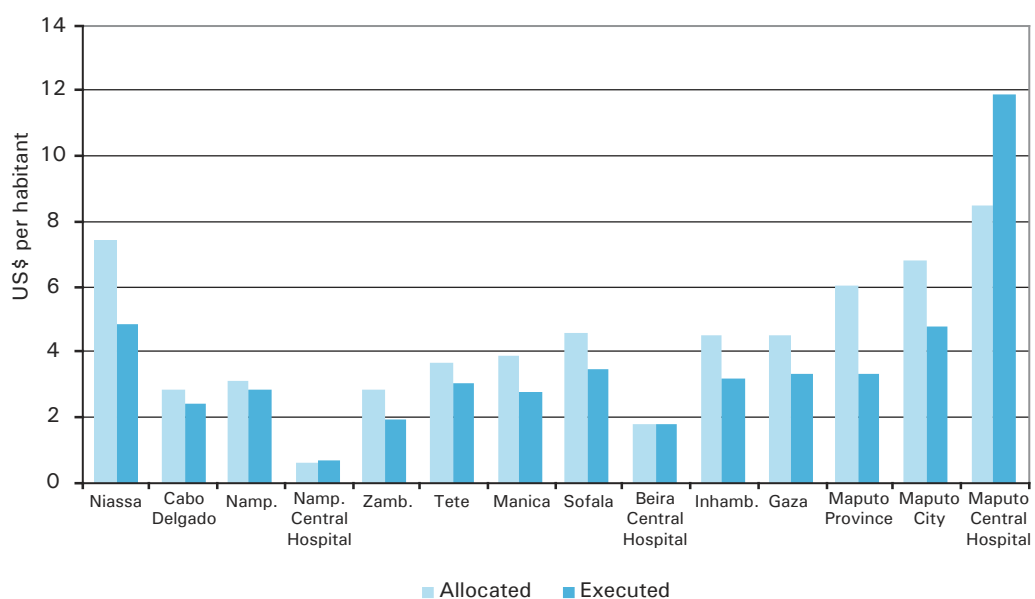
Dividing health funding as reflected in 2005 State Budget by the total estimated population gives a total level of budgeted health funding of around US\$10.0 per capita. PARPA II aims to increase this amount to US\$15 per capita by 2009 (GoM 2006, p. 103). However, if the total Ministry of Health funding in 2005 is used as the numerator, the health budget in per capita terms is about US\$17.7 per person, of which US\$10.4 per person was actually spent (Ministry of Health, 2006).⁴⁶ Although this was an increase from the previous year (US\$13.3 per capita budgeted and US\$9.3 per capita spent), it remains less than the recommended “minimum package” to meet basic health needs in low income countries of both the World Bank and World Health Organisation and below the average for Sub-Saharan Africa, which was estimated at US\$31.9 in 2002.⁴⁷

⁴⁵ Much of the information on provincial investments is not available due to a lack of information on external funds, explaining why some provinces realise execution rates as low as zero.

⁴⁶ This is based on a total population figure for 2005 of 19.4 million (INE, 2005) and a total sectoral budget figure of US\$344 million, of which US\$202 million was executed.

There is significant variation between provinces in terms of resource allocation and expenditure (see Figure 3.30), and allocation of resources is not fully consistent with the health status indicators pattern. Estimated expenditure per person in 2005, for example, varied from approximately US\$2 per person in Zambezia province to approximately US\$5 per person in Maputo City, while data from the 2002/03 IAF suggests that 17.6 per cent of the population in Zambezia reported having been ill in the previous week compared to a much lower 10.6 per cent in Maputo City (Van den Broeck, 2005).⁴⁸ It should be stressed however that the amounts in Figure 3.30 are only very broadly indicative of differences in spending and are in no way meant to capture all resources spent – expenditures by the General Common Fund, the Common Fund for Medicines and some off-budget projects are not captured and neither are expenditures on central-level administration in Maputo.

Figure 3.30: Indicative per capita provincial health expenditure, 2005



Note: All allocation and expenditure figures include own receipts, recurrent budget, investment budget and provincial common fund.

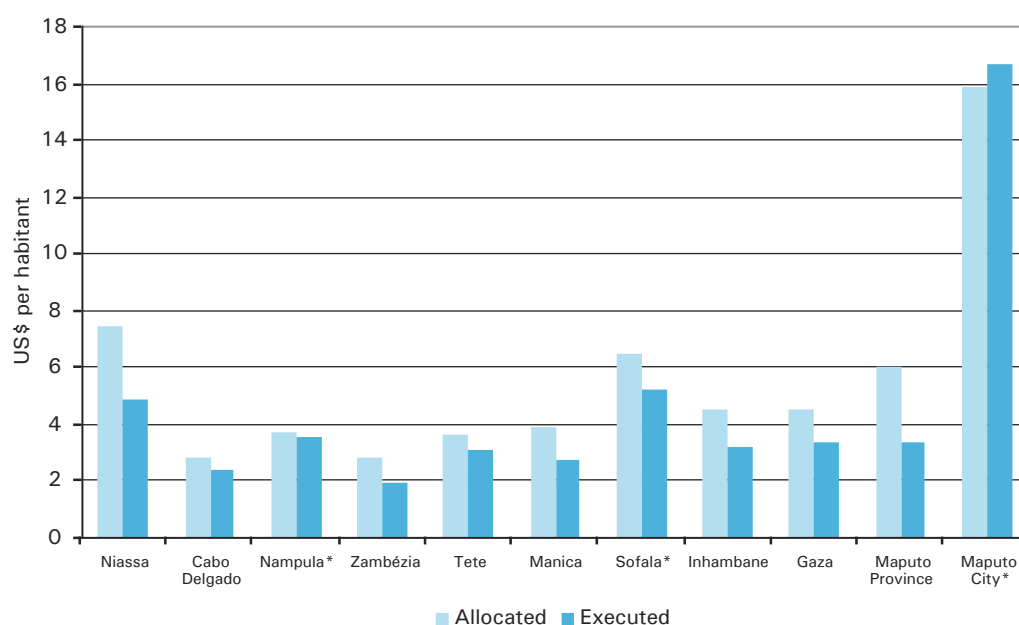
Source: Adapted by the MPD from Ministry of Health, 2006

Including the Nampula, Sofala and Maputo City Central Hospitals in the provincial figures would produce even greater disparities. This is not common practice in sectoral calculations of per capita expenditures because the Central Hospitals are intended to be of benefit to the entire population in the region, not simply the province in which they are located (Maputo Central Hospital also aims to provide some specialist nation-wide services). Their inclusion is however justified in an analysis focusing on the poorest members of society, who have lower mobility and are often unlikely to seek formal medical attention at all, let alone journey to a hospital in a different province. Were the Central Hospitals to be included in provincial per capita calculations, inter-provincial disparities in health spending would be even higher, as is illustrated in Figure 3.31.

⁴⁷ 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 the "Better Health in Africa" (World Bank, 1994); and US\$35 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 World Bank (2005), Table 2.14 – Health: expenditure, services and use.

⁴⁸ Niassa's per capita expenditures are very high due to the higher costs involved in providing basic services in remote rural areas.

Figure 3.31: Indicative per capita provincial health expenditure, 2005



Note: *Includes Central Hospitals. All allocation and expenditure figures include own receipts, recurrent budget, investment budget and provincial common fund.

Source: Adapted by the MPD from Ministry of Health, 2006

These disparities in budget allocation have been attributed in part to weak links between the health sector's annual planning and resource allocation system, the sub-sectoral strategic plans developed by some directorates and the broader sector-wide planning system, specifically the lack of clear prioritisation of objectives and any attempt at costing within the PESS, which outlines the overall strategy of the health sector. A fundamental difficulty in producing costings within the sector is the lack of information on unit costs.

In addition to disparities in health expenditure between particular provinces and districts, disparities also exist between expenditure on primary and tertiary health facilities. This is of particular importance when talking about children, since tertiary care facilities tend to be in urban areas (while child morbidity and mortality rates are higher in rural areas) and they focus on less cost-effective curative care, rather than more wide-reaching preventive care. A recent study to evaluate approaches to supporting health sector development at the provincial level found that in the five studied provinces, governmental health expenditures were biased towards higher-level facilities (Costa et al, 2006). A number of recent studies have noted the high proportion of health expenditure on tertiary facilities in Mozambique as compared with other countries (Costa et al 2006 and WB 2004b). It is estimated that 38 per cent of health care expenditure is made on the tertiary care level, a figure that differs considerably from the figure in South Africa (25 per cent) and in Uganda, Malawi and Ethiopia (around 11 per cent).

B. Water sector

According to the State Budget, the proportion of total public resources allocated to the water sector was 2.8 per cent in 2003, 2.3 per cent in 2004 and 2.5 per cent in 2005. However, the financial information provided by the sector, which captures much more external assistance, suggests that this proportion is around 5 per cent of the total budget (GoM and PAP, 2006). Of those funds, roughly two-thirds are

covered by external financing. In the rural water supply and sanitation programme this proportion is even higher, at an estimated 80 per cent of the overall budget according to the National Water Directorate figures. The largely internally financed “recurrent” component of the State Budget is spent almost exclusively on civil servants’ salaries (around 98 per cent), while the “investment” budget is used to finance additional recurrent expenditures such as goods and services and salaries for project staff, and capital projects.

Within the sector, nearly 90 per cent of expenditures cover water supply and sanitation, with the remainder going to water resource management. Of that 90 per cent, the key distinction is between spending in rural and in urban areas. Indeed, a key challenge in sectoral financing, as well as for the sector as a whole, involves addressing the large urban-rural disparities. The overall spending on urban water has historically exceeded that on rural water. In spite of the considerable disparities observed between urban and rural areas, per capita spending on the expansion of water access for those as yet unserved has been estimated to have been around six times greater for urban than rural areas in 2003 and 2004 (WB 2005).

The relative lack of resources for expanding rural water supply coverage has been compounded by the relatively high costs involved when compared to those in other countries in the region. Expanding rural water supply means the drilling of wells and installation of hand pumps (nearly 75 per cent of the population presently rely on groundwater) and, crucially, ensuring their sustainability. Drilling a borehole, together with the provision of a hand pump, costs US\$10,000 in Mozambique as compared to \$5,000 - \$7,000 in Malawi, Tanzania, Zambia and Ghana (WB 2003). This is principally due to weak institutional capacity and unusually high drilling costs for the region and the lack of a national framework for bidding for groundwater drilling projects. Moreover, Mozambique’s very low population density means that each pump serves around 250 people, making the per capita cost of a new borehole and hand pump around US\$50.

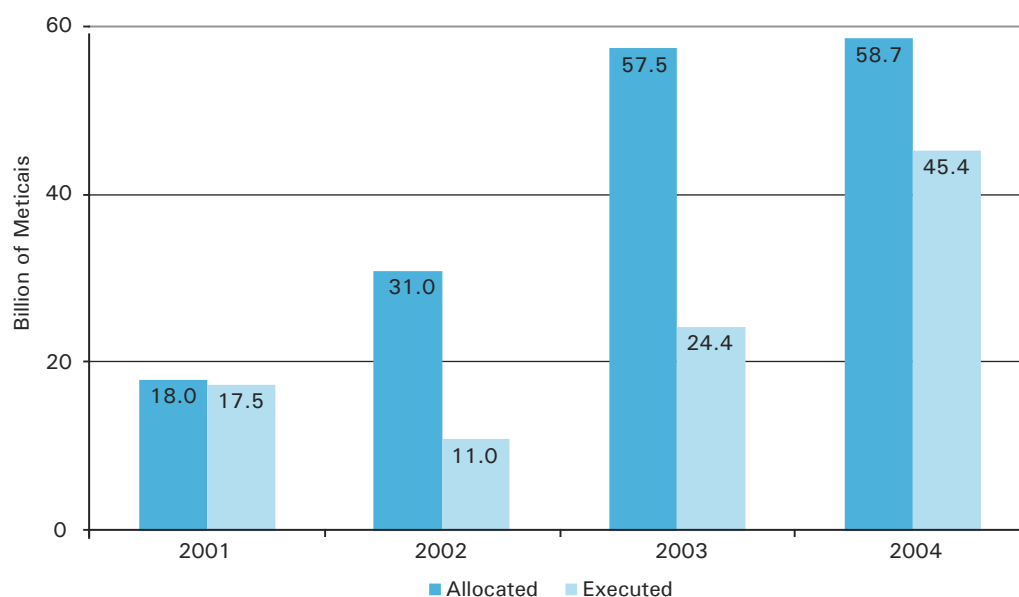
Extensive rural water supply projects are currently under development in order to begin to redress this imbalance. Projects worth an additional US\$135 million are also being drawn up by other international partners. It is essential that these initiatives should continue to be demand-led and accompanied by mechanisms to ensure the long-term sustainability of rural water points to ensure that the proportion of non-functional wells does not increase (WB, 2005).

While the chance of meeting the MDG for water and sanitation has been rated as “unlikely” in the second MDG National Report, projections show that, in financial terms at least, this does not necessarily have to be the case.

Without assuming any improvements in efficiency, the investment required to meet the MDG in rural areas has been estimated at around US\$15 million per year, as compared to an estimated average annual capital investment of US\$9 million in rural water in recent years (WB 2005; GoM, 2006). The recently developed Rural Water and Sanitation Strategic Plan also presents cost projections to 2015 for the attainment of the MDGs in rural water and sanitation (GoM, 2006). Its scenario for achievement of the MDGs will cost an estimated US\$180 million for rural water and around US\$11 million for rural sanitation. In the context of the size of the above-mentioned investments being developed in the sector these estimates are not prohibitively high. Urban water supply expansion will also receive a significant boost from the forthcoming Millennium Challenge Account funding of around US\$125 million over the next five years for urban water supply in towns in the four northernmost provinces (GoM, 2005).

The agenda for expanding water supply to meet the MDGs does not, however, simply include the required volume of financing. If this rapid expansion is to be realised, the sector's poor budget execution rates will need to be addressed. Sector figures indicate that the overall execution rate for internal investment spending was about 65 per cent in 2005 (compared to around 55 per cent in 2004), while the National Water Directorate (DNA) within the Ministry of Public Works and Housing executed only 47 per cent of its budget (compared to 53 per cent in 2004). Sectoral figures available for rural water provide a good illustration of the problem.

Figure 3.32: Comparison of allocation and execution of internal resources in the State Budget, 2001 - 2004



Source: National Water Directorate, cited in GoM (2006)

As with other service delivery sectors, timely disbursement of funds from the Ministry of Finance is cited by the sector as a cause of this problem, with many months seeing very limited or even non-existent disbursements due to liquidity constraints. This is illustrated by the fact that the more financially autonomous institutions in the sector – the Investment and Assets Fund for Water Supply (FIPAG) and the Southern Region Water Administration (ARA-sul) – were able to realise execution rates of 100 per cent and 94 per cent respectively according to sector data.

The sector also faces a growing debt burden, which reached around US\$2.5 million by the end of 2005 (GoM and PAP, 2006). The key drivers of increased debts are arrears in VAT payments and other counterpart contributions that the National Water Directorate has incurred under externally funded projects. As discussed in Chapter II, many donors refuse to pay these charges on their investment projects, and under Mozambican law the Government must assume the responsibility to meet contractors' claims. However, the budgetary allocations made to meet these fiscal charges are very often inadequate, mainly due to fiscal constraints limiting domestic revenues available for counterpart funding. While this problem affects the health and education sectors it is particularly pronounced in the water sector. This is seriously delaying the execution of externally funded projects, thereby reducing their economic returns and increasing the costs of procurement, as contractors incorporate delays and non-payment of VAT into their bids (Orlowski, 2006). For the Government, the

ideal solution involves the international cooperating partners dropping their exemption requirement – as the World Bank now does in all new agreements. This however remains a distant prospect for many donors as it would involve changes to their domestic legislation, and there would in any case be a lag during which the terms of existing agreements continued to affect the sector.

This issue also highlights the importance of institutional capacity in the sector, which is arguably the key constraint to faster expansion. There is a need for a comprehensive institutional strengthening programme, focusing in particular on planning, budgeting and financial management capacity within Government in the sector. As with health and education, the water sector is increasingly in need of improvements in the quality of services delivered and these improvements require a concerted and coherent capacity building effort, particularly at decentralised levels. Developing improved monitoring and evaluation capacity is also a high priority for the sector in order to help feed implementation experience back into programme design and budget preparation, thereby ensuring that the potentially large new inflows of financing achieve their desired objectives.

11. The national policy framework

Mozambique has been described as “policy rich but implementation poor”. In the case of child survival and development, a multitude of plans exist, often with different time-frames and targets. While effort has been made during the development of PARPA II to ensure consistency with existing national and sectoral planning documents, such the Government Five-Year Plan (2005-2009), the National Plan to Fight HIV/AIDS (PEN II 2005 to 2009), the Ministry of Health Plan to Fight STI/HIV/AIDS (2004 to 2008) and the Ministry of Health Sector Strategic Plan (2001-2005-2010), many discrepancies remain. Links between the plans and the subordination of one to another are unclear. There is no integrated plan that deals comprehensively with the issue of child survival or development, looking at linkages, for example, between health, nutrition, water and education. However PARPA II does recognise the importance of these linkages and includes strategies for closer collaboration between these various sectors.

The 2005 report of the Special Rapporteur on the Right to Health, Mr. Paul Hunt, highlighted the discrepancy between the many commendable policy initiatives in Mozambique and capacity to implement these policies, noting that ‘without more health resources - and more health professionals enjoying improved terms and conditions of work - it will be impossible for Mozambique either to achieve all the health-related Millennium Development Goals or to make satisfactory progress towards the realisation of the right to health’ (Paul Hunt 2005).

A. Health

In 2001, the Ministry of Health developed a national strategic plan for the health sector (PESS) for 2001-2005-2010. The PESS, which is the overall strategic framework for co-ordination of national and international inputs in the national health system, emphasises the Ministry of Health’s commitment to a nationally led, sector wide approach (SWAp). A Code of Conduct, defining the vision and rationale for the SWAp and the commitments of all stakeholders, was signed in 2000 and revised in 2003. A Memorandum of Understanding for the on-treasury sector wide pool for Support to the Health Sector between the Ministry of Health, the Ministry of Planning and Finance and the common fund contributors (“Prosaude”), was signed in 2003⁴⁹

⁴⁹ The Ministry of Planning and Finance has since been divided into the new Ministry of Planning and Development and the Ministry of Finance.

and was revised in 2005. The on-budget and on-treasury Common Fund complements the existing off-treasury Provincial Common Fund and the Pharmaceutical Common Fund.

The PESS sets out the common direction for the sector and aims at the consolidation of the existing network of health services, with a focus on poverty alleviation and prioritising disadvantaged population groups. The PESS was subject to a thorough mid-term review process in 2005, which found that while the document retained its validity in providing a common direction for the health sector, it was rather ambitious and lacked clear prioritisation for linking to the resources available to the sector. As a result, it was proposed that certain areas outlined in the plan were reviewed in light of the changed context, as they were no longer considered relevant or cost effective (Martinez et al. 2006).

The PESS has been complemented by a sector-wide Medium Term Expenditure and Financing Framework (MTEF), which has been produced twice, first for 2001-2005 and then for 2004-2008, as well as by a Health Sector Investment Plan for 2004 to 2008. Since 2000, monthly joint "operational" meetings (Health-SWAs), are held and chaired by the Ministry of Health. Biannual high level policy meetings (CCSs), have been taking place since 2001, and the first Annual Joint Evaluation was held in 2002. Also, since 2002, the Ministry of Health has prepared Annual Operational Plans (POA), in an attempt to plan activities and resources in a more integrated manner, thereby overcoming the compartmentalisation of the vertical programmes managed by the Ministry's national directorates, and facilitating a more transparent and accountable means of implementation. The POA also serves as a trigger for the disbursement of common funds.

In 2005 and 2006, the Ministry engaged in the development of a National Health Policy, aiming to provide a strategic framework and vision in the health sector. An important feature of this health policy is the setting of time-bound targets for child survival and development in line with the MDGs. The draft of this policy was instrumental in ensuring that PARPA II also includes specific targets, such as reducing the under-five mortality rate to 140 per 1,000 and the underweight prevalence to 17 per cent by the year 2009 (see Chapter II). The linkages between the PESS and the health policy, however, remain unclear.

In addition to the broader health sector policies, there are a number of sub-sectoral strategic plans, such as the National Strategic Plan for STIs and HIV/AIDS (PEN-ITS/HIV/SIDA, 2004-2008), which set specific targets for accelerating the health response to the AIDS pandemic, including treatment, PMTCT, and voluntary testing and counselling, and the Human Resource Development Plan (2006-2010), which has also recently included an accelerated training plan, primarily prompted by the needs imposed on the sector by the increasing HIV/AIDS health care demands. A nutritional plan has also been developed and the Ministry of Health is currently in the process of trying to operationalise this.

The national strategy for HIV/AIDS is outlined in the second national Strategic Plan to Combat HIV/AIDS (PEN II) covering the period 2005 to 2009. The PEN II is a multi-sectoral plan articulated around seven areas⁵⁰, and provides the guiding framework for all sectoral strategies on HIV/AIDS, including the Ministry of Health's PEN-ITS/HIV/AIDS, in keeping with the concept of the 'Three Ones' as espoused by UNAIDS. In the areas of treatment, PMTCT and VCT, it builds on the targets established in the PEN-ITS/HIV/SIDA. The review of these targets by the Ministry of Health at the time

⁵⁰ The seven areas of the PEN II are: Prevention, Advocacy, Stigma and Discrimination, Treatment, Mitigation, Research and Co-ordination. The National Aids Council (CNCS) has the overall mandate of coordinating the implementation of the PEN II.

of the preparation of PARPA II resulted in the substantial decrease of the PMTCT related target. This is a clear example of the lack of hierarchy among existing plans and suggests a lack of commitment to operationalisation of plans that have often been developed through very consultative processes. However, it also reflects the fact that, even in the international context, the process of forecasting and setting targets for HIV/AIDS interventions is a dynamic and evolving one, and is constantly improving as more experience is gained at country level and more timely and better quality data becomes available.

A number of legal and policy instruments are also particularly relevant to children, including the Code of Marketing of Breast Milk Substitutes adopted in 2005, the policy on Infant Feeding in the Context of HIV/AIDS (2005), the legislation relating to the production of iodised salt and the decree 41/2001 of 2001 regarding tax exemption for nationally produced iodised salt. Of particular significance is the forthcoming Child Health policy, which will include a strong component on IMCI at health facility and community levels and neo-natal care. Finally, the 1998 Strategic Plan for Food Security and Nutrition is being updated under the leadership of SETSAN.

In general, the various plans, and more particularly PARPA II, provide a credible medium-term strategy for child survival and development by clearly focusing on the expansion of the primary health care system for the most vulnerable population in the most disadvantaged areas. The main challenge ahead is the operationalisation of the strategies outlined in PARPA II, particularly regarding the review of criteria for allocating resources to the most disadvantaged areas.

B. Water and sanitation

Improving access to water and sanitation is one of the key Government priorities under PARPA II. PARPA II is supported by the National Water Policy (NWP), which was approved by the Council of Ministers in 1995 through Resolution 7/95 and established sector principles and policies towards achieving the country goals. The NWP has recently been the subject of a thorough review process, both in order to update the targets outlined in the NWP and also to ensure greater emphasis on water as a resource for socio-economic development. A revised version of the NWP was produced in 2005 and has been submitted to the Council of Ministers for approval in 2006.

The revised NWP 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, NGOs and CBOs. The NWP has the following key objectives:

- Satisfaction of basic needs of human water consumption, on the basis of a safe and reliable drinking water supply of a minimum of 20 litres per day.
- Improvement of sanitation in urban and rural areas as an essential tool for the reduction of water-borne diseases (such as cholera and diarrhoea) and better quality of life.
- Water efficiently used for economic development.
- Water used for environmental conservation.
- Reduced vulnerability to floods and droughts.
- Joint management of shared river basins to promote regional peace and integration.

The National Water Directorate (DNA), under the Ministry of Public Works and Housing, is responsible for the coordination of activities in the water sector and is

supported by key sector stakeholders represented through the Water and Sanitation Core Group, a donor coordination group for water and sanitation and the Water and Sanitation Working Group (GAS). A Centre for the Development of Strategic Studies in Water and Sanitation (CEDESA) was established in 2003, also under the Ministry of Public Works and Housing, with the aim of improving data collection and management in support of the strategic planning, monitoring and evaluation of the sector's performance.

In the NWP, 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 (Aide Memoire: Preliminary Mission Report, AMCOW-EU Mission, May 2005). The National Water Directorate is currently developing a Millennium Development Goal 'Road Map' in order to operationalise the NWP and provide a detailed costing of the targets for reaching the MDGs.

CHAPTER IV

EDUCATION, INFORMATION AND CHILD DEVELOPMENT



1. Introduction

Education is a fundamental right that is guaranteed by the Constitution of Mozambique, which states that “education constitutes both a right and a responsibility of all citizens” (Article 88). Education is one of the most powerful instruments for reducing childhood poverty and inequality, and consequently features prominently in international child rights conventions. The importance of education, particularly primary education, in advancing economic and social development and in reducing poverty is well documented. A recent attempt to account for the relative contributions of physical and human capital and technological progress to economic growth in Mozambique estimated that educational improvements over the period 1999-2004 accounted for 13.9 per cent of observed growth, indicating the high returns to education for economic growth (Jones, 2006).

As noted in the previous chapter, education plays an essential role for 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. People with the lowest levels of education are largely found in the poorest segment of the population and children growing up in households whose members have low education levels are themselves among the most excluded from education.

Box 4.1: International conventions on children’s rights to education

Convention on the Rights of the Child, Article 28

States Parties recognise the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular: (a) Make primary education compulsory and available free to all; (b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need; (c) Make higher education accessible to all on the basis of capacity by every appropriate means; (d) Make educational and vocational information and guidance available and accessible to all children; (e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

African Charter on the Rights and Welfare of the Child, Article 11

1. Every child shall have the right to an education.
2. States Parties to the present Charter shall take all appropriate measures with a view to achieving the full realization of this right and shall in particular: (a) Provide free and compulsory basic education; (b) Encourage the development of secondary education in its different forms and to progressively make it free and accessible to all; (c) Make higher education accessible to all on the basis of capacity and ability by every appropriate means; (d) Take measures to encourage regular attendance at schools and the reduction of drop-out rates; (e) Take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community.

This chapter is divided into four sections. The first section provides an overview of education in Mozambique, covering (i) access to primary and secondary education, in terms of enrolment, attendance, dropout and completion, with an emphasis on issues of equity; (ii) HIV prevention education for children and young people; and (iii) literacy. The second section analyses the causes of the challenges Mozambican children face in terms of access to and quality of formal education. The third provides an analysis of

education financing and the fourth section outlines the national policy framework for education. The experience of orphaned and vulnerable children (OVC) with regard to education is addressed specifically in Chapter V.

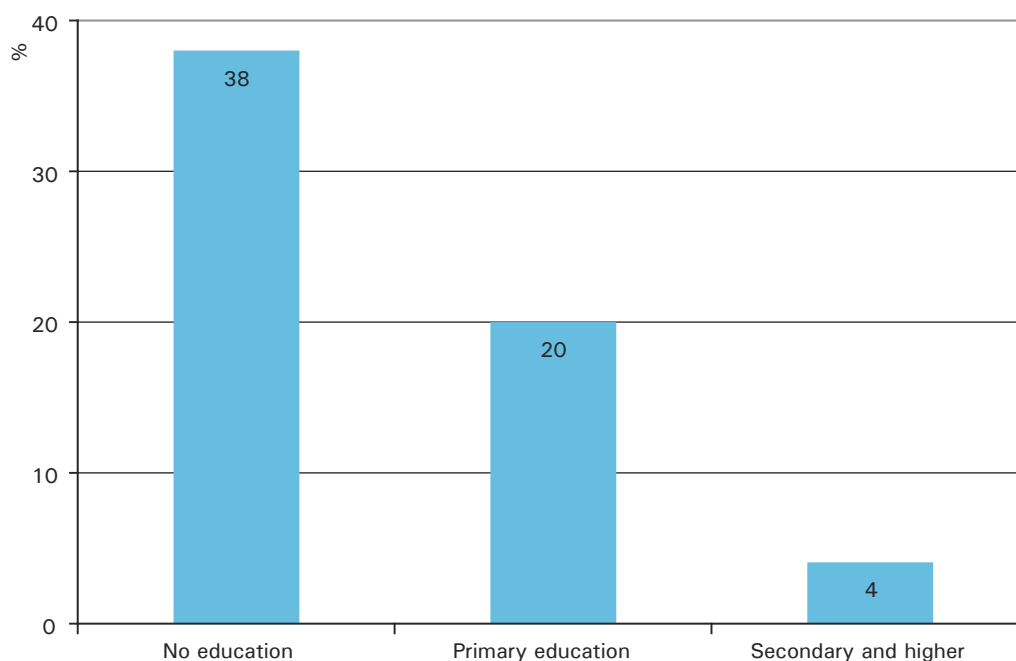
2. Overview of children's deprivations in relation to education and information

A. Severe education deprivation among children

The deprivation indicator is the proportion of children aged between 7 and 18 who have never been to school and are not currently attending school. About one in five children are severely deprived of education, with massive disparities by province, area of residence, sex, level of education of the household head and wealth. There are massive variations in education deprivation by province, particularly affecting children in Niassa, Nampula and Zambezia provinces, in which over one third of children aged between 7 and 18 have never been to school.

Severe education deprivation correlates strongly with levels of household poverty, with about one third of children living in households in the lowest three wealth quintiles suffering education deprivation. All household surveys conducted in recent years in Mozambique have pointed to a direct correlation between the level of wealth of a household and both school enrolment and attendance of children within the household. There is also a direct correlation between severe education deprivation and whether the head of the household in which the child lives has an education. For example, among households in which the household head has no education, 38 per cent of children are severely deprived of education, compared with 20 per cent of children in households in which the household head has a primary education and 4 per cent of children in households in which the household head has a secondary level or higher education.

Figure 4.1: Percentage of children with severe education deprivation by level of education of household head

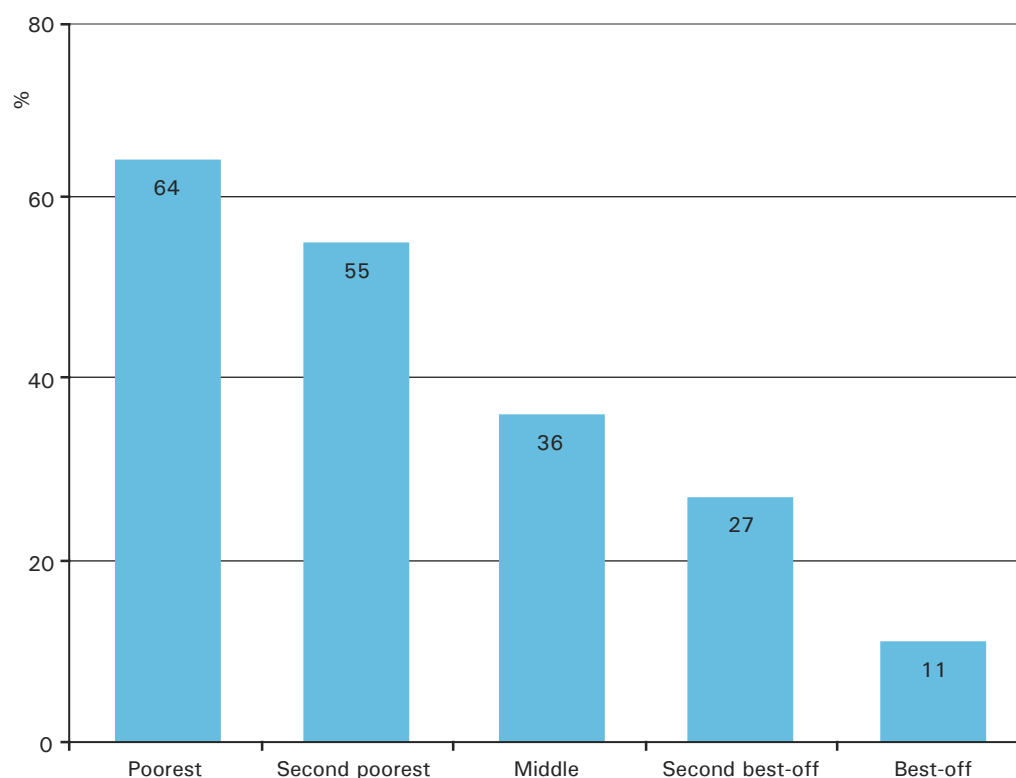


Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

B. Severe information deprivation among children

The deprivation indicator is the proportion of children aged between 5 and 18 with no possession of and access to radio, television or newspapers at home. Overall, 39 per cent of children in Mozambique are facing severe information deprivation and as with all other deprivations, there are significant disparities by province, area of residence, sex, wealth and level of education of the household head. The level of deprivation varies between provinces, from 14 per cent in Maputo City to over half of children aged 5 to 17 (53 per cent) in Zambezia province. Almost twice as many children living in rural areas face severe information deprivation as in urban areas (46 and 24 per cent respectively). Among children in the poorest households, 64 per cent are facing severe information deprivation, as compared with 11 per cent in the best off households. There is also a direct correlation between the level of education of the head of the household in which a child lives and the level of information deprivation, with 53 per cent of children living in households in which the household head has no education experiencing severe information deprivation, as compared with 10 per cent of children in households in which the household head has a secondary level or higher education.

Figure 4.2: Percentage of children with severe information deprivation by wealth quintile



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

Table 4.1: Percentage of children with severe education and information deprivations

	Percentage of Children with Severe Education Deprivation	Percentage of Children with Severe Information Deprivation
Province		
Niassa	38	47
Cabo Delgado	25	50
Nampula	34	38
Zambezia	34	53
Tete	29	39
Manica	18	24
Sofala	24	29
Inhambane	12	42
Gaza	12	40
Maputo	5	27
Maputo City	3	14
Area of Residence		
Urban	12	24
Rural	31	46
Sex		
Male	21	21
Female	28	28
Level of education of the household head		
No education	38	53
Primary education	20	35
Secondary and higher	4	10
Wealth index quintile		
Poorest	38	64
Second poorest	36	55
Middle	30	36
Second best-off	16	27
Best-off	4	11
Total	24	39

Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

3. The education system

The legal basis for Mozambique's National Education System (NES), 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). In contrast to the Convention on the Rights of the Child, the law does not establish that education, including primary education, should be both compulsory and free.

The general education system in Mozambique is divided into primary and secondary education (see Table 4.2). Primary education consists of seven years of schooling divided into two levels. The lower primary level comprises grades 1 to 5 (ensino primário do primeiro grãu, or EP1) and should normally be attended by children aged 6 to 10 years. The upper primary level comprises grades 6 and 7 (ensino primário do segundo grãu, or EP2) and should be attended by children aged 11 and 12 years. The two levels 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 (there were already around a hundred such EPC schools in operation in 2006).

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 grãu, or ESG1) and the second level comprises grades 11 and 12 (escola secundária geral do segundo grãu, or ESG2). The first level should normally be attended by children aged 13 to 15 years, while the second level should be attended by children aged 16 and 17 years.

Table 4.2: The general education system in Mozambique

Level	Grade	Official age of attendance
Primary Education		
EP1	1 – 5	6 – 10
EP2	6 – 7	11 – 12
Secondary Education		
ESG1	8 – 10	13 – 15
ESG2	11 – 12	16 – 17

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 tertiary level, there are two main publicly financed universities in Mozambique: 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.

4. Access to schooling and attendance

The significant contribution of education to overall growth in Mozambique is a reflection of the enormous progress made in expanding the education system initiated during the war years and pursued more successfully since 1992. In the period 1992 to 2005, the number of learners in primary schools trebled, from approximately 1.3 million to over 3.8 million, while the number of learners in secondary schools increased from about 45,000 to 245,000. The massive increase in the number of students has been driven by an expansion of the public school network at primary and secondary levels, from around 3,600 schools in 1992 to over 10,200 in 2005. On average, each year around 500 new schools have been constructed and 3,500 new teachers recruited. In 2004, school fees were suspended and have now been abolished for primary education. As a result of these changes, the Gross Enrolment Ratio at lower primary school level (EP1) increased from 60 per cent in 1992 to 131 per cent in 2005 while the Net Enrolment Ratio increased from 32 per cent to 83 per cent over the same period. This remarkable expansion was made possible by increased public spending supported by external funds. In 2005, the education sector accounted for 19 per cent of the total expenditures recorded in the State Budget Execution Report.

This rapid increase in enrolment has not been matched by increases in investment in the quality of education provided or by adaptive strategies for such massive increases in student numbers (the “access shock”). Indicators on the quality of education, such as the proportion of teachers who are qualified and the ratio of learners to teachers, have worsened. In the lower level of primary education, there was on average 1 teacher for every 74 learners in 2005.

While the lower primary school completion rate has improved, it remains very low. More than half of primary school age children leave the educational system before having completed Grade 5, without adequate reading, writing and numeracy skills. Furthermore, only around one third successfully complete their primary education, making the attainment of the MDG relating to education improbable by 2015. This problem is exacerbated by incomplete schools (i.e. those that are not able to offer places to all students eligible to move into the next grade every school year), which according to data from the Ministry of Education and Culture numbered approximately 2,300 at EP1 level in 2005, therefore representing some 27 per cent of all EP1 level schools.

Significant inequalities also persist in terms of access, based on where a child lives, whether the child is a boy or a girl and on the level of poverty in his or her household. There are currently approximately 660,000 children of primary school age (6-12) in Mozambique who are not attending primary school.

Two sources of information are used in the following analysis: administrative data from the Ministry of Education and Culture (MEC) and the household surveys conducted by INE, with a particular focus on the 2003 Demographic and Health Survey (DHS).

A. Trends in gross and net enrolment ratios

The Gross Enrolment Ratio (GER) and Net Enrolment Ratio (NER) in public schools have continuously increased since the end of the civil war, both at primary and secondary education levels. This analysis focuses on trends over the period 1999 to 2005, which corresponds to the period covered by the first Education Sector Strategic Plan (ESSP).⁵¹ At primary level, in the period 1999 to 2005, the GER in EP1 increased from 85 per cent to 131 per cent, while in EP2 it increased from 22 per cent to 47 per cent. During this period, the public primary school system absorbed on average 240,000 new learners each year, with the absolute number of learners enrolled in EP1 and EP2 increasing from about 2.2 million in 1999 to over 3.8 million in 2005. Over the same period, the NER in EP1 and EP2 increased substantially, from 50 per cent to 83 per cent in EP1 and from 2.5 per cent to 7 per cent in EP2.

Access to secondary education follows a similar pattern of increase, with the absolute number of students enrolled in ESG1 and ESG2 more than trebling between 1999 and 2005. In ESG1, student enrolment (excluding nocturnes) increased from about 64,006 to 210,128 and in ESG2 the number of children enrolled increased from 8,368 in 1999 to 25,737 by 2005. However, access to secondary education remains extremely limited and highly inequitable. In 2005, GER in ESG1 and ESG2 were 17 per cent and 4 per cent respectively, while NER in ESG1 was 4 per cent and in ESG2 only 1 per cent. Access to secondary education remains the privilege of very few children, mostly those in urban areas and from the wealthiest quintile of the population.⁵² In 2005, there were 156 public ESG1 schools, concentrated in 97 of the 146 districts and 33 municipalities of the country. The same year, the number of ESG2 schools in the country was only 35, concentrated in urban centres in 27 districts and municipalities.

⁵¹ The ESSP originally covered the period 1999 to 2003. It was de facto extended until 2005 in the absence of a second Strategic Plan. The second strategic plan was approved in 2006 for the period 2006 to 2011.

⁵² It should

Table 4.3: Gross and net enrolment ratios in public schools, 1999 – 2005

Year	EP1 Grades 1-5	EP2 Grades 6-7	ESG1 Grades 8-10	ESG2 Grades 11-12
Gross Enrolment Ratio (GER)				
1999	85.3	22.4	6.3	1.4
2000	92.1	25.3	7.6	1.5
2001	101.2	29.2	8.5	2.0
2002	106.5	32.9	10.6	2.4
2003	112.7	36.9	12.0	2.9
2004	121.2	42.7	13.8	3.4
2005	131.3	47.0	17.0	3.7
Net Enrolment Ratio (NER)				
1999	50.1	2.5	1.4	0.2
2000	54.7	2.7	1.7	0.2
2001	61.1	3.3	1.9	0.3
2002	64.1	3.6	2.3	0.4
2003	69.4	4.5	2.7	0.5
2004	75.6	5.6	3.0	0.5
2005	83.4	6.7	3.9	0.6

Source: MEC

Box 4.2: Methodological note and definition of key indicators

Data on enrolment are collected by the MEC through the “School Survey”, which takes place on 3 March each year. The survey also provides data about repetition and includes several indicators related to educational quality and equity. Data on completion rates and dropout are also collected by the MEC on an annual basis, at the end of the academic year, when examinations have been completed (“School Results”).

Gross Enrolment Ratio (GER) is calculated as the ratio of all children enrolled in a given education level (without age restrictions) compared with all children in the age range formally corresponding to that education level. GER in EP1 therefore corresponds to the total number of children that are enrolled in EP1, independently of their age, divided by the total number of children in the population in the 6 to 10 years age group.

Net Enrolment ratio (NER) is calculated as the ratio of all children in a given education level who are of the right age for that level compared with all children in the age range formally corresponding to that education level. NER in EP1 therefore corresponds to the total number of children between 6 and 10 years old who are enrolled in EP1, divided by the total number of children in the population in the 6 to 10 years age group.

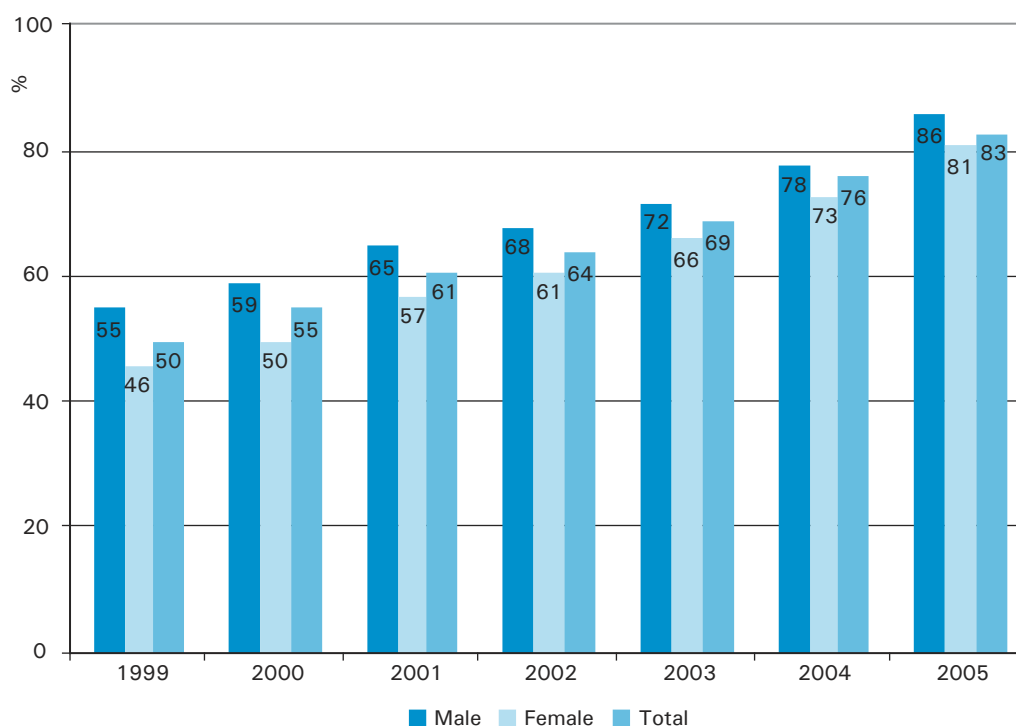
The net enrolment ratio is considerably lower than the gross enrolment ratio, due to the high number of over-aged children in school, as a result of late enrolment and high repetition rates. The NER is a measure of the efficiency of the education system in recruiting and retaining children of the “right” age while the GER is a measure of both total enrolment and the extent of over-aged enrolment. Both measures use a denominator of population data generated by INE following the 1997 population census. Their quality is therefore highly dependent on the population projections used, particularly at sub-national level. In several instances, the NER calculated by the MEC at district level have indicated NER over 100 per cent, which is by definition not possible. For the first time in 2005, the annual School Survey indicated NER over 100 per cent at provincial level (Maputo

City with 105 per cent), indicating the urgent need to update the population denominators and to review the MEC data collection process (Holms & Martínez, 2005). Such an update will only be possible following the 2007 population census.

Enrolment data only indicate whether a child is registered at school at the beginning of the school year rather than whether a child is actually attending school. While many children may be enrolled in school, they are not necessarily attending school. Measuring attendance is therefore critical as it provides a more accurate picture of the state of the education sector. Attendance rates are measured through household surveys. The various surveys conducted by INE over time systematically indicate that attendance rates (net or gross) are lower than enrolment ratios measured through the administrative monitoring system of the MEC.

The massive increase in enrolment has been accompanied by a gradual closure of the gender gap between girls and boys, together with reduced provincial disparities. The absolute gender gap in enrolment in EP1 decreased from a 25 percentage point difference in GER in 1999 to 17 a percentage point difference in GER in 2005. Enrolment rates in 2005 for boys and girls were 140 per cent GER among boys versus 123 per cent GER among girls and 86 per cent NER for boys compared with 81 per cent NER for girls. However, girls remain disadvantaged in the central and northern regions.

Figure 4.3: Net enrolment ratio in EP1 from 1999 to 2005



Source: MEC

The net enrolment ratio in EP1 varies greatly between provinces, from 70 per cent in Nampula province to universal enrolment in Maputo Province. The ratio of over 100 per cent NER in Maputo Province in 2005 is likely to indicate the use of inaccurate population denominators, as an NER of over 100 per cent is theoretically impossible (see Box 4.2: "Methodological note").

Table 4.4: Gross enrolment ratio, absolute gender gap and net enrolment ratio in EP1 in 2005 (public and private schools)

Province	Gross Enrolment Ratio				Net Enrolment Ratio			
	Male	Female	Total	Absolute Gender Gap	Male	Female	Total	Absolute Gender Gap
Niassa	145	125	135	20	94	88	91	6
Cabo Delgado	145	119	132	26	84	75	79	9
Nampula	128	105	117	23	73	67	70	6
Zambezia	141	116	128	25	88	78	83	10
Tete	140	124	132	16	92	88	90	4
Manica	151	128	139	23	87	81	84	6
Sofala	135	111	123	24	82	73	77	9
Inhambane	139	137	137	2	84	89	87	-5
Gaza	144	143	144	1	87	92	89	-5
Maputo	159	160	159	-1	103	108	105	-5
Maputo City	140	143	141	-3	94	100	97	-6
Mozambique	140	123	131	17	86	81	83	5

Source: MEC 2005 School Survey – all figures have been rounded up or down to the nearest whole number

In terms of GER, gender parity in enrolment ratios has almost been achieved in the southern provinces, with the absolute gender gap at 1 (no gap) or close to 1 in Inhambane, Gaza, Maputo Province and Maputo City (in Maputo City and Maputo Province, there are more girls enrolled in EP1 than boys). In the rest of the country, the gender gap of girls relative to boys enrolled in EP1 varies from 16 per cent in Tete province to as high as 26 per cent in Cabo Delgado province. In terms of NER, the pattern is similar, with more girls enrolled than boys in Inhambane, Gaza, Maputo Province and Maputo City. The variation between provinces is much smaller, however, ranging from -6 in Maputo City to 10 in Zambezia province and the national average is 5, compared with 17 for GER.

B. Trends in repetition, dropout and completion rates

Despite a slight decrease in repetition and drop-out rates at EP1 level during the period 1999 to 2005, repetition and drop-out rates remain high, at 11 per cent and 8 per cent respectively. In EP2, repetition rates and drop out rates also indicate a downward trend. Repetition rates decreased from 25 per cent in 1999 to 6 per cent in 2005 and drop-out rates decreased from 9 per cent to 8 per cent for EP2 during the same period.

Completion rates in both EP1 and EP2 show a marked improvement over the period 1999 to 2004. In EP1 completion rates increased from 27 per cent to 48 per cent. In EP2, completion rates increased from 11 per cent to 29 per cent by 2004. However, completion rates remain low, with under half of Mozambican children completing the lower level of primary education and fewer than one third of children completing EP2. Completion rates in EP1 are substantially lower for girls than for boys. In 2004, the completion rate for EP1 was 39 per cent for girls compared to 57 per cent for boys. The gender gap is slightly less at the upper level of primary education, where the EP2 completion rate for girls was 23 per cent compared to 35 per cent for boys.

Rates of transition between grades are a key indicator of system efficiency. Arndt and Muzima (2005) estimate rates of transition as a measure of how quickly students progress through the education system. They find a marked trend of reduced

repetition and drop-out rates at nearly all grade levels from 1999 to 2004, with an accompanying improvement in the probability of moving to the next grade level. However, the continuing extreme gap between high enrolment and low completion rates indicates massive inefficiencies in the education system, with wasted learning opportunities for children and wasted resources for poverty reduction.

Table 4.5: Repetition and completion rates in public schools in 1999 and 2004

Year	EP1	EP2	ESG1	ESG2
	Grades 1-5	Grades 6-7	Grades 8-10	Grades 11-12
Repetition Rate				
1999	23.9	24.9	25.8	11.7
2004	20.8	20.3	25.1	7.8
Completion Rate				
1999	26.5	10.7	2.0	0.6
2004	48.0	28.9	5.2	1.3

Source: MEC

C. Attendance

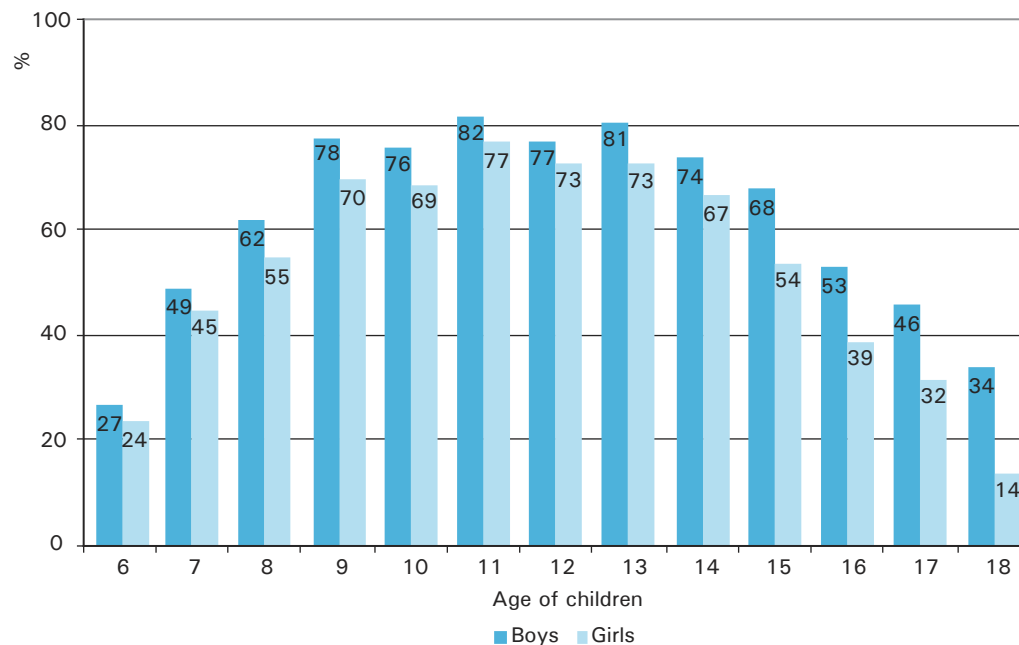
Analysis of attendance rates provides a more informative picture of the education sector in Mozambique in that they indicate whether a child is actually attending school (according to household surveys data), as opposed to simply being enrolled in school (according to the Ministry of Education and Culture data). Trends in school attendance over time confirm the positive trends in school enrolment. However, a much smaller proportion of children are attending school than are enrolled in school. For example, while NER in EP1 was 69 per cent in 2003, the DHS conducted in 2003 indicates that the net EP1 attendance rate for that year was 54 per cent.

It is worth noting that the primary school attendance data collected by the DHS are significantly lower than the data collected in 2002/2003 during the Household Survey on Living Conditions (IAF) and the more recent 2004/05 IFTRAB. In 2003, the DHS indicated that the primary school attendance rate was 60 per cent (57 per cent for girls and 63 per cent for boys). The IAF indicated a net primary school attendance rate of 66 per cent (64 per cent girls and 68 per cent boys), while the IFTRAB indicated that the attendance rate in primary school had improved substantially to 71 per cent, with almost no gender gap (70 per cent for girls compared to 72 per cent for boys). The source of this discrepancy is not immediately apparent. One possible explanation is related to the timing of the survey period. The data collection for both the IAF (2002/03) and IFTRAB (2004/05) surveys was conducted over a one-year period, covering two different school years. In contrast, the 2003 DHS was conducted over a short period of time (four months of data collection), during a single school year. It is possible that those IAF and IFTRAB interviews which were conducted during the vacation period lead to an overstatement of attendance figures by interviewees. It is also likely that the IFTRAB figures captured the positive effects of the abolition of school fees for the 2005 school year. On the principle that attendance rates should provide a snapshot of the situation in a given school year (and a given fee structure) and are therefore best measured through surveys of short duration that coincide with that particular year, the 2003 DHS data are given preference in this analysis.

Although girls' enrolment and attendance rates are overall lower than boys', there were no differences by gender in the degree of disparity between enrolment and attendance at primary level. In 2003, the net attendance rate (NAR) for girls was 51 per cent, compared with a NER of 66 per cent. For boys, the net attendance rate was

57 per cent, compared with a NER of 72 per cent. At secondary level, the gender gap was also pronounced in terms of gross attendance rate (GAR) (18 per cent attendance among girls compared to 25 per cent among boys), although less marked in terms of NAR (7 per cent girls and 8 per cent boys).

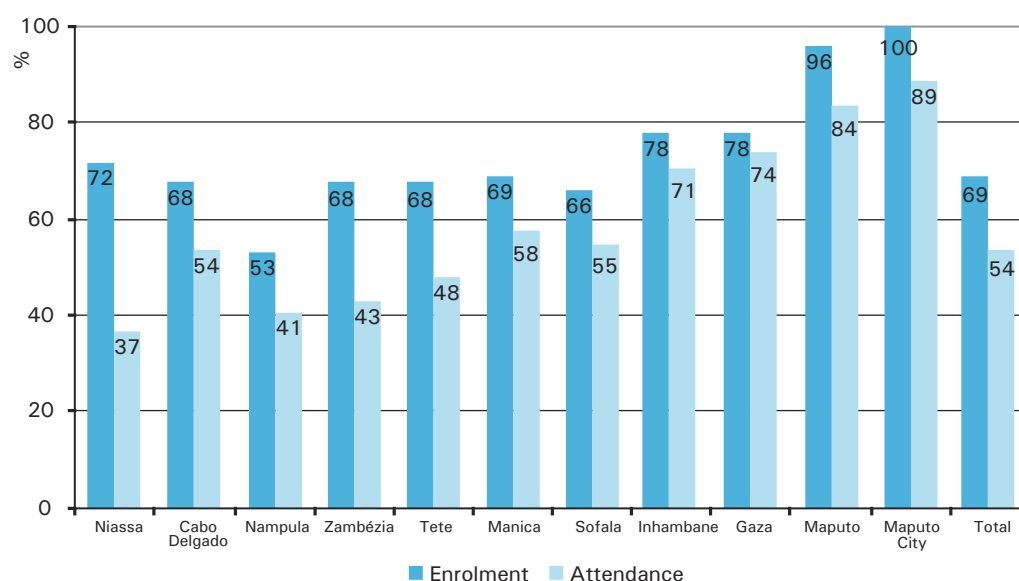
Figure 4.4: Children attending primary education by age and sex



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

There are striking differences between enrolment and attendance rates at provincial level and between attendance rates across different provinces. In Niassa province, primary net attendance among girls was only 40 per cent compared to 92 per cent for girls in Maputo City. In 2003, in Niassa there was also a 35 percentage point difference between the provincial net attendance rate in EP1, estimated at 37 per cent (DHS 2003) and the net enrolment ratio recorded the same year as 72 per cent for the province.

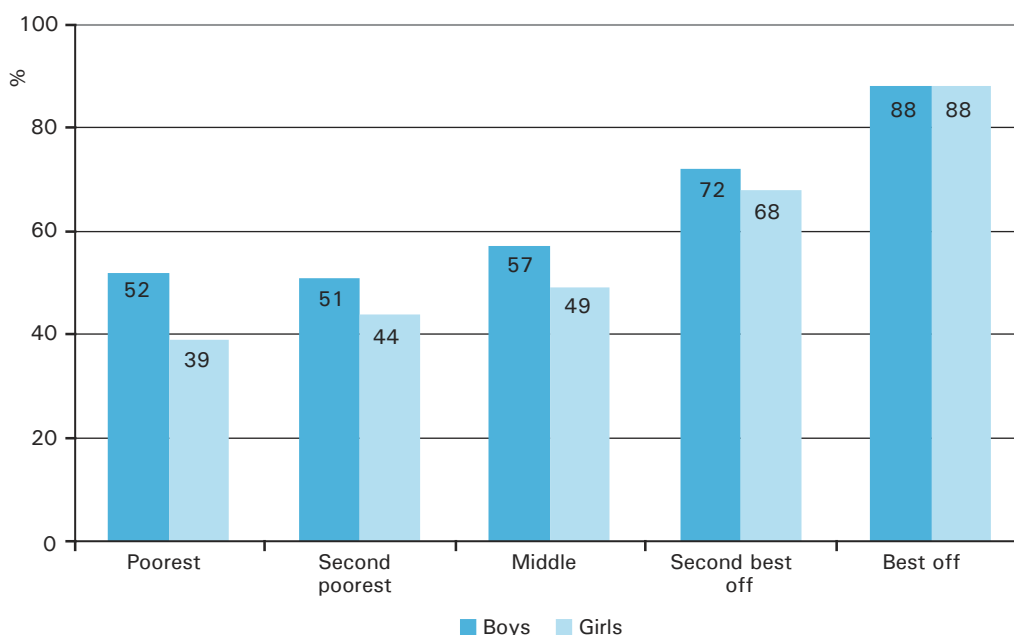
Figure 4.5: Net enrolment and attendance in EP1 in 2003



Source: DHS 2003 and MEC

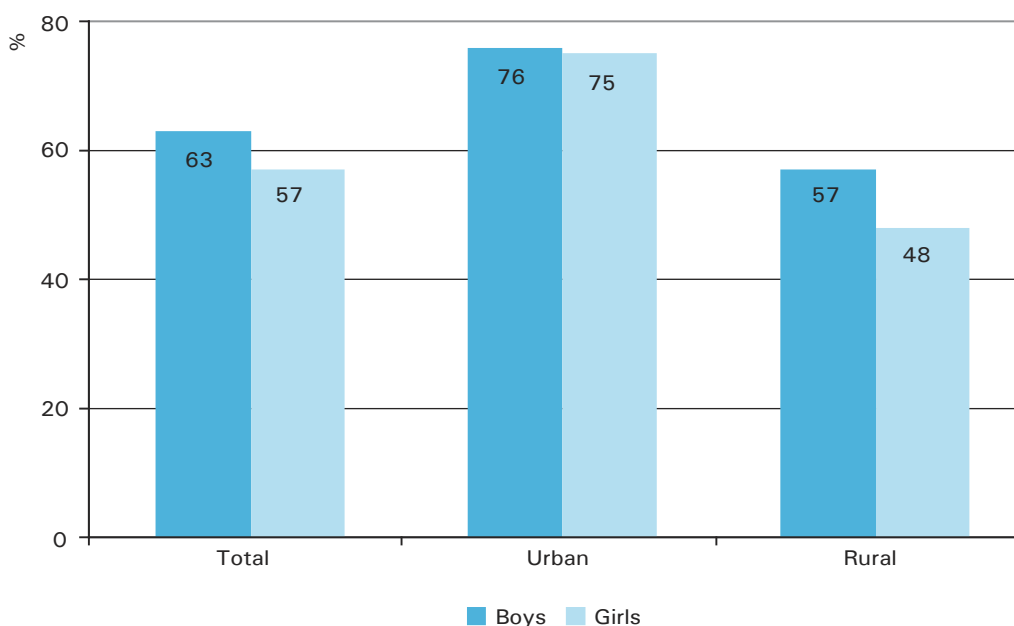
While there was almost no difference in urban areas between the proportion of girls and boys attending school, the gender gap in rural areas was marked, with only 48 per cent of girls attending primary school compared to 57 per cent for boys. Disparities among boys and girls are also marked according to the poverty level of the household in which a child lives. For example, among the poorest households, the net primary school attendance rate among boys was 52 per cent, compared to only 39 per cent among girls. Only among the best off households was the gap close, with 88 per cent attendance for each sex. This indicates that girls in the poorest households are discriminated against in terms of access to education, as such households tend to favour access to education for boys.

Figure 4.6: Net primary school attendance rate by sex and wealth quintile



Source: DHS 2003

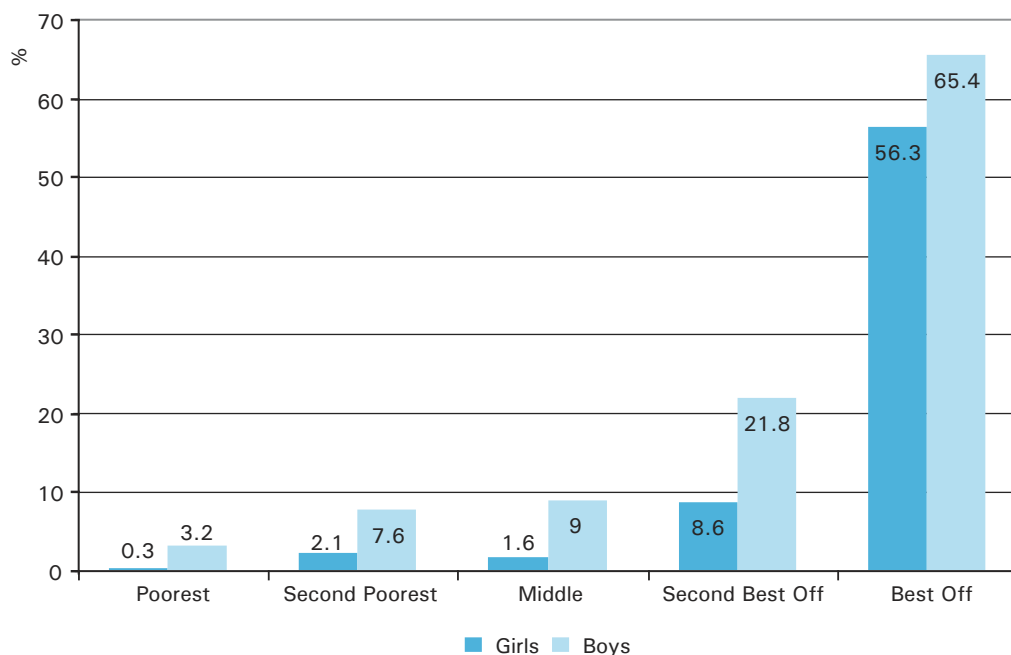
Figure 4.7: Net primary school attendance rate (EP1 and EP2)



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

DHS data show that the wealth level in the household in which a child lives has an even stronger influence on his or her access to secondary education. The Gross Attendance Rate (GAR) at secondary school among the wealthiest children is 30 times higher than among the poorest children (61 per cent versus 2 per cent). Data disaggregated by wealth index quintile also show clearly that girls in all households face substantial levels of discrimination in terms of their access to secondary education and in all but the wealthiest households, these levels of discrimination are substantial.

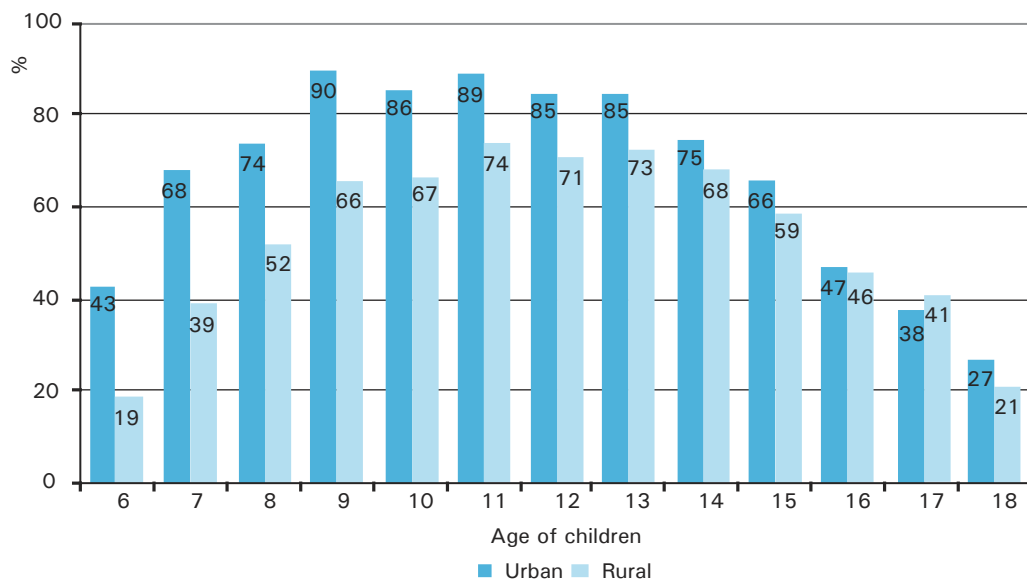
Figure 4.8: Gross attendance rate in secondary education by wealth quintile



Source: DHS 2003

A child's area of residence also has a huge impact on the age at which he or she begins school, with children in rural areas entering school much later than children in urban areas. At 6 years of age, only 19 per cent of children in rural areas attend primary school compared to 43 per cent of urban children. At 7 years of age, the gap widens, with 39 per cent of rural children being in school compared to 68 per cent in urban areas. For older children attending primary school (16 and 17 years old) the gap in attendance is the narrowest. Children's patterns of residence are different for secondary education, as many move to boarding facilities in rural towns, rather than studying while living at home. However, at secondary level, net attendance (NAR) was eight times higher in urban areas than in rural areas (16 per cent compared with 2 per cent) and gross attendance (GAR) was 9 times higher (45 per cent urban versus 5 per cent rural). The substantial differences in net attendance rates and gross attendance rates at secondary level also reflect the impact of late entry and repetition, resulting in the majority of children studying at secondary level being older than the intended age for that level.

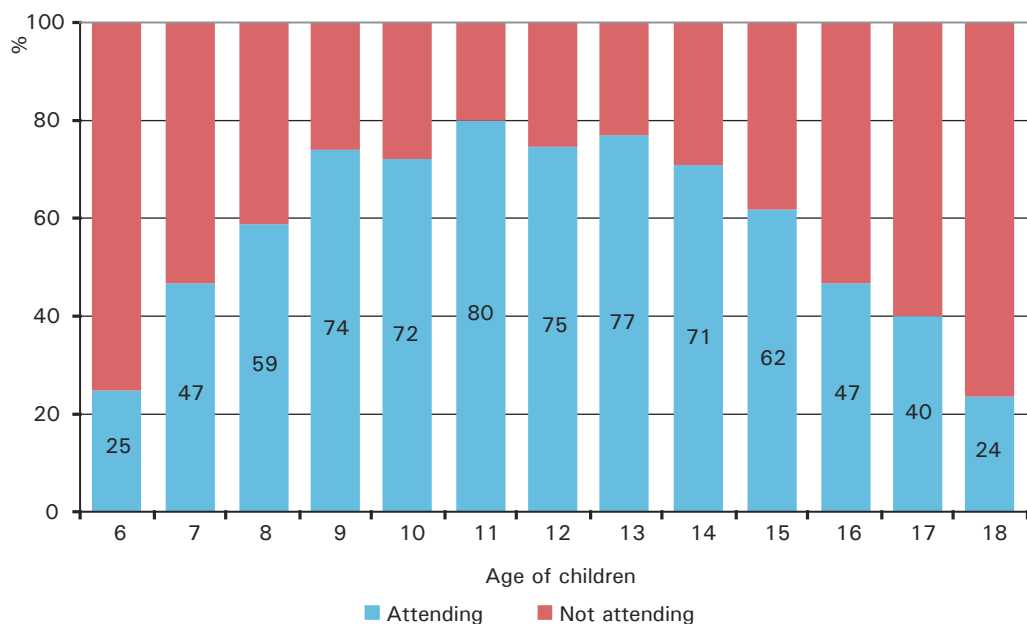
Figure 4.9: Children attending primary education by age and areas of residence



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

Primary education attendance rates are highest among children aged 9 to 14 years, with a peak amongst 11 year-old children, of whom 80 per cent attend primary school.

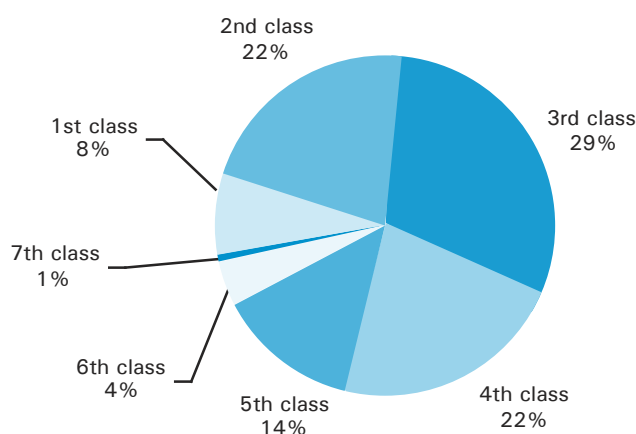
Figure 4.10: Children attending primary education (grade 1 to 7) by age



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

At 11 years of age, a child should normally be attending grade 6 in EP2. Strikingly, however, only 4 per cent of 11 year-old children attending school are in the sixth grade. The overwhelming majority of 11 year-old children (95 per cent) are still attending lower primary education (EP1), with most in grade 3.

Figure 4.11: Distribution of 11-year-old children by class attended

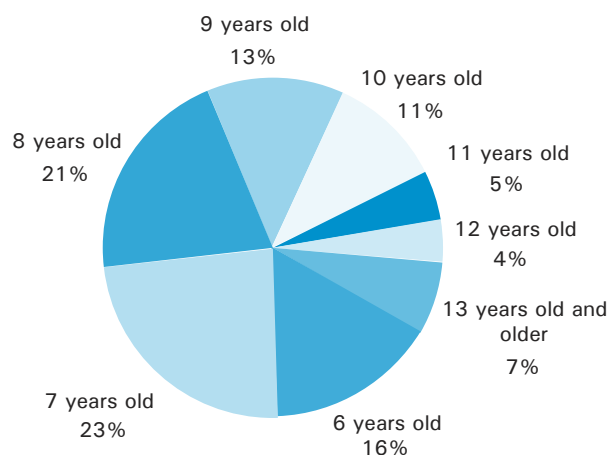


Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

This 'over-age' phenomenon in the lower level of primary education, the result of late entry into the education system and high levels of repetition, has several negative implications. It has serious 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.

This situation also poses serious challenges for school based HIV/AIDS prevention programmes. Children aged 10 to 14 years of age are regarded as being in the "window of hope", as most are not yet sexually active or are moving into being sexually active (about 30 per cent of children have already had sex by age 14).⁵³ Concentrating HIV prevention efforts on this "window of hope" has the potential to break the cycle of the pandemic. Teaching about HIV prevention to these children is therefore critical for controlling the AIDS pandemic and avoiding new infections. The mixture of older children in the age group 10-14 with younger children of 6, 7 or 8 years of age therefore presents a challenge for the implementation of a large scale and comprehensive HIV/AIDS prevention programme in schools as specific materials and methodologies are required for different age groups.

Figure 4.12: Distribution by age of children attending grade 1 of primary education



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

⁵³ In 2003, the DHS indicated that among young people aged 15 to 17 years old, 31 per cent already had sex (28 per cent girls and 31 per cent boys). In rural areas the percentage was 35 per cent compared to 27 per cent in urban areas.

5. Literacy

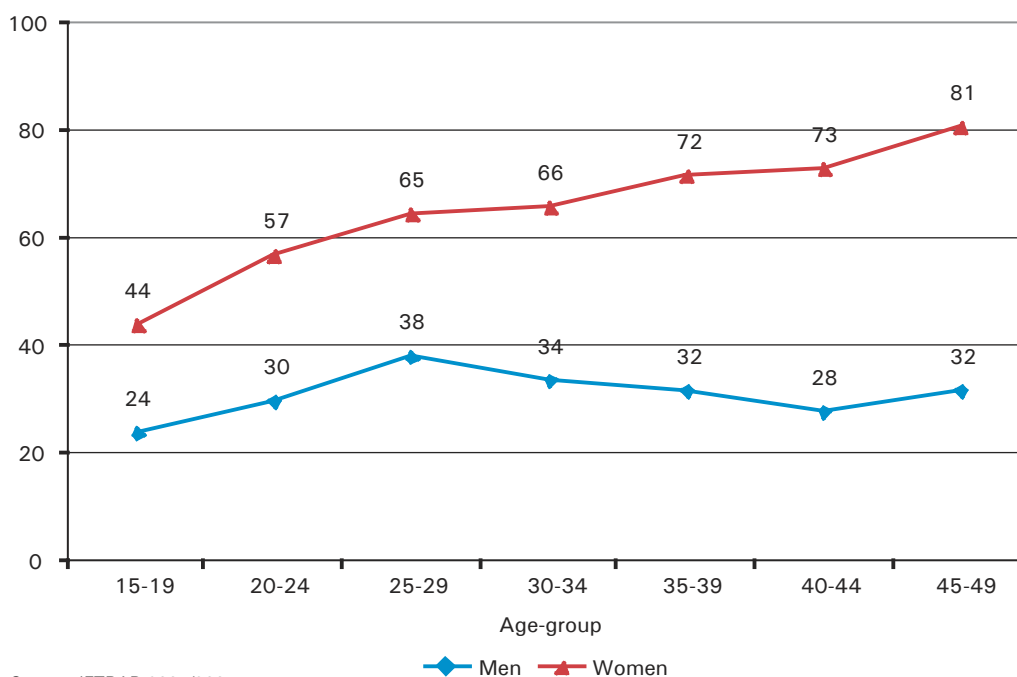
The 2004/2005 IFTRAB shows that slightly over half (52 per cent) of the population of Mozambique is not literate, with significant disparities between rural and urban areas (66 and 26 per cent not literate respectively) and between women and men (67 per cent non-literacy among women compared to 34 per cent among men). These figures support the findings of past household surveys, which have consistently shown the rates of non-literacy among women to be almost twice as high as those among men. The 2003 DHS, for example, showed 62 per cent of women were not literate compared to 33 per cent of men.

The IFTRAB data reveal important variations in literacy levels between provinces, which follow those generally observed for the primary education indicators, with the lowest rates of literacy being in the provinces with some of the lowest rates of school attendance - Cabo Delgado, Zambezia, Nampula and Niassa - and the highest levels of literacy being in Maputo City and Maputo Province, which consistently have the highest levels of enrolment and attendance in primary school. The four provinces of Cabo Delgado, Zambezia, Nampula and Niassa are also those with the highest gender gap in terms of literacy.

The 2003 DHS indicated that the level of household wealth, as in access to education, is an important factor in the level of literacy, with both women and men in the poorest households being significantly more likely to be non-literate than those in the best off households. Among women, 88 per cent of those from households in the poorest quintile were not literate, as compared with only 20 per cent of women from households in the best off quintile.

While literacy rates remain low, the IFTRAB data confirm a positive trend whereby a greater proportion of younger Mozambicans, particularly women, are literate. While 80 per cent of Mozambicans over 65 years of age are not literate, the figure is 34 per cent among young people aged 15-19 years. The gender gap in terms of literacy is also lower among young people, reflecting progressively more equitable access to education by sex.

Figure 4.13: Illiteracy rate



Source: IFTRAB 2004/2005

Lack of literacy is directly correlated with low life expectancy, high rates of child mortality, unemployment and consequently with an income insufficient to guarantee the basic needs of households. As shown in this analysis, severe deprivation among children is directly related to the level of education of mothers, with systematically better health and education outcomes for children whose mothers had a primary education. The impact is even greater among children whose mothers have attained secondary or higher education (who are also more likely to come from households in the higher wealth quintiles and from urban areas).

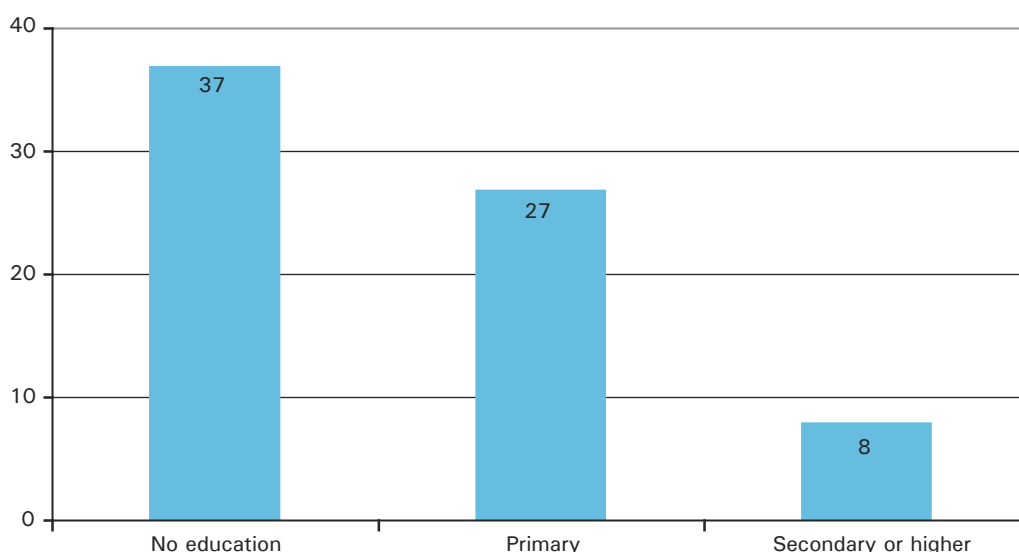
6. Children and HIV prevention education

Adolescents, particularly adolescent girls, are disproportionately affected by the AIDS epidemic. Estimates of age specific HIV prevalence among young people aged 15 to 24 indicate that almost three times as many females as males are HIV positive. In 2006, projections show that HIV prevalence was 8.9 per cent among young women 15 to 19 years of age compared to 2.9 per cent among young men in the same age group. In the age group 20 to 24 years old, HIV prevalence is estimated at 22.6 per cent among women compared to 7.5 per cent among men (INE 2004).

The increasing incidence of HIV infection in young girls is caused by a combination of biological and social factors. Biologically, women are more susceptible to infection as semen carries a higher viral load than vaginal fluid and remains in the vagina for some time and women have higher prevalence of genital ulcers and undetected STIs. Girls are furthermore vulnerable to infection as their vaginal tissue is less resistant than in adult women. Socially, girls and women have less control over sexual decision making (including condom use), are subject in some areas to harmful traditional practices (e.g. dry sex) and have much higher rates than boys of childhood marriage.

The average age of starting sexual activity is young. Estimates in 2003 of an average age of 16 for sexual debut mask wide geographical and socio-economic differences. For example, the DHS in 2003 indicated that almost half of young women 15 to 24 years of age in Niassa and Cabo Delgado provinces reported having had sex before 15 years of age, compared with 16 per cent in Maputo City. Among young women with no education, 37 per cent reported having had sex before the age of 15, compared with 8 per cent among young women with secondary or higher education.

Figure 4.14: Percentage of young women 15-24 years old who had sex before age 15

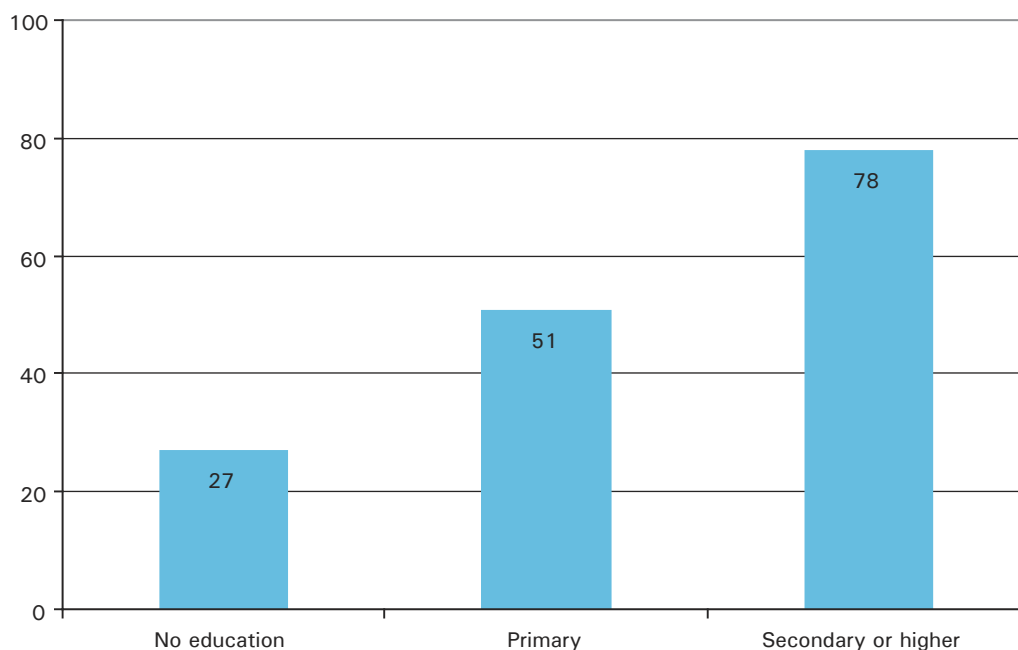


Source: DHS 2003

Knowledge about HIV and HIV prevention greatly improved between 1997 and 2003. For example, the proportion of young women in the age group 15 to 24 knowing that the use of condoms can prevent HIV transmission more than quadrupled from 13 per cent in 1997 to 54 per cent in 2003. In 2003, the DHS indicated that over 95 per cent of young people 15 to 24 years of age had heard about AIDS, with little variation by province, area of residence, level of education and socio-economic status. Knowledge about means of transmission is low. Overall, only 47 per cent of young women and 63 per cent of young men of 15-24 years of age knew about the two main ways to protect themselves from contracting HIV (using condoms or having sex only with one faithful uninfected partner). There were marked provincial variations in levels of knowledge. In Cabo Delgado province, knowledge of two prevention methods among young women was as low as 17 per cent. Even in Maputo City, where young women have many more opportunities to access information than in the rest of the country, knowledge of two HIV prevention methods was only 65 per cent.

Levels of knowledge about HIV/AIDS directly relate to levels of education. For example, among young women 15-24 years of age with no education, only 27 per cent had knowledge of the two main HIV prevention methods, compared to 78 per cent among young women who had attained secondary level or higher education.

Figure 4.15: Knowledge of HIV prevention methods (two main ways) among young women 15 to 24 years old



Source: DHS 2003

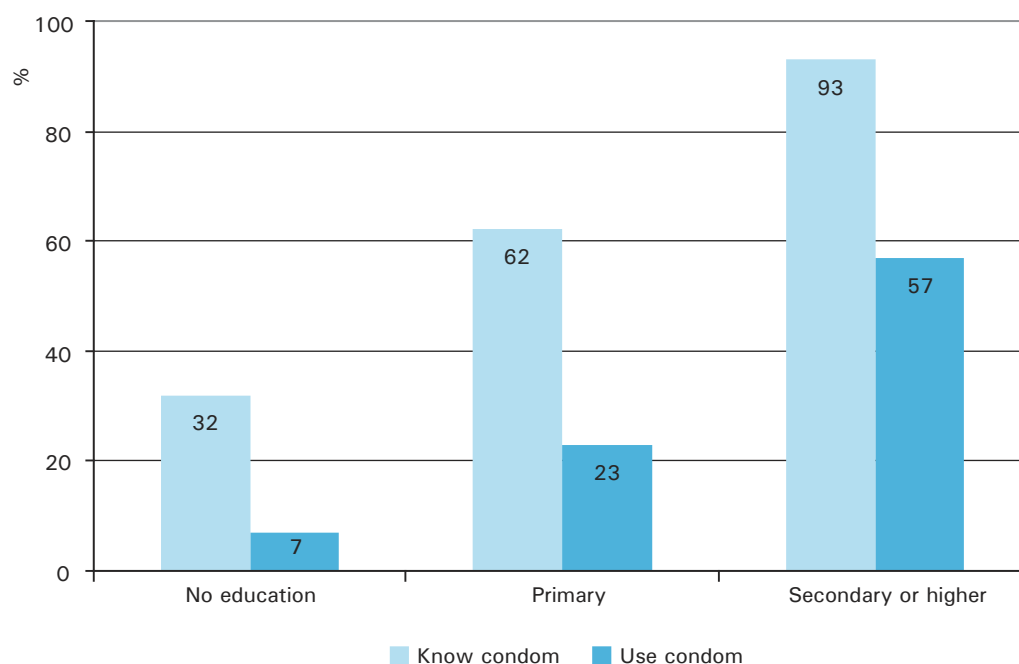
The 2001 National Survey on Reproductive Health and Sexual Behaviour of Young People found that young people hear about HIV/AIDS from a variety of sources. The full ranking of young people's sources of information about HIV/AIDS was as follows: radio in first place, followed by friends and relatives, teachers, health workers, television and brochures/pamphlets (INJAD 2001).

The level of misconception about HIV transmission remains very high. For example, in 2003, over half of young people had the incorrect belief that HIV can be transmitted by mosquito bites, with serious gaps between women's knowledge (39 per cent held the correct belief that mosquito bites cannot transmit HIV) and men's (50 per cent).

In addition, there is a serious gap between knowledge about HIV/AIDS and taking action to prevent its transmission. While the use of condoms among young people greatly improved between 1997 and 2003, condom use is still dangerously low. In 2003, the DHS indicated that 12 per cent of young women and 27 per cent of young men in the age group 15 to 24 said they had used a condom the last time they had sex, compared to 2 per cent and 11 per cent respectively in 1997. There are massive differences according to education level, with only 1 per cent of young women with no education using a condom the last time they had sex compared to 46 per cent among young women who had attained secondary or higher education. The use of condoms during high risk sex (defined as sex with a non-marital or non-cohabiting partner), is also very low, at 31 per cent (29 per cent among young women compared to 34 per cent among young men). In Gaza province, which has one of the highest HIV prevalence rates in the country, only 9 per cent of young women reportedly used a condom in their last high risk sexual encounter.

Reasons for discrepancies in levels of knowledge and behaviour are many and complex. In many places condoms are not easily available. Young people may lack the psychosocial life skills to apply the knowledge effectively. Girls especially may lack the assertiveness and negotiation skills to extricate themselves from situations in which they may be at risk of contracting HIV and boys may be unable to ignore peer pressure to start having sex at an early age and to have multiple partners and frequent sexual encounters.

Figure 4.16: Condom knowledge and condom use at last high risk sex among young women 15-24 years of age



Note: (1) condom knowledge refers to the percentage of women 15-24 years of age who say that people can protect themselves from contracting HIV by using condoms; (2) condom use at last high risk sex refers to the percentage of women who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the 12 months preceding the survey.

Source: DHS 2003

The level of testing for HIV among young people is also very low, estimated at less than 5 per cent in 2003. Beyond the lack of knowledge and high level of stigma, the lack of access to service remains a key constraint for young people. While Voluntary Counselling and Testing (VCT) facilities have rapidly expanded, from 18 centres in 2002 to 158 in 2005, these centres are attached to health facilities and there is limited geographical coverage. Since 1999, the Government has also rapidly expanded a network of Youth Friendly Health Services (YFHS), where young people from 10 to 24 years of age have free access to information about HIV/AIDS. In 2005, there were 133 YFHS in the country, covering about half of all districts. The YFHS are however mostly attended by young people from urban areas and less than 10 per cent of attendees are among the “window of opportunity” age group (i.e. 10 to 14). In addition, very few YFHS offer testing facilities. In the May 2006 Mozambique Youth Report on UNGASS, young people noted that “the existence of YFHS in the provinces and districts has been an important achievement, but their location makes it difficult for young people to reach, due to long distances from their residences, that reduced the capacity for access”.

7. The immediate and underlying causes of education deprivation

The analysis below categorises causes as immediate or underlying, although there is overlap between the different categories. A number of recent studies have provided insight into the complex and interrelated factors influencing school access and retention in Mozambique. This section draws largely on the findings of two complementary studies. The first is a Poverty and Social Impact Assessment (PSIA) conducted by the World Bank in 2004 to assess the impact of lowering the costs of schooling (WB 2004). The second is a study conducted in 2004 aimed at assessing the barriers to girls’ education at district level in Zambezia province (Justiniano et al. 2005).

A. Immediate causes of education deprivation

The pattern of access to education has been described above, with characteristics of a child’s residential area, sex and age being key in characterising their access to and progress through education.

The immediate causes of education deprivation for Mozambican children include low uptake of education opportunities, low household incomes, lack of access to and lack of quality of education.

(i) Direct education costs

The direct costs of education are cited as a major barrier to children enrolling and staying in school (INE 2003b: 74; Justiniano et al 2005: 25). Direct costs of education include school fees (until 2004), materials (such as books), food, uniforms or clothing and possible in-kind contributions to school upkeep. The 2002/3 IAF showed, for example, that 25 per cent of children aged 6 to 17 years who had dropped out of school gave the main reason as the cost of schooling (‘school is expensive’) (INE 2003b: 74).

Both fees and the non-fee related costs of education were thought by education guardians and education sector staff to be equally influential (before the suspension of fees in 2004) in decision making about whether a child enrolled or continued in school (WB 2005:30). These costs were particularly significant for children of the poorest families (WB 2005: 42). There was some difference between rural and urban areas, with the inability to pay for uniforms being more significant in urban than rural areas.

The IAF showed that in 2002/3 expenditure on 'education' represented on average 0.7 per cent of monthly household expenditure (INE 2003b: 32).

The Ministry of Education and Culture suspended compulsory school fees in 2004. The full impact of this measure, which came into force in January 2005, on the levels of enrolment and retention, and its impact on the poor in particular, has yet to be evaluated. A recent study reviewing the available evidence noted that net enrolment ratios in EP1 and EP2 have increased significantly between 2005 and 2006, although it was not possible to attribute this solely to the abolition of school fees, as other measures over the same period, such as the completion of 306 new EP1 schools and 206 EP2 schools and an EP1 enrolment drive broadcast on national radio, would also have influenced enrolment. The study also noted the symbolic value of abolishing school fees, signalling the Government's willingness to reduce the costs of education for parents (Avenstrup, 2006).

The fact that Mozambique has witnessed massive increases in enrolment since the country's return to peace in 1992, suggests that the cessation of conflict played a role in increasing enrolment. As a result of this ongoing increase in enrolment since the end of the war, the impact on enrolment of reducing fees may not be as pronounced as has been the case in other countries.⁵⁴ The impact at school level of the loss of income from school fees has also not yet been evaluated. There may be some degree of passing on the costs to households (for example, requiring more parental or student contribution to school maintenance and upkeep). However, the introduction of the Direct Support to Schools (known by its Portuguese acronym, ADE) programme in 2003 may have compensated in part for the loss of schools' local income and acted as a buffer, enabling schools to purchase materials which would otherwise have been bought by parents and education guardians. The ADE programme means that annual grants of up to US\$200 are provided, in tranches, directly to primary schools to procure school materials, such as textbooks, that benefit both teachers and pupils. The management and use of the funds is the responsibility of school councils comprised of teachers, parents, the school director and the district director. However, ADE funds are not currently sufficient for basic school needs and eligible expenditure is prescribed at central level. Schools are requesting increases in annual amounts received through ADE and more autonomy to identify their own needs.

(ii) Lack of relevance

The PSIA found that 32 per cent of those interviewed considered the current school curriculum to be lacking relevance (WB 2004: 29), a finding supported by the findings of the Zambezia study. This may also explain the main reason given in the IAF by 16 to 17 year olds for not attending school i.e. 'lack of interest' (INE 2003b: 74). In an attempt to address this complaint, the Government introduced a new curriculum in grades 1, 3 and 6 in 2004, aimed at tailoring education to the local context. 80 per cent of the curriculum is core content developed at the national level, whilst the remaining 20 per cent can be defined at the district or provincial level. Another important aspect of the new curriculum is the flexibility that it gives teachers to use the local language, since a further complaint of the former curriculum was its reliance on Portuguese, which is not spoken by the majority of the Mozambican population. While evidence suggests that the new curriculum has been positively received

⁵⁴ However, evidence from other countries shows that the abolition of school fees can have a dramatic impact on school enrolment. In Tanzania, for example, the abolition of school fees in 2001 led to an increase in net primary enrolment from 57 per cent to 85 per cent by 2002 (World Bank 2004: 8). This 'access shock' can lead, however, to significant decreases in the quality of education unless rapid coping strategies and increased investment are in place. A shift to a mass education system for all, from an elite system for the few, requires a rethinking of the education system and t

by teachers, many of them have not been trained in its content or application and awareness of the new curriculum is limited among parents (Justiniano et al 2005: 19). The Ministry of Education and Culture is currently developing a new curriculum for secondary level (RM 2006: 6) and a transitional programme for eighth grade is being introduced in 2006.

Insufficient attention has been paid to what children are actually learning in the classroom. The final primary school examination and the intermediate tests in grades 3 and 5 give some indication. However, there are no learning assessments that assess reading ability and numeracy. Learning outcomes are greatly affected by language policies. Overwhelming evidence has shown the importance of learning in the child's mother tongue. Mozambique introduced local language instruction in the first three grades in 2004. The impact of this policy has not yet been evaluated and bilingual education experts claim that five years of learning in the mother tongue is essential for literacy skills (while simultaneously learning the second language).

(iii) Distance from school

In Mozambique, proximity to school has been identified as a key determinant of primary school enrolment and retention: the further a child lives from a school, the less likely they are to attend (WB 2005: 110). The long distance that many children have to travel to get to school is frequently cited as a major reason for low enrolment or attendance.

The IAF conducted in 2002/3 showed that 74 per cent of households were located within half an hour on foot of the nearest primary school, with significant disparity between households in urban areas and those in rural areas (91 and 67 per cent respectively). Similar findings were indicated by the 2005 IFTRAB, which showed that 70 per cent of households were located within 30 minutes on foot from the nearest primary school (86 per cent in urban areas and 64 per cent in rural areas).⁵⁵

For secondary level schools, the percentage was much lower. Only 22 per cent of households surveyed were located within 30 minutes of the nearest secondary school, with a massive variation between urban and rural areas. Those living in urban areas were over ten times more likely to live within half an hour of a secondary school than those in rural areas (42 per cent versus 3 per cent). 87 per cent of children living in rural areas were travelling over an hour to get to the nearest secondary school, compared to only 12 per cent in urban areas (INE 2003b: 74).

In the 2002/3 IAF, distance was given as the third main reason for children dropping out of school (8 per cent), after lack of relevance (31 per cent) and cost (25 per cent) (INE 2003b: 74).

(iv) Poor quality of teaching and learning processes

The ECSP states that, 'Poor teacher training, insufficient materials, and lack of pedagogical support, has meant that most teachers rely on teacher centred didactical methods, emphasizing repetition and memorization over learner-centred approaches that encourage creative thinking and skills based learning. Teachers are poorly equipped to deal with some of the challenges that the system poses, such as the reality of mixed age teaching in large and in multi-grade classes, not having didactical materials and of dealing with challenges such as gender disparities and HIV/AIDS' (MEC 2006: 33).

⁵⁵ The IFTRAB questionnaire did not ask distance to the nearest secondary school.

Absenteeism is also common among teachers, partly due to the impact of HIV/AIDS and also as a result of low morale among teachers. Teacher salaries are often paid months in arrears, especially for newly recruited teachers, leading them to abandon their posts or to give precedence to non-teaching activities that guarantee an income for themselves and their families. Other forms of support for teachers in terms of supervision and assistance when moving to a different post are also often lacking (MEC 2006; PAP 2004).

The 2004/2005 IFTRAB showed that 47 per cent of those surveyed were dissatisfied with their local school, with a significant difference between those in urban and rural areas (28 and 61 per cent respectively). The highest level of dissatisfaction was found in Zambezia province, at 73 per cent, and the lowest in Maputo Province, at 12 per cent. The main reasons given for their dissatisfaction were the lack of materials (31 per cent); the poor condition of school facilities (29 per cent); the lack of books (17 per cent); the lack of teachers (6 per cent); and the payment of bribes (1.5 per cent). Higher levels of dissatisfaction were recorded in rural areas than in urban areas for all of these issues with the exception of bribery, which was slightly more prevalent in urban areas, and was most prevalent in the province of Nampula (cited by 6 per cent as a cause of dissatisfaction) (INE 2006). Increasing the volume of resources in the hands of schools and their capacity to manage the resources and define local level strategies for school improvement is vital in this regard.

a. Lack of materials

A major barrier to quality education often cited is the lack of basic school materials, and in particular text books. The current textbook-learner ratio is not known, but it is estimated to far exceed the ECSP target ratio of 1:1 in all subjects. An estimated 25 per cent of learners have all of the required textbooks (MEC 2006: 2). While progress was made in distributing large quantities of books with the introduction of the new primary curriculum in 2004, there are several remaining challenges. The textbooks delivered by the Government tend to arrive very late and leakages to the black market and weak distribution mean that the required quantities do not always arrive in schools. In theory, after the initial delivery, schools should receive an additional 30 per cent of text books to account for any books not returned or damaged by learners at the end of the year, but this delivery often does not materialise. Exercise books, pens and pencils are in principle the responsibility of parents. Although the Direct Support to Schools funds can be used to purchase these items, in light of the many other competing needs, few exercise books are purchased and many parents do not have the money to pay for these materials.⁵⁶

b. Poor condition of school infrastructure

The low quality of education in Mozambique is reflected in the physical state of school infrastructure. Few Mozambican schools currently provide a school environment conducive to learning and in a recent national study on governance and corruption the lack of adequate facilities in schools was cited by respondents as the main obstacle to attaining an education (41 per cent of respondents gave this 5 on a scale of importance from 1 to 5) (Austral: 70).

The construction of schools and classrooms in Mozambique has not kept pace with the rapid increase in enrolment and there is a chronic shortage across the country. In 2005, there were 70 students for every classroom (MEC 2005). According to

⁵⁶ The ADE/OVC pilot programme includes extra funds specifically to cover materials for all learners in its four target districts, on the premise that this is a major barrier to access for the poorest (as well as negatively affecting quality). It is envisaged that this programme will be taken to national scale by beginning of 2008.

the ECSP, between 1999 and 2005, the percentage of pupils studying in precarious classrooms or without a classroom remained stable at 56 per cent. There is a particular shortage of secondary schools in the country: the 2005 Joint Review of Government and donor performance reported that the number of children who completed primary education exceeded the existing vacancies in secondary schools by 70,000 (GoM and PAP, 2006). Anecdotal evidence suggests that this is leading to displacement of children from primary-level classrooms to allow secondary-level classes to be taught.

Although the Government has made considerable efforts to accelerate school construction, through the Ministry of Education and Culture school construction programme and the mobilisation of community and donor resources, construction is expensive and poorly monitored, leading to quality concerns. In order to address this problem, a low cost construction policy was approved in 2005 and the Education and Culture Strategic Plan envisages building 4,100 primary classrooms per year through community-managed construction at a cost of no more than US\$12,000 per classroom, with the aim of reducing the learner-classroom ratio from 90:1 to 78:1 (MEC 2006: 20). This model is currently being piloted and 618 primary schools were built in 2005 (see Box 4.3: "Lessons learned and recommendations from the first phase of the Ministry of Education and Culture Accelerated School Construction programme").

Many of the existing school buildings are in a state of disrepair, without roofs, windows, desks, chairs or electricity. Temporary solutions have often been used to keep students under shelter until proper classrooms can be built. As noted in Chapter III, a serious concern is the lack of water and sanitation facilities in the majority of schools, which can have a detrimental impact on children's health, and prevents girls from conducting their sanitary needs in dignity and privacy. In 2005, an estimated 70 per cent of schools were without water and sanitation facilities. In addition, the majority of schools have no health programmes or facilities.

Box 4.3: Lessons learned and recommendations from the first phase of the MEC Accelerated School Construction programme

- Private sector companies did not apply during the bidding process because the financial ceilings were too low
- NGO participation was low due to poor communication about the programme
- Most of the schools were thus built by the communities
- The financial ceilings needed to be revised according to inflation and the differing levels of accessibility to schools
- The time frame for school construction should be six months instead of three
- Technical assistance in the communities needs to be efficient and consistent during the entire process of school construction
- There is a need to ensure or create capacity in the provinces and districts to manage the programme
- MEC needs to disseminate information and better communicate the programme and its objectives in order to attract potential partners.

Source: MEC: Documento número 10/RAR7, April 2006

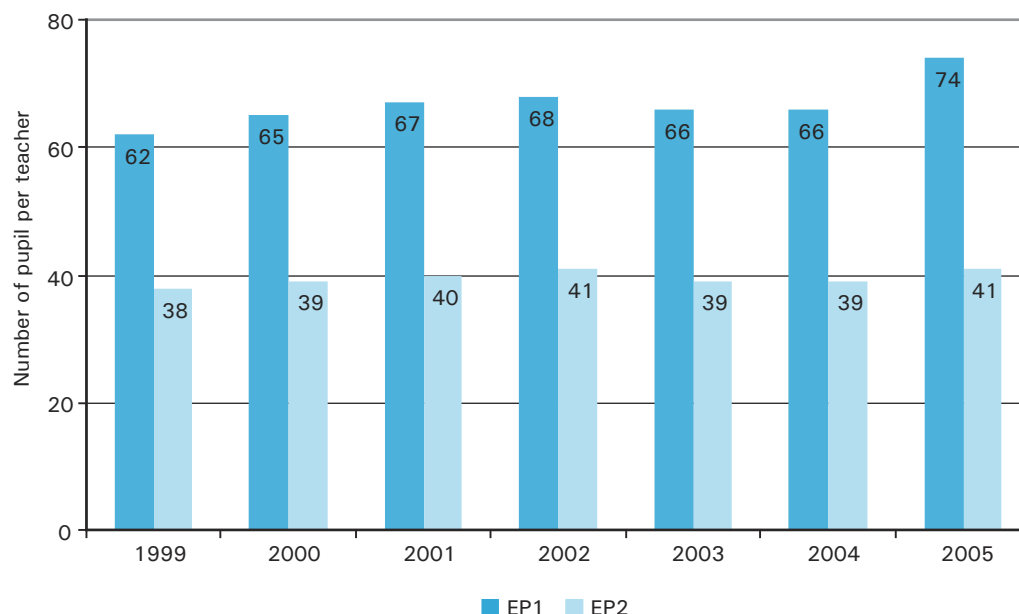
c. Lack of teachers

The lack of teachers has led to a rapid increase in learner-teacher ratios in recent years. In 2005 the learner-teacher ratio was 74:1, up from 65:1 in 2000. There were significant disparities between provinces, with the learner-teacher ratio ranging from 59:1 in Maputo Province to 103:1 in Zambezia province. Such large classes have led

to the need for two or even three shifts in both primary and secondary education, which raises safety concerns for children attending the evening shifts.

The deteriorating learner-teacher ratios also seem to have disproportionately affected secondary level education. A recent study showed that between 1992 and 2004, the learner-teacher ratio deteriorated by 11.2 per cent at primary level (EP1 and EP2) and by 88.7 per cent at secondary level, reinforcing the higher priority given to primary education (Arndt et al: 42).

Figure 4.17: Pupil/teacher ratio in primary education

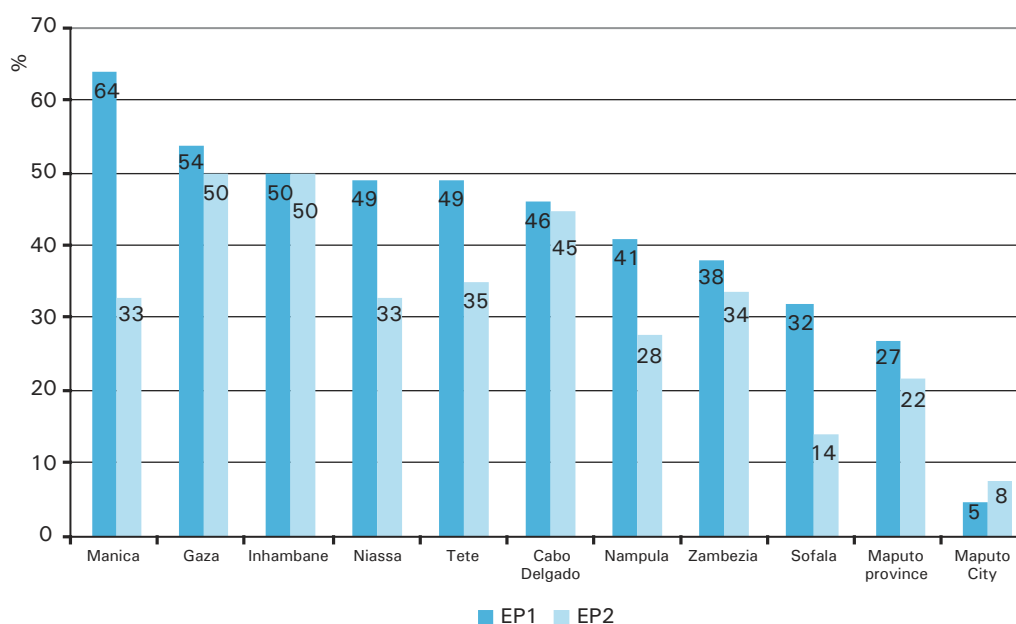


Source: MEC

d. Lack of qualified teachers

With the rapid increase in primary school enrolment over the past decade, the demand for qualified teachers has increased dramatically. The education sector has been unable to meet this demand, which has led to increased recruitment of teachers, often recent secondary school graduates, without the necessary pedagogical training. In 2005, at primary level, only 58 per cent of teachers at EP1 level were qualified, and 68 per cent at EP2 level (MEC 2005). In certain districts and provinces the situation is even more extreme (e.g. 92 per cent of EP1 teachers in Ibo district in Cabo Delgado province were untrained in 2005). The Ministry of Education and Culture is currently training 5,000 teachers a year out of an annual requirement of 7,000, which means that 2,000 untrained teachers must be recruited to fill the gap (MEC 2005: 28). However, with the exception of Maputo City and to some extent Maputo Province, there is little correlation between enrolment ratios and the presence of trained teachers in a given province.

Figure 4.18: Untrained teachers by province and level



Source: MEC

The increase over time in the proportion of unqualified teachers is particularly acute at secondary level, where 38 per cent of all teachers were unqualified in 2004 compared to only 7.5 per cent in 1992 (Arndt et al 2006: 42). A worsening of this situation is envisaged, due to the loss of trained teachers (especially at secondary level), to better paid jobs in other sectors, to non-teaching posts in the education sector, or as a result of the impact of HIV/AIDS (MEC 2006).

One of the major problems underlying the lack of qualified teachers is the current teacher training system. There are currently various different programmes, institutions and models in place with corresponding separate administration. The current system is composed of the following models:

Pre-service training

- The Centros de Formação de Professores Primários (CFPPs) train teachers for basic education level (EP1). Entrants have completed 7th grade of primary education and receive three years of training, comprising a combination of academic subjects and professional skills.
- The Institutos do Magistério Primário (IMAPs) train teachers for both EP1 and EP2 education. Entrants have completed 10th grade education and receive one year of training, comprising a combination of academic subjects and professional skills.
- Teachers for secondary school level are trained at the Pedagogical University in Maputo, although many IMAP graduates are recruited for secondary teaching.

In-service training

In addition to pre-service training, there are also in-service distance training courses, guided by the Instituto de Aperfeiçoamento de Professores (IAP - Institute for Teachers' Improvement), intended to upgrade untrained teachers and strengthen the capacity of trained teachers. In-service training is particularly important in light of the curriculum reform initiated in 2004 and for this reason, a system of continuous professional development, known as CRESCER, was introduced the same year. CRESCER is in the process of implementation and at the end of 2005 had covered 44 districts (PAP 2005).

The system is faced with a number of challenges, particularly the lack of appropriately qualified and experienced teacher educators and limited resources of the CFPPs, which mean that they lack the capacity to produce the desired results. Materials are often out of date and students complete their three years of training without any exposure to new teaching methodologies.

A major objective of the ECSP is to improve the quality and efficiency of both pre-service and in-service teacher training through ensuring a coordinated, coherent system of pre-service training and the provision of continuous in-service support and training for all teachers. From 2007, a new Teacher Training Strategy will be adopted, implying a new model of teacher training, designed to respond to the rapidly increasing demand for teachers:

- 10th Grade + 1 Year (of professional training) - for EP level teachers.
- 12th Grade + 1 year (of professional training) - for ESG levels teachers.

e. Lack of female teachers

School drop-out is a particular problem among girls, attributed to various factors, including cultural factors such as early marriage, the lower priority afforded to girls' education, and household roles which often mean that girls are more likely to drop out to take care of younger siblings, parents or relatives in the case of illness. Evidence indicates that there are several benefits to increasing the ratio of female to male teachers in terms of the impact on retention of girls in school. Women teachers not only provide valuable role models to young girls to encourage them to continue with their education, but also lessen the probability of abuse of learners. It is also good for boys to see women in a professional role. In 2005, however, only 31 per cent of all EP1 teachers were women and 23 per cent at EP2 level. Significant disparities between provinces were evident: in Cabo Delgado only 8 per cent of teachers at EP2 level were women, compared to 38 per cent in Maputo City (MEC 2005).

(v) Violence and abuse in schools

The prevalence of violence, sexual abuse and harassment in schools has been identified by parents as a factor influencing their decision to send their children to school, and particularly for girls, as a factor influencing their attendance. The situation in relation to abuse in Mozambican schools is documented in Chapter V.

In 2003, the Ministry of Education issued a decree (Despacho 39/GM/2003), stressing the importance of the values of education and the morale of the school and consequently banning teachers from having sexual relations with female students. The forthcoming Children's Act also reaffirms the duty of school management to report to the relevant authorities any cases of mistreatment of learners (RM 2006: 23). It is clear, however, that there is a need for increased awareness of this issue, among, learners, teachers, school principals and communities. A strong stance should be taken by school principals, including speaking out against violence and abuse, taking disciplinary actions against teachers involved in cases of abuse, establishing monitoring systems, and encouraging increased involvement of parents in the functioning of the school, with the support of School Councils.

Box 4.4: The anonymous teacher

This is the real magician.

It can only be considered magic that a human being...

- With little or no training
- With little support and professional guidance
- Who lives in a thatched hut, badly ventilated and scarcely illuminated
- With no shops close by, and water miles away
- At five or ten kilometres from school, that she or he will have to walk
- Who receives a salary just enough to buy a week's food, how many times paid late
- And that doesn't even buy clothes or furniture
- Two times a day (in the morning and in the afternoon)

... Is able to make a child...

- Who walked five to ten kilometres to get to school
- After a night sleeping on a ragged mat
- In a hut with many cracks and roaming cold
- Not having eaten much
- After having had to complete diverse domestic chores

... Learn to read, write and count...

- In the shadow of a tree
- Sitting on the ground
- In groups of 70 children
- With no chalk nor didactic means
- With no books nor notebooks
- With no pens nor pencils

It's magic, for the esoteric; a miracle, for the religious. Heroism, for the people and for each child who, from that nothing, acquires knowledge and develops skills.

These are the anonymous heroes of each nation. They are not heroes of war. Their only weapons are a tremendous love for children and a tenacious desire to contribute to a better world. They are the heroes of peace.

By Carlos dos Santos

B. Underlying causes of education deprivation

The underlying causes of education deprivation for Mozambican children include parental attitudes to education and to the different children in the household, parental levels of education, cultural factors and poverty.

(i) Perceptions of the value of education

The perceptions of education and the value placed on education by a child's parent(s) or guardian are important determining factors influencing both the enrolment and retention of the child in school. The Zambezia study (Justiniano et al 2005: 30) showed that the majority of interviewees considered education important for the development of the children and the community. Reasons cited in support of this opinion included:

- Literacy skills are useful for reading and writing in the community;
- Portuguese language is useful for interacting and getting around in town;
- Basic mathematics skills are useful for counting sacks of crops and for trading in the market;

- The school represents or is a link to modern life;
- The skills acquired in schools are useful for acquiring salaried jobs, hence access to a more secure life (on economic grounds) and material goods;
- The school is expected to teach behaviour (such as respect for elders and social skills).

Both the Zambezia study and the PSIA, however, indicated that there are various factors that influence parents' perceptions of education, and subsequently their decision as to which of their children will attend school and for how long. These include factors such as the perceived quality of the school, including the relevance of education and the language in which it is taught; cultural factors and the opportunities for further education. The PSIA indicated, for example, that in rural areas parents could not see the practical application of knowledge gained through primary education and many were sceptical about the long-term benefits of education, since the possibility of children continuing their education after EP1 level was much less likely, due to the lower coverage of EP2 and secondary schools in rural areas (WB 2005: 49-50).

In the context of widespread poverty, the perceptions of education become particularly important. Among poor families, the benefits of education must be weighed against the scarcity of resources and the opportunity costs of child work, and therefore negative perceptions of the quality of education or its value in a given context can result in the decision to remove a child from school. In such cases, the evidence suggests that girls or orphaned children are likely to be the first to be withdrawn from formal education. Orphaned children, particularly maternal orphans, are systematically found to have lower school attendance than non-orphaned children (see Chapter V).

(ii) Low level of education of parents

The level of education of a child's parents is another important factor as to whether or not the child will enrol in or attend school. The IAF, for example, showed that in households where the household head had no education, 17 per cent of children aged 6 to 17 years were not currently enrolled in school, compared to only 4 per cent among households where the household head had achieved secondary level education or higher (INE 2003a: 85). The 2003 DHS showed that 38 per cent of children aged 7-17 living in households in which the household head had no education had never been to school, compared to only 4 per cent in households where the head had a secondary level education or higher (MPD/INE/UNICEF 2005). Among 6 to 12 year-olds the figures were 51 and 10 per cent respectively. In terms of attendance, the IAF showed that the probability of a child attending school, both at EP1 and EP2, had a direct correlation to the parent's level of education. Children of parents with some level of education were found to be much more likely to be attending school than those of parents with no education. As in the case of a child's health status, the impact of the mother's level of education proved to be particularly significant for a child's schooling (INE: 2003a; WB 2005: 111).

(iii) Cultural factors

Cultural factors can play a major part in influencing the enrolment and retention of children in school in Mozambique, particularly among girls.⁵⁷ Gender is a major factor influencing school enrolment and retention, particularly in the context of cultural practices and traditions. The Zambezia study indicated that due to social expectations

⁵⁷ It is also important to highlight the positive role of culture and ensure that the school and the education system values traditional Mozambican culture and the local culture of the child's own community – the inclusion of a local curriculum component is important to this end.

surrounding gender or perceptions of the quality of schools, some parents do not consider education to be appropriate for girls. Reasons given in recent studies for girls not attending school included their parents taking them out of school when they began menstruating, considering that primary education is a place for children and expressing concerns that school would alienate them from local culture and traditions (Justiniano et al 2005: 33).

A particularly common reason for girls not attending or dropping out of school is early marriage or pregnancy. DHS data from 2003 indicated that 18 per cent of girls aged 20-24 had been married before the age of 15 and 56 per cent before the age of 18. Available data show that married girls are much less likely to attend school than their unmarried peers and that girls are likely to drop out of school to get married (this issue is discussed further in Chapter V). The IAF study showed that among girls aged 6 to 17 who had dropped out of school, 3 per cent said that they had dropped out due to pregnancy and 10 per cent due to marriage (INE 2003b: 74).

The Zambia study findings also highlighted the impact of the practice of 'lobolo', the traditional ceremony when a girl is married into another family, which involves the delivery of money or material goods to the family of the bride in order to formalize the marriage. This tradition is particularly important among poor families, where the money gained is an important means of sustaining the family. The findings showed that many families view lobolo as a return on the 'investment' made on a girl and that in order to achieve a high price, parents take care to ensure that a girl remains a virgin and does not have contact with older boys. School was seen by some parents as having a potentially 'corrupting' influence on their daughters, and others feared that attending school could lead to them becoming pregnant, thus lowering the price of 'lobolo' (Justiniano et al 2005: 34-36).

The Zambia study highlighted children's own attitudes affecting their education. One such example is the concept of 'curtir'. 'Curtir' is a Portuguese term meaning 'to have fun with friends' (slang: 'kicking'), used to describe a lifestyle among young people influenced by the desire to break away from traditional norms and values and focus on a more modern, urban lifestyle, in which the acquisition of material goods is given particular importance.

The study showed that this lifestyle or its pursuit can have serious implications for children's education. For boys, it may result in them dropping out of school to seek paid work to enable them to fulfil their material aspirations, often working as traders in the markets. For girls, it may mean dropping out of school to find money, often through various forms of transactional sexual relations. Girls may also become pregnant as a result of this lifestyle and consequently drop out of school. The findings of the Zambia study showed that this lifestyle was given particular value by girls, who showed little interest in education and 'were rather looking for ways to acquire a modern-inspired status (*está na moda*), where clothes, look and a liberalised view on adolescents' lifestyle prevails' (Justiniano et al 2005: 38). The fact that girls are apparently being brought up to over-value their physical appearance and under-value school achievement is an indication of existing gender-stereotyping in the country. Young people that return to school often experience a vicious cycle, whereby low achievement leads to their seeking other ways to boost their self-esteem and gain recognition and fulfilment, and may result in turn in low school achievement and drop-out.

(iv) Impact of natural disasters

In light of the chronic nature of drought in Mozambique, the vulnerability of many households to food insecurity can have a major impact on children's school attendance. Many of the households in rural areas are dependent on subsistence farming and lack of food in a family due to failed rains or a poor harvest can have negative implications for a child's education. It may lead to the child dropping out of school to find food; becoming malnourished and too sick to attend school; or employing negative coping strategies such as child prostitution in order to contribute to family income. A vulnerability assessment conducted in drought-affected districts in 2005 found that in some areas children, and particularly girls, had dropped out of school due to hunger or in order to help their parents by working on the family 'machamba' (small plot of land) (RM 2005: 25).

The pattern of natural disasters in Mozambique varies. Whilst reports show that the country suffers from some form of natural disaster in some area every year, coastal areas are prone to rapid onset disasters, such as floods and cyclones, whereas inland areas, especially in the south and central regions are more prone to slow onset disasters resulting in prolonged periods of shortage of food in terms of quantity and nutritional variety. The impact on children's education depends on the pattern of disaster, its scale and the capacity of government (sometimes supported by the international community) to respond. For example, the massive and devastating floods of year 2000 in the coastal areas of the south and centre of the country were met by a huge international relief effort, including the rebuilding of schools. It is likely that, although extremely disruptive for a short period, these floods had less negative effect on children's education in the long term than the current smaller scale protracted food scarcity affecting some parts of the country for a number of years, reducing children's capacity to walk distances to school and increasing the need for them to work to contribute to household survival.

(v) Poverty

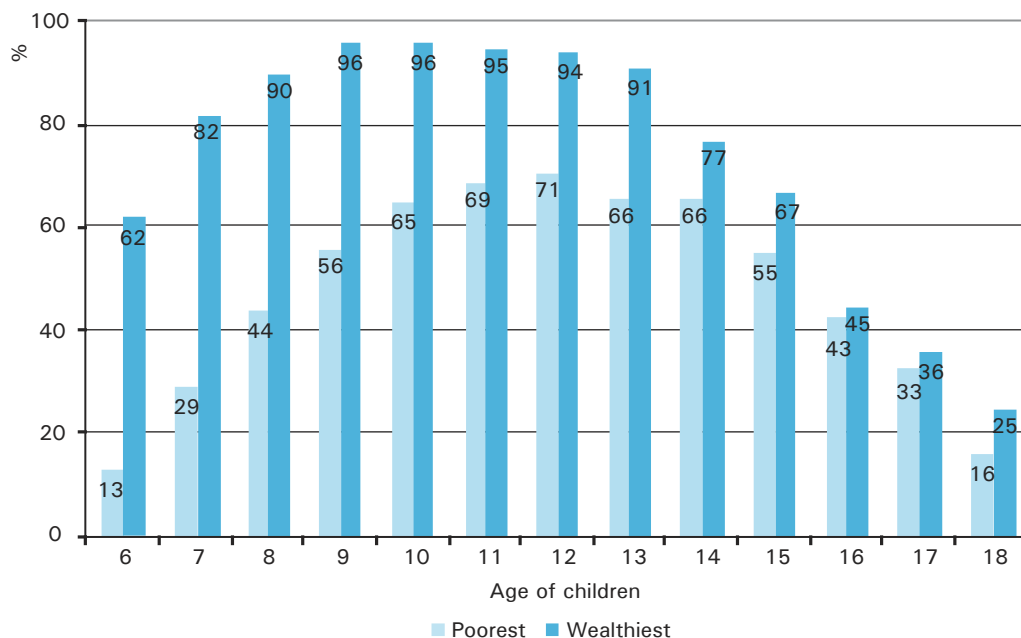
As already seen in Chapter II, many households in Mozambique live in absolute poverty. All of the available information points to the fact that many school-age children in Mozambique are engaged in both formal and informal work. The 2004/05 IFTRAB, for example, found that 32 per cent of children were involved in productive activities, with up to 40 per cent in rural areas compared to 16 per cent in urban areas (see Chapter V). These figures did not include domestic work undertaken by children. In interviews conducted with policy makers and education officials as part of the PSIA, all interviewees perceived 'opportunity costs' (the costs to the household of time spent at school meaning that a child is unavailable to carry out work outside or inside the home) to be the most important barrier to education, ahead of direct costs (WB 2005: 29-30).

The 2003 DHS showed that children from households in the best off quintile were almost twice as likely to be attending primary school as children from the poorest households, at 88 and 45 per cent respectively (NAR). Differences at secondary level are more extreme, with only the richest children attending (for example, a child from a household in the best off quintile being thirty times more likely to attend school than a child from the poorest households [GAR]).

The gender gap in primary education decreases as the level of household wealth increases, which is evidence that when resources are scarce, the education of boys is prioritised over that of girls.

Qualitative studies have also indicated a range of reasons why children from the poorest households may not be enrolled in or attending school, including illness, food insecurity, embarrassment at not having different or nice clothes to wear every day, or (before the abolition of direct school fees), ignorance surrounding the school fee exemption policy.

Figure 4.19: Children attending primary education by age and wealth quintile



Source: INE/MPD/UNICEF 2005, additional analysis of the DHS 2003

Conversely, attaining a good education is one of the main tools to break the cycle of poverty. A recent study on poverty in Mozambique found that the level of education of the household head is the most important determinant of household consumption, particularly in urban areas (WB 2005: 45). Similarly, the deprivation-based analysis of childhood poverty showed that children living in households in which the head had no education were consistently more likely to suffer from any of the deprivations than children living in households in which the household head had secondary education or higher (INE/MPD/UNICEF 2005).

8. Financing education

The cost implications of inefficiencies within the education system are enormous. It takes an average of 21 input resource years to produce one primary school graduate in Mozambique, compared with the 7 years needed in theory.⁵⁸ These inefficiencies continue through the system so that on average 212 resource years are required for a student to reach the final year of secondary school, which should theoretically take 12 input years (WB, 2003b).

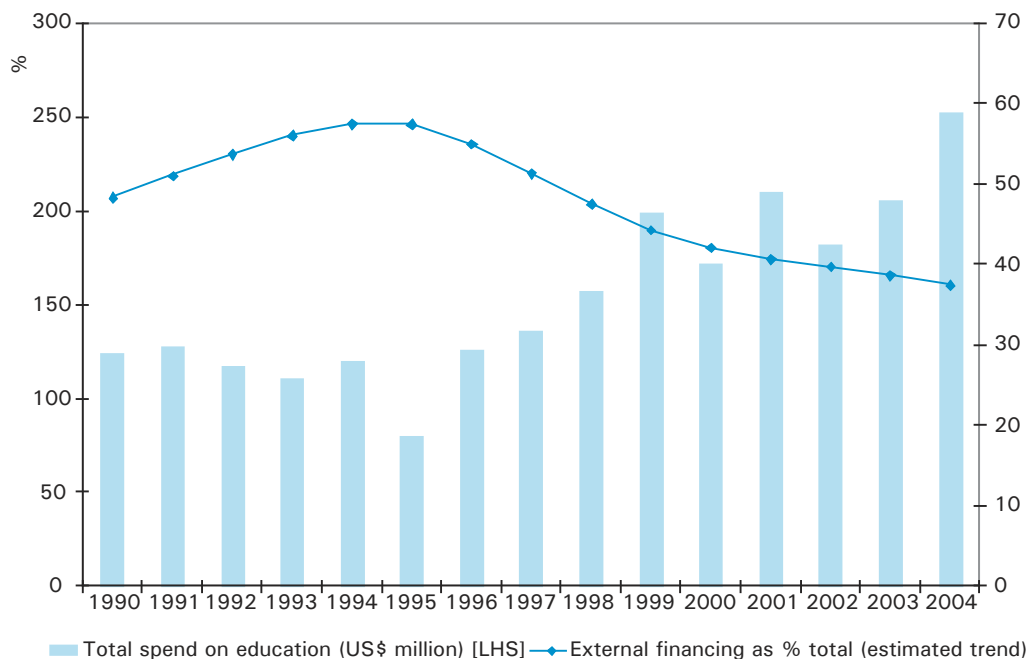
A. Global sector resources

Education financing has been the key to facilitating the rapid expansion of the sector in the post-war period, with an average of 500 new schools constructed and 3,500 new teachers recruited each year since independence. As with the financing of the health sector, a large part of this growth has been driven by external assistance.

⁵⁸ A "resource year" represents the resources required to put one child through one year of schooling.

The associated large off-budget resource flows make the CGE a less than complete reflection of public resource allocations. In compiling a series of sectoral expenditure data one must therefore turn to other sources: Figure 4.20 presents some of the broad sectoral funding patterns identified, compiled from a range of sources.⁵⁹

Figure 4.20: Estimated spending on education, 1990 – 2004 (US\$ million)

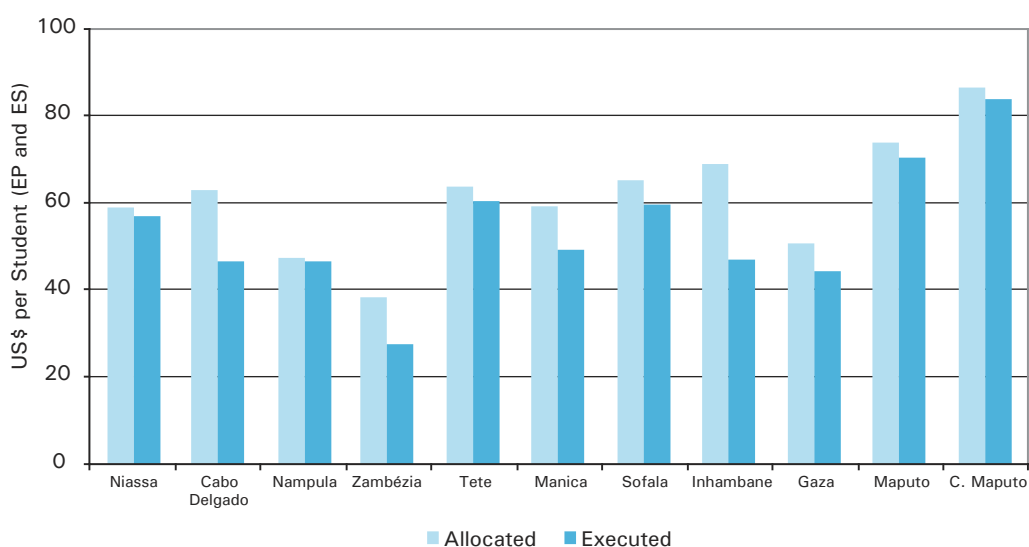


Source: Arndt, Jones and Tarp (2006)

Global public sector education financing totalled about US\$253 million in 2004, having grown by an annual average of 7.7 per cent in nominal terms over the period 1990 to 2004 and has remained relatively stable as a share of GDP, averaging around 4.7 per cent. Expressed as a share of the total Government budget, education spending stood at 18.9 per cent in 2005, illustrating the priority given to education expenditures by Government. Within recurrent expenditure, salaries make up the vast share, comprising approximately 75 per cent of recurrent expenditures in recent years. As regards the State Budget allocation between levels of the education system, primary schooling (EP1 and EP2) has historically received the overwhelming share of resources (64 per cent of total expenditure in 2004 for example, compared with 14 per cent allocated to secondary education [CGE, 2004]). Figure 4.21 provides an indication of how funds were allocated by province per student in 2005, based upon the total number of students enrolled in primary and secondary education at the beginning of the school year. These figures can only be regarded as indicative as some internal and many external funds - both those that are completely “off-report” and other vertical projects that are captured in the CGE but not broken down by province - are not included. However, it does suggest that allocations per student vary quite substantially across the country, with particularly high spending in the southernmost provinces, especially around the capital. Funds spent per student in Zambezia (the most populous province) were just over one third as much as those spent per student in Maputo City.

⁵⁹ The data – compiled in Arndt, Jones and Tarp – was collected from World Bank (2003); MPF and MINED (2004); Conta Geral do Estado (2002, 2003, 2004) and the authors’ estimates.

Figure 4.21: Indicative per student provincial education expenditure, 2005



Source: CGE 2005, Mapa II-7-1 and IV-5-1 and INE Anuário Estatístico 2005

B. Challenges for sector finance

The structure of financing within the sector has evolved in response to the imperative to rapidly expand primary schooling. The Education for All (EFA) initiative and the achievement of the MDGs remain the top priorities for many sector stakeholders. However, there are growing concerns regarding the need to invest in the post-primary school system (i.e. secondary and technical schools) so as to catch-up with demand for places (for example, there were 70,000 more graduates from the primary system than there were places in ESG1 in 2005) and produce sufficient numbers of qualified teachers to staff primary schools. The quality of education at all levels of the system is also a glaring issue: staffing primary education with teachers meeting the recently agreed “10+1” training level would require a budget share for education of more than 40 per cent, a learner: teacher ratio of over 100 or an undesirable reduction in the primary enrolment ratio (Verspoor, 2006).

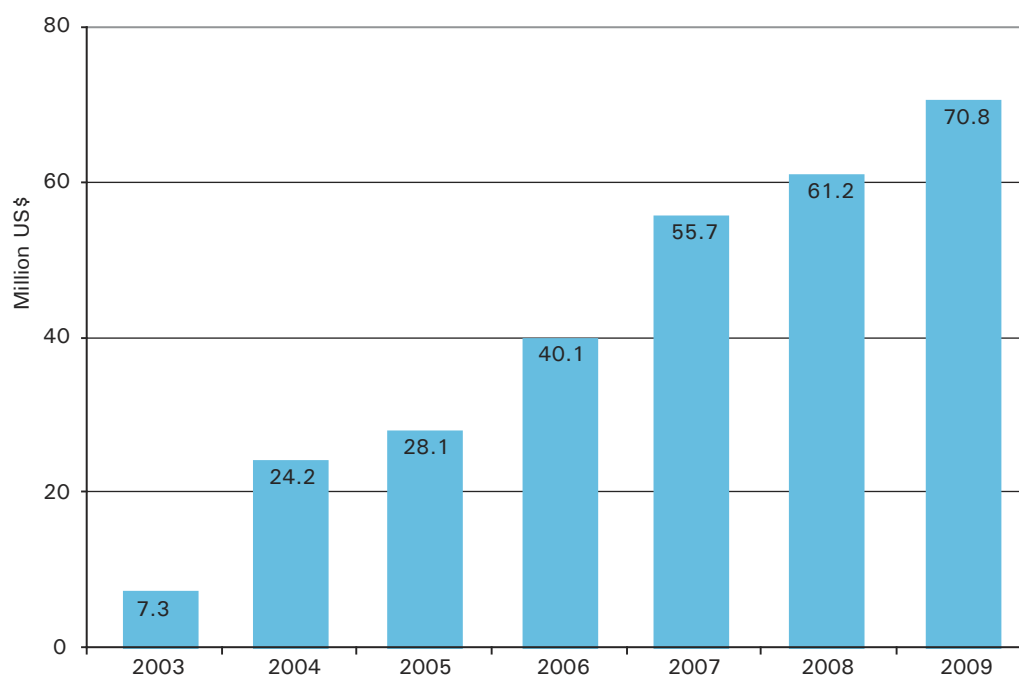
These challenges in turn demand changes in the financing of the sector, both in terms of the overall resource envelope and in terms of the allocation and type of funding. Various trade-offs are faced inside and outside the sector that need to be considered. Prominent among these is the need to build a stable and sustainable current budget allocation for the sector to support sector recruitment and training needs. The current budget is financed predominantly from Government revenues, which are constrained by the size of the tax base and the need to avoid placing too great a burden on the formal sector. Moreover, the need to maintain macroeconomic stability precludes substantial increases in recurrent expenditure, and especially salaries: the IMF programme in Mozambique includes an implicit cap on total government salary expenditure at under 8 per cent of GDP (Arndt, Jones and Tarp, 2006).

The Ministry of Education’s request for 11,500 new teachers in the 2006 State Budget was met with sufficient funds for only 4,715 teachers (GoM and PAP, 2006). This was not purely a question of rigid application of fiscal limits. The Ministry of Education and Culture’s bargaining position was undermined by a lack of accurate teacher needs projections and the related problems of having no unified teacher training strategy (which was subsequently adopted in November 2005) and contradictory figures regarding the existing numbers of teachers within the public education system.

The Ministry of Education and Culture, the Ministry of Finance and the Ministry of State Administration (MAE) each have different teacher numbers figures. A reconciliation exercise is currently underway to address this situation.

Addressing these issues has necessitated a change in the structure and emphasis of external assistance. Aid to education has historically been channelled into discrete capital investment projects, as opposed to recurrent budget activities, and in particular teachers' salaries. This is now changing. As has happened in the health sector, sector budget support through the sector common fund (FASE) has increasingly come to finance programmes of a nature usually financed by the current budget. The FASE is an ever more important channel for donor activities in the sector, financing the Direct Support to Schools programme (ADE), low-cost school construction, book distribution and in-service teacher training (CRESCER) (GoM and PAP, 2005). Figure 4.22 shows total FASE donor commitments from 2003 to 2009. Funding is set to increase by an average of US\$10.6 million per annum over the period if commitments are delivered. This will help to ensure that the ratio of current spending on goods and services to spending on salaries is maintained at a reasonable level. The second Education and Culture Strategic Plan targets 33 per cent in 2009. Using FASE funds to pay teacher's salaries is not an option, as salaries must be met through the current budget.

Figure 4.22: Common fund (FASE) donor commitments, 2003 – 2009



Source: MEC

On the financial resources side, recruitment needs therefore demand an increase in the level of government-wide General Budget Support (GBS) coupled with an agreement between the Ministry of Planning and Development, the Ministry of Finance and the Ministry of Education and Culture on accompanying teacher recruitment and training targets within the sector. Moreover, efforts to bring more sector funding on-budget will increase the information available to the Ministry of Planning and Development and the Ministry of Finance regarding total public resources in the sector, and should therefore be accompanied by clear targets and dialogue between these central agencies and the sector about recurrent resource requirements to avoid stagnation or reductions in the "internal" component.

Making the complex financing choices highlighted above is far from straightforward, and simple availability of funds is not the only constraint to increases in the number and quality of teachers – human resources for planning and finance within the Ministry of Education and Culture also require attention. Sector capacity to manage, plan and undertake analytical work for an increasingly complex system remains weak and needs to be addressed (MEC, 2003). For example, teacher needs estimates have to date been submitted to the Ministry of Planning and Development and the Ministry of Finance on an annual basis, derived from requests submitted to the Ministry of Education and Culture from provincial directorates, and the Ministry involvement in the formulation of the CFMP has been limited. This is not a fully sound basis from which to plan for the building of the sector, particularly when the impact of the AIDS pandemic on staffing is considered. While some work has already been undertaken in this respect in preparation for the Education and Culture Sector Strategic Plan (Cole, 2006), much remains to be done.

One recommendation already being discussed is to develop a Ministry of Education and Culture institutional development programme in order to build capacity in the areas of human resources, financial management, planning and monitoring at all levels (GoM and PAP, 2006). The Directorates of Planning and Cooperation and of Administration and Finance are particularly important. For international partners this means that capacity development and provision of expert Technical Assistance – to date an ad hoc process – needs to be given greater attention, and undertaken in a systematic, long-term manner, oriented around priorities set by the Ministry and funded through FASE.

The current costing of the second Education and Culture Strategic Plan shows that there is a finance gap that should inform CFMP negotiations for 2008 and 2009. An argument for additional funding for education could be made considering its contribution to sustaining Mozambique's current growth levels. As primary education currently receives the internationally recommended 50 per cent allocation, increased financing would be channelled to post-primary sectors. There is a danger that if those sectors do not capture increased resources the primary budget will not be maintained.

9. The education policy environment

A. The policy framework

The general policy environment in Mozambique is favourable to the progressive realisation of children's right to education. Both PARPA II and the Education and Culture Strategic Plan (ECSP) for the period 2006 to 2011 present credible strategies for delivery of universal primary education, based on expansion and improved efficiency and quality.

(i) PARPA II

There are strong arguments within PARPA II on the relationship between education, poverty reduction and economic growth, with an emphasis on the role of girls' education in particular. There is also an affirmation of education as a right. The strategies to shift primary education expenditure from parents to the State, including the abolition of school fees, direct financing grants to schools and free text books, are a clear demonstration that the Government is progressively delivering on fulfilling children's right to education.

PARPA II also consistently demonstrates a commitment to reduction of the disparities that are prevalent at every level of the system, stating that, "Investment in the education sector should be targeted at the most ill-favoured regions, oriented in the

sense of providing education for everyone” (GoM 2006; p. 88). It is notable that the objectives for each level of the system, i.e. primary, secondary, technical and tertiary, each include a specific reference to inclusion on the basis of gender, vulnerability and special needs. An array of strategies to increase girls’ education is outlined, including the sensitive but critical issue of sexual abuse in schools. A commitment to increasing the access and retention of orphaned and vulnerable children is also included, particularly linked to the Direct Support to Schools programme (ADE). The vital roles played by health and nutrition in ensuring that children, especially the most vulnerable, are able to attend and learn is noted, with a Government commitment to developing a school feeding policy.

The critical HIV/AIDS issues affecting the sector are well captured, namely mitigation of impact on the system (particularly teacher mortality and absenteeism), guaranteeing that orphaned and vulnerable children are retained in the system (in line with the HIV/AIDS UNGASS declaration), combating stigma and accelerating, improving, and tailoring national HIV prevention programmes with participation of young people.

(ii) The Education and Culture Strategic Plan

The first Education Sector Strategic Plan (1999-2003, extended to 2005) placed great emphasis on access and coordinated the dramatic expansion of enrolment seen in recent years. The Education and Culture Strategic Plan (2006-2011) aims to strike a balance between continuing to extend access to provide universal primary education, increasing the expansion of the post-primary sector and maintaining quality at all levels, along with ensuring equity. A notable policy change is the commitment gradually to merge the two levels of primary education into a single seven-year cycle of primary education (EPC). The plan is also accompanied by a costing framework, which aims to fit within the national Medium Term Fiscal Framework (CFMP).⁶⁰

The three key objectives of the ECSP are: (i) the expansion of access to basic education throughout all regions of Mozambique; (ii) the improvement of the quality of education services; and (iii) the strengthening of the institutions and the administrative framework for effective and sustainable delivery of education. In addition, there is an important emphasis on HIV prevention and mitigation through the school system.

The ECSP has a more sophisticated approach to dealing with the implications of the massive expansion of the education system than the first strategic plan. Hard political and budgetary choices had to be made in developing the ECSP, moving from an education system for the few that was inherited from colonial times to a system for all and tackling the impact of the “access shock” from recent years of accelerated access without corresponding reforms and resources. These included an accelerated teacher training strategy and an accelerated construction programme. The successful school finance programme, ADE, is to be consolidated and planned for increased volume of funds to schools in 2007. However, there is a policy gap with regard to the forthcoming increase in demand for secondary education.

B. Policy challenges and gaps

The major policy that needs to be updated concerns secondary education. There is massive public demand for an expanded secondary system, and increasing numbers of primary graduates are creating further pressure. Failure to sequence the expansion of secondary education is already jeopardising the resources for primary education (classrooms, teachers, and potentially budget execution) and the situation will

⁶⁰ The CFMP was drafted without MEC written input as the second sector strategic plan costings were not ready, and have therefore not been included in the 2007 State Budget. However, there will be the opportunity to renegotiate the CFMP allocations for 2008 and 2009 as those ceilings still have some flexibility.

continue to worsen. Secondary education is vital for higher level skills and human resources needed for both national development and poverty reduction. Early Childhood Development (ECD) is another outstanding area for policy development. While the mandate for ECD lies with the Ministry for Women and Social Action, the education sector has a vital role and interest and the Ministry of Education and Culture has committed to developing a joint policy with the Ministry for Women and Social Action and the Ministry of Health. There is overwhelming evidence of the importance of ECD in improving primary education outcomes by ensuring that children are ready for school (cognitively, socially and in terms of health). The challenge is in developing cost effective, institutionally sustainable, locally relevant models in a financing and service delivery partnership with civil society.

There are also various strategies and programmes that remain to be further developed:

- A national programme of School Management and Governance that includes capacity development of School Councils is yet to be planned. Currently there are ad hoc, uncoordinated programmes with very limited coverage nationally. School management is critical for translating central policy into educational outcomes. International research shows educational outcomes can vary enormously between schools even when they have the same financial resources. Management capacity is the factor that makes the key difference.
- Beyond purely educational outcomes, schools constitute a vital resource for the community and have the potential to support the well being of the child, particularly in the context of widespread poverty, vulnerability and HIV/AIDS. The ECSP displays a firm commitment to strengthening the link between the school and the community through the School Council. While ADE has provided incentives to revitalise the School Councils by giving them a real role in holding schools accountable for utilisation of resources, their capacity remains weak, and strategies to build their capacity are yet to be put in place. An integrated school management and governance programme that includes a School Council capacity development programme and brings in the human and financial resources of CSOs would appear to be an appropriate and sustainable way forward.
- Education quality is a key challenge overall, but the area of most concern is learning achievement. Learning assessments should be more widely used. Increased supervision should also focus on learning as well as teaching.
- Two successive Joint Reviews between the Government and co-operating partners have issued recommendations to develop a strategy to target the most educationally disadvantaged districts. However, concrete and holistic strategies have yet to be developed and operationalised. Similarly the positive PARPA II commitment to reduce regional disparities, including through criteria based budget allocations, is not yet operationalised. A review of experience on ADE also recommended analysing the potential of ADE to move from making budget allocations based on numbers of students in order to allocate increased budget for schools that have greater needs, as assessed by degree of gender disparities, numbers of orphaned and vulnerable children, and performance against key education indicators.
- The two recent policy developments in the areas of teacher training and low cost construction are hugely significant. However, there will be many challenges in their actual implementation. Beyond teacher training, the accurate projection for teacher recruitment and the negotiation of budget allocation with MoF (and IMF constraints) is a challenge for the Ministry of Education and Culture.

CHAPTER V

CHILD PROTECTION



I. Introduction

All children have the right to protection from violence, mistreatment, exploitation and abuse, including sexual abuse, as enshrined in articles 19, 34, 35 of the International Convention on the Rights of the Child. The physical and psychological effects of violence, abuse and exploitation affect a child's well being and development and are likely to influence the child's behaviour and attitudes throughout their childhood and into adulthood. The terrible psychological impact on children of watching their parents die as a result of AIDS is also widely recognised. Whilst the direct impact of a society's failure to adequately protect its children is difficult to quantify and the impact on poverty not directly documented, the physical and emotional security of children, especially in being protected from abuse or mistreatment by those in positions of trust and authority, contributes to the emotional health and stability of a society, as well as to its individual members' capacities to lead useful and productive lives.

Over the past two years significant steps have been taken by the Government of Mozambique to improve both the policy and legal instruments for the protection of children from violence, abuse and exploitation and to ensure access by the most vulnerable of these children to basic social services. In 2004, a legal review was conducted, with an analysis of gaps in existing legislation and areas in need of urgent reform in order to make Mozambican legislation an effective framework for the protection of children. On the basis of this analysis, the Ministry of Justice initiated the drafting process for a Comprehensive Children's Act, expected to be finalised and approved in 2006.

The Ministry of Women and Social Action has also developed a National Action Plan for Children (2006-2010), which was approved by the Council of Ministers in March 2006. The National Action Plan for Children (NAPC) is a compilation of priority actions for children identified in the line ministries' sectoral plans. The NAPC is intended as a road map to support the development of pro-child Economic and Social Plans (PES) by the Government. To that effect, the NAPC proposes the creation of a Children's Council for the effective monitoring of progress made by each line ministry in achieving sectoral objectives for children.

Under the overall umbrella of the NAPC, the Government in 2006 also approved a Plan of Action for Orphaned and Vulnerable Children (PoA OVC) in the context of HIV/AIDS. The PoA OVC is intended to accelerate the response to the emergency needs of orphaned and vulnerable children (OVC). The costed interventions set out in the PoA OVC follow two complementary lines of action: firstly, strengthening national capacities as a pre-condition for expanding the response to OVC and secondly, providing direct support to the most vulnerable children. A crucial achievement of the PoA OVC was the adoption of a Mozambican definition of "vulnerable child" (MMAS, 2006:11), essential in informing policy development and creating the basis for the targeting of social protection interventions.

In Mozambique, vulnerable children are:

- Children affected by HIV/AIDS, or infected by HIV/AIDS;
- Children living in households headed by other children, youth, women or elderly persons;
- Children living in households headed by a chronically ill adult;
- Children living on the street;
- Children living in institutions (orphanages, prisons, mental health institutions);
- Children in conflict with the law (children being prosecuted under law for minor crimes);

- Children with disabilities;
- Child victims of violence;
- Children who are the victims of sexual exploitation;
- Child who are victims of trafficking;
- Children married before the legal age;
- Child refugees or children who have been internally displaced.

This chapter has two sections. The first section addresses the protection of children from violence, abuse and exploitation, providing an analysis of the situation regarding: (i) children in conflict with the law, (ii) violence and sexual exploitation, (iii) trafficking, (iv) child marriage, (v) working children and reviewing the legal framework for protection. The nature of violations of children's rights such as child labour, trafficking or sexual abuse means that quantitative data are not easily available. Qualitative studies and in depth analysis of the situation in specific provinces are used here to provide insights into the present situation.

The second section addresses the issue of social protection for the most vulnerable children, paying particular attention to the impact of HIV/AIDS on vulnerability levels of communities, families and children. This section provides an overview of the situation of orphaned and vulnerable children and their access to basic social services, with particular attention being paid to the situation of child-headed households, to disabled children and to children in emergencies. The section reviews the policy framework for social protection, the capacity of governmental institutions to implement social protection schemes and the extent to which these are effective tools to reach vulnerable children.

2. Protection of children from violence, abuse and exploitation

A. Children in conflict with the law

In Mozambique, little reliable and systematic information exists on the situation of children in conflict with the law, but all of the available evidence suggests that the current system does not afford such children protection in line with the minimum standards enshrined in international instruments including the CRC (Articles 37 and 40), the Beijing Rules for the Administration of Juvenile Justice (1985) and the Riyadh Guidelines for the Prevention of Juvenile Delinquency (1988).

In 2003, Save the Children Norway conducted a study on the situation of children in conflict with the law in Mozambique (SCN 2003). The study was carried out in the provinces of Nampula, Sofala and Maputo, through interviews with stakeholders including children in conflict with the law and their families, other prison inmates and police and justice officials.

The findings showed that at least 25 per cent of all prison inmates interviewed were under the age of 18. Children represented the second largest group of inmates in the prison system and at particular times of the year, the largest group. Comparisons of numbers with those from preceding years indicated that the number of prison inmates, including children, was increasing at a faster rate than the national rate of population growth (of about 2 to 3 per cent per year).

The study showed that the average age among the children interviewed was 16 or 17. Although Article 42 of the Penal Code states that children under the age of 16 are not criminally liable, of those under the age of 21 interviewed for the study, 18 per cent were found to be under the age of 16, including children as young as 12. The study also showed that the principles of due process had not been followed in many cases

involving children. 45 per cent of the children reported having been detained illegally for longer than the official 48 hour period, with an average detention of three months. Of the 38 per cent of the children who had been sentenced, on average for seven months in prison, many had been given no information regarding their trial.

Based on data from research and interviews undertaken as part of the Save the Children study, it was possible to establish a profile of children in conflict with the law in Mozambique and the prison conditions in which many of them find themselves.

Children in conflict with the law

The majority of the children interviewed were:

- Male
- Poor
- Orphaned or from separated parents
- Living on the outskirts of the cities or on the streets
- Not in possession of identification documents
- Living outside a family environment
- Outside the education system
- Showing signs of poor health and nutrition and psychological and behavioural problems
- Imprisoned for minor offences, such as petty theft, vandalism or failure to carry identification papers
- Re-offenders, trapped in a cycle of petty crime

The prisons

The majority of prisons visited had:

- Serious lack of human resources and materials, with a noticeable impact on staff motivation
- Poor conditions in relation to health, food and hygiene facilities
- Children often sharing rooms with adults
- Treatment of the children by police authorities and justice officials inconsistent with the minimum standards enshrined in international human rights instruments
- Physical abuse against the child inmates commonly taking place, with 68 per cent of the children interviewed reporting that they had suffered some form of physical abuse

The high percentage of children and young people in the prison population found by the 2003 study was confirmed in the 2004 Annual Statistical Report on the Prison System in Mozambique (GoM 2005b). The report recorded 10,864 inmates in prisons at the end of 2004, well above the reported capacity of 7,649 and showed that 17 per cent of the prison population was composed of adolescents, defined as 16-19 year-olds. This was a significantly higher proportion than in all of the other SADC countries, among which the percentage of the prison population who were adolescents ranged from 0 per cent in Botswana to 9.6 per cent in Malawi. The report also indicated that 9 per cent of the prison population was made up of women, a higher percentage than all of the other SADC countries, with the next highest being Botswana, with 5 per cent of the prison population being women.

The main and underlying reason identified in the 2003 study for children being in conflict with the law was poverty, although a number of additional reasons were given, including a decline in moral values, increased access to violent films, the breakdown of families, lack of education and lack of employment.

The 2003 study found that an effective institutional framework to support the enforcement of international and national laws relating to the protection of children was not in place at any stage of the legal process. For example, there is currently only one 'Tribunal de Menores' (children's court), in Maputo city and none in any other province. There are also very few provisions for restorative, rather than punitive justice, and no rehabilitative or correctional facilities for children and young people, which would enable them to gain training and skills to reintegrate successfully into society. It was noted in the study, however, that some of the children were detained in so-called 'open prisons', which offered increased opportunities for productive activities to support inmates in re-integrating and assuming a constructive role in society.

The 2004 legal review highlighted many of the prevailing problems with the current system for children in conflict or in contact with the law, relating to both the legislation in this area and the mechanisms for its enforcement:

- The 1971 legislation (the SJAM, decree 417/71) providing for civil jurisdiction and the application of measures of protection, assistance or education by civil courts and juvenile courts, is widely inapplicable in the country and is not fully compliant with international child rights standards;
- There are currently no institutions or programmes for children aged below 16 years (the minimum age of criminal liability) and the authority with jurisdiction over children in conflict with the law below 16 (Tribunal de Menores) has limited powers and scope to deal with such children;
- Children aged above 16 years are not dealt with in a separate system from adults and imprisonment is a frequent recourse for punishment;
- No 'diversion' system appears to have been established as yet, either for younger children or for those aged 16 and 17 years (Sloth-Nielson and Gallinetti, 2004: 51).⁶¹

Reaffirming the findings of the 2003 study, the 2004 review found that children's rights during detention in police custody and in prison were frequently violated, with children being detained for lengthy periods without being brought before a court and being arrested for petty offences, such as a failure to be in possession of personal identification documents.

The forthcoming Children's Act is intended to address many of the concerns raised in regard to the juvenile justice system. The Act reaffirms the minimum age of criminal liability as 16 and outlines in detail the principles and procedures to be followed in order to ensure that the rights of children in conflict with the law are upheld, including both those under the age of 16, who are presumed under law to be incapable of committing offences, and those aged 16 and 17. The Act also proposes non-punitive measures, including the issuance of reprimands, the obligation to repay damages and community service (GoM 2006c). While the development of the Children's Act is a positive development, it is clear, however, that considerable efforts should be made both to strengthen and expand the institutions responsible for enforcing the provisions of the new Children's Act and to ensure increased coordination between all of the organisations working in this area.

⁶¹ Diversion is the referral of a child away from formal court processes, which means that the child does not suffer the stigmatisation inherent about appearing in court, nor does the child acquire a criminal record.

Box 5.1: Street children in Maputo: the experience of Associação Meninos de Moçambique

Due to their vulnerable circumstances and prominence in urban areas, street children are especially likely to fall into conflict with the law. Associação Meninos de Moçambique, an organisation that works directly with children living on the streets of Maputo, estimates that there are under 400 children and young adults living full time on the street in the capital. There are many more children, however, who spend their days on the streets and go home at night.

Among the children reached by Associação Meninos de Moçambique, the major reasons given for living on the streets are: (1) parents remarrying; (2) being orphaned; and (3) running away from home.

“My mother and father separated. Because of this my mother died. I decided to come here to look for family and friends because I lived in Maputo when I was a kid.” Roberto, 17

There are a number of organisations that provide schooling and basic medical care for street children in Maputo, and in addition the children themselves often form small communities. ‘Giglika’ (meaning ‘collapse’ in Shangana) is home to one of these communities. 23 children and young adults, aged from 13 to 20, live there. As the name suggests, Giglika is where a tower block formally stood near the centre of Maputo, and the children have made money selling off the metal and bricks as scrap. Now they often still work together, sometimes pooling the money they have earned through begging, washing cars and prostitution, and buy cheap chocolate, cigarettes and other items in order to resell them for a profit.

“I have lived at Giglika since 2001. I was separated from my parents and began to live downtown. I found some friends and one of them brought me here to live. My dream is to find my family again.” Eugenio, 13

According to Associação Meninos de Moçambique and the children themselves, the main health risks faced by street children are malaria, cholera and STDs. Only around 10 per cent of the children and young adults living on the street are girls, but they are especially vulnerable, as prostitution is a common way of earning money.

“When there is a big event here, a concert, a meeting of presidents... things like that, they [the police] come here and take us to the prisons. It happens all the time, last week it happened because there was a concert here.” Benjamin, 19 who has lived on the streets for 11 years

Source: Interviews with Associação Meninos de Moçambique and children, 2006 (J. Wordsworth)

B. Violence, sexual exploitation and abuse

The available information raises concern over the incidence of domestic violence and sexual abuse, including sexual abuse in schools. The 2001 National Survey of Reproductive Health and Sexual Behaviour of Young People and Adolescents (INJAD) (INE 2001) indicated that, as a child or teenager, 30 per cent of women and 37 per cent of men had directly witnessed violence between their parents and that 15 per cent of women and 20 per cent of men had suffered physical abuse by a relative in their youth. These findings reinforce anecdotal evidence that domestic violence and abuse are widespread in Mozambique.

As many as 34 per cent of women who participated in a study carried out for the Ministry for Women and Social Action in 2004 reported having been beaten. The perpetrator of the violence was most frequently the woman's husband or a close relative or acquaintance. 10 per cent of respondents reported having been subjected to some form of sexual abuse. Women in rural areas reported higher levels of violence than women in urban areas (UEM 2004).⁶² The 2004 Ministry for Women and Social Action study concluded that the cultural acceptance of violence is a major cause of domestic violence. DHS findings from 2003 also describe a generally accepting attitude among both men and women towards violence:

- 54 per cent of women stated that men had the right to beat them under certain circumstances, such as leaving the house without informing the husband or refusing sex. Women in the poorest quintile were most likely to demonstrate an accepting attitude to this violence. An attitude of acceptance was more prevalent in rural areas, where 57.5 per cent of women accepted violence compared to 48.2 per cent in urban areas.⁶³
- 41 per cent of men demonstrated an accepting attitude to violence, with no notable variation between urban and rural areas. Men in the poorest quintile were more likely to be accepting (42.6 per cent) compared with men in the wealthiest quintile (38.6 per cent) (INE 2005: 48-50).

There are currently 96 help centres established in Mozambique for women and child victims of violence and abuse. These centres reported 16,000 cases in 2004. Although this figure is not disaggregated by age, it is estimated that half of these victims were children (Government response to UN Questionnaire on Violence against Children). In its 2004 study "Don't suffer silently", the organisation "Women and Law in Southern Africa (WLSA) analysed data of the centres for assistance in Maputo City and Province, and in Sofala province for 2000 to 2003. According to this study, a total of 289 cases of violence and abuse against children were registered: 213 of these were against girls between 0 and 16 years of age. The great majority of the crimes were committed within the direct family environment (WLSA 2004). According to the figures in the Public Prosecutors report of 2004, there were 134 cases of violence against children and 110 cases of violence against women that year. Given the prevailing context of acceptance of domestic abuse and low levels of confidence in the police and justice system, these small numbers suggest that the vast majority of cases went unreported.

Case studies suggest that there is a high level of sexual abuse in the school system. In a recent study supported by Save the Children, CARE International, MEC and Rede-CAME/FDC, it was estimated that at least 8 per cent of school children had suffered physical sexual abuse (SC et al 2005).⁶⁴ A further 35 per cent had experienced sexual harassment involving verbal persuasion. Actual levels of sexual abuse are likely to be higher, as 22 per cent of the girls interviewed did not recognize forced intercourse as abuse and as many as 35 per cent did not consider that verbal harassment constituted abuse (ibid: 9-11).

⁶² The Study, conducted in 2004 for the Ministry by the Universidade Eduardo Mondlane, Centro de Estudos da População, included 2,052 women between the ages of 18 and 45 in Maputo City and Province, Sofala, Manica, Zambezia and Nampula (UEM 2004).

⁶³ The DHS indicator is the percentage of women between the ages of 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.

⁶⁴ The study focused on girls aged 15 or older, using 1,190 questionnaires in Maputo City, Maputo, Gaza, Inhambane, Sofala and Nampula provinces (SC et al 2005).

Girls at greatest risk of abuse were:

- Over 15 years of age (67.5 per cent of cases);
- Enrolled in lower grades (particularly EP2, with 45.2 per cent of cases);
- Not living with both parents (73 per cent).

The fact that many of the students are over-age for their class level could be a contributing factor to the level of violence and abuse in schools. At EP1 level, it is not uncommon to find young children in the same class as children aged 13 or above. There was little difference between rural and urban locations (49 and 51 per cent of cases respectively). In 37 per cent of cases the perpetrator of the abuse was a teacher. The majority of cases were one-off incidents (87.5 per cent) rather than recurring abuse. In 85 per cent of cases, girls reported that school authorities had no knowledge of the abuse (ibid: 31-50).

In a 2004 Youth Profile commissioned by the Ministry of Youth and Sport and UNICEF, 20 per cent of girls who participated in the study reported that abuse was a problem in schools.⁶⁵ However, interviewers noted that many students and teachers appeared unwilling to talk about the subject. Students reported that they were forced to choose: provide sex, pay money or face expulsion from school.

The majority of cases of sexual abuse reported by girls were settled in private, usually with a fine paid by the teacher to the girl's family. Cases were only referred to the authorities when these negotiations were not successful. The 2005 study drew a similar conclusion: "Frequently, measures for the resolution of this type of crime are negotiations between the families involved. The authorities are only involved when there is no consensus in the negotiation, for instance, when the accused is not willing to pay the fines imposed" (SC et al 2005: 9-11).

Teachers involved in abuse tended to target vulnerable children who were less able to refuse to cooperate. Abuse was found to be endemic in schools where the principal and deputy principal were involved and to be greatly reduced when those in positions of authority were active against the practice. The incidence of abuse was also lower in schools that held regular parent-teacher meetings and where parents complained directly on hearing about such abuse (UNICEF and MDJ 2004: 37-39).

Box 5.2: A student's experience of sexual abuse at school

Student: Every night the headmaster calls a girl and touches her without her consent. When anyone asks him why he does that, he answers by asking if it is wrong to look.

Interviewer: Have you ever heard of sexual abuse? What would sexual abuse be for you? Can you give me an example?

Student: Yes, I have heard of it, it is when an older person has a sexual relationship with someone that does not want to. For example: trying to kiss a girl even though she does not want to be kissed.

Interviewer: Have you had a problem related to sexual abuse?

Student: Yes, the headmaster came at night to the boarding school and tried to kiss and fondle me by using force.

Interviewer: How did you feel after he tried to kiss you by using force?

Student: I felt bad, I became sad and fearful.

Source: Study report on Sexual Abuse of Girls in Mozambican Schools Save the Children, CARE International, MEC and Rede-CAME/FDC 2005

⁶⁵ The study was based on interviews with 240 adolescents and 147 adults in Xai Xai, Manica, Gondola, Nicoadala and Nhamathanda (UNICEF 2004).

Intergenerational transactional sexual relationships between girls and older men are thought to be common in Mozambique. A 2003 study in Zambezia (Bagnol, B and Chamo, E) quoted other sources suggesting that between one eighth and one quarter of adolescent girls have transactional sexual relations with men at least ten years older than themselves. Such relations form part of a complex web of different sexual relationships, both for the girls and for men. The study reported that girls seek out such contacts because of the perceived social status and access to economic gains available. Men seek out young girls because their sexuality is perceived to be more exciting than older women, they may be less able to refuse, and they are thought to be less likely to be infected by HIV.

The widespread incidence of transactional sexual relations between women and men in Mozambique and the cross-generational incidence of such relations make it difficult to identify the boundaries between this type of sexual interaction and commercial sexual exploitation of children. Girls engaged in exchanging sex for some form of monetary or in-kind benefit do not usually regard themselves as “prostitutes”. The negatives effects of such exchanges are not seen to be the accepting of money or goods for sex, per se, but the fact that such relationships do not lead to marriage and may mean that a girl becomes pregnant without the father being identified, resulting in the girl’s family becoming responsible for the upkeep of the baby.

Box 5.3: Milking the cow

In 2004, Options Consultancy Services and Population Services International (PSI) Mozambique conducted a qualitative study among young women in Maputo engaged in cross-generational transactional sex, in order gain a more in-depth understanding of the phenomenon, which is thought to contribute significantly to the spread of HIV/AIDS in Mozambique. The study used the PEER (participatory ethnographic evaluation and research) method, based upon training members of the target group (peer researchers) to carry out in-depth qualitative interviews among their peers.

The study revealed that the young women engaged in cross-generational and transactional sex had a complex sexual network involving multiple partners, including both transactional and non-transactional relationships. These sexual partnerships were classified into a range of different types of relationship: *namorados* (same age boyfriends, with whom there is a perceived relationship of trust); *pitos* (partners for sexual pleasure and with whom there is no economic exchange); *sengue* (older married men) and *amante* (lovers).

The *sengue* and *amante* were both transactional relationships. All of the young women stressed that the primary motive for transactional sex was economic, and that they had no emotional attachment or expectations beyond exchange of sex for money and other economic benefits. However, transactional relationships were perceived to be distinct from prostitution, as transactional exchange always took place in the context of a relationship, whereas prostitution was considered a one-off business encounter with a client.

Rather than perceiving themselves as passive or coerced victims of relationships with older men, the young women interviewed saw themselves as active agents involved in a continuing process of defining their social and sexual identity and making choices about the risks in which they engaged. Transactional sex was conceptualised as a strategy by which they were able to reverse the existing balance of gender and power relations. Through the power of their sexuality, the young women were able to extract financial resources from men in order to access the material goods and life-style that symbolise modernity and success. This strategy was referred to as ‘to *sengue*’, derived from the Portuguese adaptation of a local term ‘*sengar*’, meaning ‘to milk the cow.’

The aspirations expressed by the young women were to have a home, financial security, freedom, independence, social status and respect. Lack of employment opportunities for women, lack of access to education, corruption, low wages in employment sectors in which women predominate and poor communication between parents and children were identified as major factors constraining the achievement of these aspirations, in addition to gender norms and stereotypes, which present an image of women, and particularly girls, as sexual objects and commodities.

The young women expressed a pride and esteem in having the power to obtain and maintain a *sengue*. The relationship had to remain clandestine, however, as with discovery a young woman ran the risk of her reputation being ruined and being labelled a 'puta' (whore), as well as losing access to her financial resources.

The findings of the study showed that the young women had high levels of knowledge regarding HIV and AIDS and high awareness of the risks associated with multi-partner and unprotected sex. Nonetheless, they were explicit about their lack of negotiation power over condom use with their *sengue* and *amante* and stated that attempts to negotiate condom use may threaten the relationship with the *sengue*. The risk of losing the immediate economic resource of the *sengue* and therefore social status was perceived to far outweigh the longer-term risk of contracting HIV and AIDS. Abortion was referred to as the main means of contraception, despite the many stories referring to unsafe abortions with severe health consequences.

The study proposed a number of opportunities for intervention, endeavouring to take into account the potential loss of power and status which could result from changes in behaviour by the young women. Suggested interventions included: a focus on the more immediate risks than HIV/AIDS of such behaviour, such as pregnancy, unsafe abortion, and STIs; using peer researchers as an entry point to stimulate sustained communication strategies among their peers that support positive changes in peer group norms; using the mass media to challenge the social norms that accept men seeking this type of service, targeting men as well as women, and challenging the tacit acceptance of cross-generational transactional sex.

Source: Hawkins, K, Mussa, F and Abuxahama, S, Milking the Cow: Young women's constructions of identity, gender, power and risk in transactional and cross-generational sexual relationships

The Government's Five Year Plan 2005-2009 (GoM 2005) aims to establish a national database on violence and sexual abuse, adopting measures to strengthen legal protection and support for the victims of abuse and undertaking a review of the legal code to identify laws that might be discriminatory (GoM 2005a: pp42- 45). This is reinforced in the PARPA II, which envisages the elaboration and implementation of strategies and plans for the prevention and protection of victims of domestic violence, and the strengthening and expansion of the network of centres for the protection of victims of violence (GoM 2006b: 82).

The National Action Plan for Children outlines seven activities to protect children from violence, neglect and sexual exploitation (MMAS 2005c: 26):

- Sensitising parents, teachers and other community members on the prevention of violence and corporal punishment;
- Undertaking training and capacity building for people involved in law enforcement - including those working on the borders - in the identification and detention of child traffickers;

- Establishing effective mechanisms for the implementation of legislation in accordance with international conventions on the prevention and combating of child trafficking;
- Establishing mechanisms for the implementation of legislation against corporal punishment in schools, the penal system and the family;
- Establishing partnerships with other organisations around the prevention of sexual abuse of children;
- Sensitising children, educators, families and communities on the effects and prevention of sexual abuse of children;
- Establishing rigorous mechanisms for the monitoring of tourist activities, traditional cultural practices and other activities that encourage sexual exploitation of children, including child pornography.

Awareness raising is essential, not only at community level, including in schools, but also for professionals in contact with children. Appropriate media attention also serves to raise awareness, promote open discussion and encourage communities to respond to cases of abuse and exploitation. Strengthening the availability of support and rehabilitation services is another key dimension. The effectiveness of such responses is significantly enhanced by the existence of an effective coordination mechanism.

Box 5.4: A bridge across the Zambezi: what needs to be done for children?

In 2006, Save the Children published a report based on research undertaken in 2004 and 2005 aimed at gaining a better understanding of the existing vulnerabilities and risks facing children in the town of Caia and the locality of Chimuara, both located in Sofala province, on opposite sides of the Zambezi river, prior to the pending construction of a new bridge across the Zambezi river.

Both Caia, in Caia district, and Chimuara, in Mopeia district, are rural areas in which the inhabitants are dependent on small-scale subsistence agriculture to provide for their families and earn an income. The challenges faced by the communities in these areas are similar to those in other rural areas, such as chronic poverty, vulnerability to natural disasters and food insecurity, leading to malnutrition among children. In addition, Sofala province currently has the highest AIDS prevalence in the country, at 26.5 per cent, and the impact of HIV/AIDS, particularly the associated increase in orphaned and vulnerable children, is placing an additional burden on the communities in Caia and Chimuara.

The National Highway meets the river on both sides and the National Road Administration currently runs a ferry service transporting traffic across the river. As a result of the ferry crossing, business owners and informal traders have opened 'barracas', guesthouses and vending stands, on both sides of the river.

The study found that the increased volume of traffic and the existence of the barracas created by the ferry crossing have raised a number of child protection concerns. The high number of visitors using the ferry service, in addition to the presence of workers from other infrastructure projects in the area, often men travelling or living alone for long periods, with relatively high incomes, have led to sexual abuse and exploitation of children, both in terms of sexual harassment or assault, and also prostitution among the so-called 'barraca girls', leaving the children highly vulnerable to HIV/AIDS and STIs. In addition, harmful child labour has been witnessed, with boys as young as ten or eleven living and working by the river, often for long hours or in hazardous settings, with serious negative implications for both their education and their health. While some measures have been taken by the district authorities to keep children out of the barracas, on the whole those interviewed considered these measures to be ineffective.

Against this background, Caia and Chimuara are the sites for the construction of the new bridge across the Zambezi, which began in March/April 2006 and is expected to take at least three years to complete. There are many positive aspects to the construction of the bridge, including economic benefits such as attracting investment and encouraging business, and also social benefits, such as the creation of much-needed employment and increased access to health services by local residents.

However, the potential negative consequences of the bridge construction have raised concerns that the construction period could exacerbate an already difficult and dangerous situation, by increasing the demand for child labour and prostitution, and consequently increasing and accelerating the spread of HIV/AIDS. The Government and donors have announced that they will take precautions to help in reducing some of the potentially harmful social impacts of bridge construction, with particular focus on controlling the transmission and spread of HIV/AIDS. Several members of the communities, however, feel that meaningful dialogue between the Government and the residents on the project, its potential negative impacts and their mitigation, is lacking, and envisage the communities being left to deal with any negative social impacts without external support.

The report proposes a number of recommendations to ensure that the rights of children are protected and their well-being promoted throughout the construction of the Zambezi bridge, including, amongst others:

- Development, awareness raising among staff and enforcement of company codes of conduct prohibiting child abuse or exploitation by construction contractors or sub-contractors;
- Strengthening the capacity of district police and the legal system to prevent, investigate and respond to possible cases of child exploitation and abuse by the workers, such as the training of district police on child rights, laws relating to child sexual abuse and their enforcement and the national law regulating the access of children to public night entertainment areas, such as bars, discos and barracas;
- Offers of financial assistance by contractors for their employees to bring their wives to live in the camps;
- The promotion of agricultural development activities in parallel to the bridge construction in order both to improve the health and well-being of children and also to provide families with a sustainable source of food and/or income to avoid the use of negative coping strategies;
- Monitoring of the child rights situation in the area by NGOs and local organisations.

While the Save the Children study highlights the need for specific actions to promote and protect the rights of children in Caia and Chimuara, the report also serves to raise awareness on the potential negative impact for children and communities of all large infrastructure development projects.

Source: A Bridge Across the Zambezi: What needs to be done for children? Save the Children UK and Norway, March 2006

The 2004 legal review found that the legal framework related to violence, sexual abuse and exploitation falls “desperately short of the range of necessary legal provisions required in this area” (Sloth-Nielsen and Gallinetti 2004: 40). The review expressed concern that provisions of the law “are not properly implemented. This may, in part, be due to the fact that the provisions do not identify a lead agency which is legally bound to ensure enforcement” (ibid: 40). Case study evidence also suggests that violence and abuse are areas in which formal and customary laws may be in conflict.

The current legal framework protecting children will be strengthened through the implementation of the 2004 Family Act and the forthcoming Children's Act, which reaffirms children's right to protection from violence, abuse, neglect and exploitation and the duty of the State to uphold this right, and provides for punitive measures to be taken against any person violating the right of the child to bodily and moral integrity (GoM 2006c).

C. Trafficking in children

The trafficking of children not only removes them from the protective environment of their family, but also increases their vulnerability to child labour, violence, sexual exploitation and abuse.⁶⁶ In Mozambique, there have been numerous reports of the trafficking of women and children, particularly between Mozambique and South Africa for purposes of labour and sexwork. Trafficking is also thought by some to be linked with the extraction of human organs for ritual purposes, with recent incidents alleged in Nampula and Niassa provinces (Amnesty International Report 2005).

It is also important to draw attention to a related but often neglected area: that of cross-border migration of children. This much broader issue is of a more voluntary and less coercive nature than trafficking. However, children who migrate are then much more vulnerable to trafficking, both in their home and destination countries, having little access to social protection mechanisms or public services. Mozambican children primarily migrate to South Africa, but also to other southeast African countries. Underlying causes of child migration include economic insecurity, lack of employment opportunities, family instability, natural disasters and prolonged sickness and death of family members, sometimes from AIDS. Very often, they soon find themselves in a situation of increased poverty, vulnerability and exploitation once they cross a border (see for example Save the Children Norway, 2000).

As regards trafficking, some of the most detailed information available comes from the report of a study on trafficking in Southern Africa conducted in 2002/3 by the International Organisation on Migration. This study found that Mozambique is both a source country and a transit country for trafficking activities in Southern Africa and that approximately 1,000 Mozambican women and children are trafficked to South Africa every year, earning traffickers approximately one million South African Rand annually (IOM 2003). The study showed that:

- Victims come from rural and urban backgrounds, from Maputo and Nampula provinces;
- Two types of victims were involved: (i) sex worker victims in Maputo who are offered sex work in Johannesburg; (ii) victims who are not sex workers are offered restaurant jobs;
- Victims are recruited by Mozambican women, working in partnership with Mozambican and South African men responsible for transportation of victims and exploitation;
- Victims are transported by mini-bus taxi from Maputo to Johannesburg;
- Some victims spend one night in transit houses where their documents and personal possessions are taken, and they are sexually assaulted to initiate and intimidate them into sex work. These transit houses are well known to local population and police;
- Sex worker victims are sold to brothels in Johannesburg central business district (CBD) for 1000 South African Rand;
- Victims who were promised restaurant jobs are sold on private order, or sold as 'wives' to mine-workers on the West Rand for 850 South African Rand (IOM 2003: 12).

⁶⁶ *Trafficking refers to the illegal transport of human beings, in particular women and children, for the purpose of selling them or exploiting their labour.*

*“Trafficking in women and children for sexual exploitation is a simmering problem in southern Africa, especially in Lesotho, Mozambique, Malawi, South Africa, and Zambia”.*⁶⁷

A Save the Children research study “Tatá papá, tatá mama: Child trafficking in Mozambique”, being finalised in 2006, concluded that:

- There is trafficking of girls for sexual exploitation, particularly but not only to South Africa;
- Most children who are trafficked are from rural or poor suburban areas;
- There is evidence of extraction of human organs but not for transplant, probably for ritual use;
- It is difficult to identify traffickers, but they appear in general to be drivers and people involved in informal cross border trade, especially between Mozambique and South Africa;
- People’s perceptions of traffickers are that they are of both sexes and use cars with tinted glass;
- People are afraid to speak out about trafficking, both at community level and within government institutions, with a “culture of silence” predominating;
- There is no systematic recording of information about cases of child trafficking;
- Border controls are inefficient, with a lack of equipment and human resources;
- There are major gaps in the functioning of criminal justice procedures, with gaps in process between police, courts, judgement and sentencing and making it difficult to follow up outcomes of prosecutions, with long delays;
- Mozambican legislation is inadequate and outdated with regard to trafficking.

In Mozambique, as in other parts of Southern Africa, poverty has been identified as the most significant factor in increasing the vulnerability of women and children to trafficking (IOM 2003). The Save the Children research study also found clear evidence that trafficking is linked to poverty and trans-national search for employment.

Mozambique has ratified the 1930 Convention on Forced Labour (on 16 June 2003) and the Convention on the Worst Forms of Child Labour (1999), which confirms child trafficking as a practice similar to slavery that must be eliminated without delay. It has also acceded (on 6 March 2003) to the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography.⁶⁸ The Government has also signed, but not yet ratified, the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children that is a complementary protocol to the UN Convention against Cross Border Crime.

There are currently no specific national laws that prohibit trafficking in persons, and no such cases have been brought before a court, although traffickers can be prosecuted using existing laws on sexual assault, rape, abduction and child abuse. The 2004 Legal Review noted the importance of strengthening the national legal framework in relation to the trafficking of children and of concluding bilateral and multilateral agreements with the major countries not parties to the UN Protocol from which children are being trafficked to and from Mozambique. It also noted the importance of strengthening legal protection in other areas that have direct bearing on the issue, such as international adoption, the protection of migrant and refugee children and sexual exploitation. The Government has acknowledged the legislative gaps in this

⁶⁷ International Organisation for Migration (IOM), ‘Data and research on human trafficking: A global survey’, Offprint of the Special Issue of International Migration Vol. 43 (1/2) 2005.

⁶⁸ Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography, New York, 25 May 2000. The Optional Protocol was adopted by resolution A/RES/54/263 of 25 May 2000 at the fifty-fourth session of the General Assembly of the United Nations. It entered into force on 18 January 2002, in accordance with article 14 (1).

area, and the new Children's Act reaffirms the right of all children to be protected from trafficking and the responsibility of the Government to take measures to prevent all forms of exploitation of children (GoM 2006c: 14).

In spite of the current absence of specific legislation on the issue of trafficking, the Government has made efforts to prevent and respond to the problem, some of which are given effect in the National Action Plan for Children. The 2005 US State Trafficking in People report acknowledged some of the recent initiatives in the areas of prosecution, protection and prevention, including an agreement signed between the Department of Migration and its counterpart in South Africa to share information and facilities; the establishment of women's shelters, intended in part to protect trafficking victims, at police stations in Maputo, Beira, Nampula and several large towns in Gaza province; and the establishment of an anti-trafficking inter-agency working group comprised of the Ministries of Interior, Women and Social Action, Justice and Health, which held its initial meeting in 2004. The report noted, however, that the Government had no national plan of action to address the issue of trafficking and that activities related to the prevention of trafficking, with the exception of those conducted by non-governmental organisations, had been limited (US 2005). Recommendations from the Save the Children study are that Mozambican legislation should be updated and contextualised, in line with government commitments made in ratifying international conventions, action should be taken to raise awareness about the forms of child trafficking, targeting principally police, judges, lawyers and civil servants and specialised institutions to provide support to children should be created and be well staffed and equipped.

D. Child marriage

The Population Council has noted that Mozambique has one of the most severe child marriage crises in the world today (Population Council, 2004). DHS data from 2003 indicate that 18 per cent of girls aged 20-24 had been married before the age of 15 and 56 per cent before the age of 18. Although these percentages had decreased since 1997 (when they were 22 per cent and 57 per cent respectively) there was no real change in the average age at first marriage, which increased from 17.4 to 17.5 years. The average age at first marriage among girls varied among provinces, from 16 years in Nampula province to 20 in Maputo City. Girls living in rural areas tend to get married earlier than their contemporaries in urban areas. Over a quarter (26 per cent) of married women aged 20-24 were found to be in a polygamous relationship. The percentages of men who had been married before the ages of 15 and 18 were considerably lower (1 per cent and 14 per cent respectively), suggesting that young girls tend to marry older men (INE 2005).

Married girls are much less likely than their unmarried peers to attend school, and girls are often removed from school in order to marry. DHS figures from 1997 indicate that 36.9 per cent of married girls aged 15 to 19 had no education and 62 per cent had primary education. Only 1.1 per cent of girls in union at that time had a secondary education (UNICEF 2005a: 36). DHS findings from 2003 indicate that unmarried girls in the same age group are 13 times more likely than married girls to be in school (INE 2005). These figures illustrate the influence child marriage has on a girl's access to education, however they also suggest that promoting secondary education for girls can serve as an important disincentive to marry.

In many cases, child marriage has an economic motivation. Often a family's decision to have a child married – be it a girl or boy – is a survival strategy to relieve the family of what they perceive to be a financial burden in the face of acute poverty. Girls are considered to be ready for marriage on reaching puberty. DHS data indicate that in

Mozambique, girls aged 15-19 in the poorest 20 per cent of the population are more likely to be married than girls from the better off quintiles, although the practice occurs in all economic levels of society (UNICEF 2005a: 36).

This suggests that economic status is a factor in child marriage, but not the sole motivation. Prevalence of child marriage is also linked to the cultural practices of specific ethnic groups. For example, Emakua girls are more likely than Cisena girls to be married before the age of 18, while Xitsonga and Xitswa girls are less so (UNICEF 2005a: 26). In southern Mozambique, the practice of lobolo - the payment of money in exchange for a bride - is common, and young brides will generally secure a higher price. In the north, polygamy is still prevalent, and a man may have three or more wives (INE 2005: 90).

Girl-child marriage is perpetuated for a number of reasons, many of which relate to 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. It may also be perceived to afford a girl protection from HIV/AIDS and other sexually transmitted infections. However, studies indicate that the opposite is in fact the case: since girls tend to marry older men and subsequently to engage in sexual relations more frequently than their unmarried peers, they are, in fact, at greater risk of infection (Population Council 2004). Moreover these girls rarely have the power or the knowledge to negotiate safe sex with their husbands.

Child marriage is not only a serious contravention of a child's rights in and of itself, but also seriously compromises a range of other rights for the child. For example, marriage during adolescence may have serious health implications for a girl. Often married adolescents receive less information on reproductive health than their unmarried peers (Haberland et al 2003: 43). As noted, they may also be more vulnerable to sexually transmitted infections, including HIV. An analysis of DHS data revealed that in Mozambique only 28 per cent of girls aged 15 to 19 who were married knew how to prevent HIV/AIDS. In contrast, in neighbouring South Africa, as many as 97 per cent of married girls knew how to prevent the disease (UNICEF 2005a: 37).⁶⁹

In addition, adolescent pregnancy and childbirth are associated with poor health outcomes both for the mother and her children. This is particularly true for very young first-time mothers (Population Council 2004). Despite the risks associated with early motherhood, in Mozambique 96 per cent of girls in union have never used contraception of any kind, the highest level among 23 countries examined by UNICEF in a recent study (UNICEF 2005a: 37).⁷⁰ After childbirth, adolescent mothers may face significant psychological, emotional and economic pressures. Child marriage is also associated with a greater likelihood of physical violence or the threat of such violence (UNICEF 2005a: 22).

International human rights instruments that have been ratified by Mozambique, such as the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women and the African Charter on the Rights and Welfare of the Child, provide protections relating to child marriage, such as the right to choose freely a spouse and to enter into marriage only with free and full consent; to decide freely and responsibly on the number and spacing of children and to have access to the information, education and means to exercise these rights.

⁶⁹ Data derived from DHS 1997 for Mozambique and DHS 1998 for South Africa.

⁷⁰ Data derived from DHS 1997 for Mozambique and various DHS for other countries.

Under the new Family Law of 2004, the Government of Mozambique has raised the legal age of marriage without parental consent from 16 to 18 years, and with parental consent from 14 to 16 years. This change partly reflects the efforts of several local women’s rights groups to speak out about the issue of child marriage (Population Council, 2004). Nonetheless, there is only limited capacity to implement the law, and traditional marriage under customary law continues to present a challenge to establishing 18 years as the minimum age of marriage.

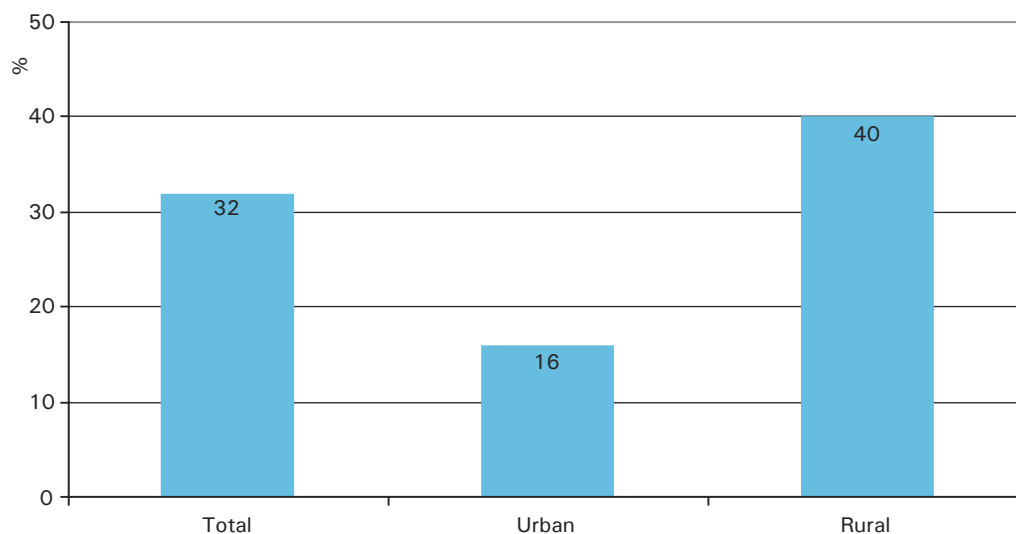
The legal measures introduced under the Family Law may be usefully supported through communication campaigns around the issue of child marriage, with particular focus on families, community leaders, local policy makers and relevant professionals. Education is also crucial to reducing child marriage, and progress can be made by improving access to education for both girls and boys, eliminating the gender gap in school attendance and promoting measures to increase school retention rates among girls. Effective mapping of child marriage within Mozambique – for example, mapping incidence by ethnic group - would support programme efforts and enhance the effectiveness of prevention campaigns.

Support for girls already in union is also essential. This may be achieved by enhancing their access to education – including non-formal education programmes, by supporting advocacy on the health risks associated with early motherhood, by improving their access to effective contraceptive methods and by developing support structures for young mothers.

E. Working children

The most recent data on child labour come from the IFRTAB survey conducted by the National Institute of Statistics in 2004/2005. The survey has not yet been fully analysed. Results presented here refer to children involved in economic activities, defined as “working on the machamba, selling products or other economic activity”.⁷¹ They do not therefore provide an indication of the proportion of children involved in domestic work, which evidence suggests is a significant proportion of the work undertaken by children. They also do not distinguish between child labour and child work.⁷²

Figure 5.1: Children economically active (7-17 years)



Source: IFTRAB 2004/2005

⁷¹ A specific module on child labour was administered to all economically active children. This module will be analysed in the latter part of 2006 and will be the subject of a specific report.

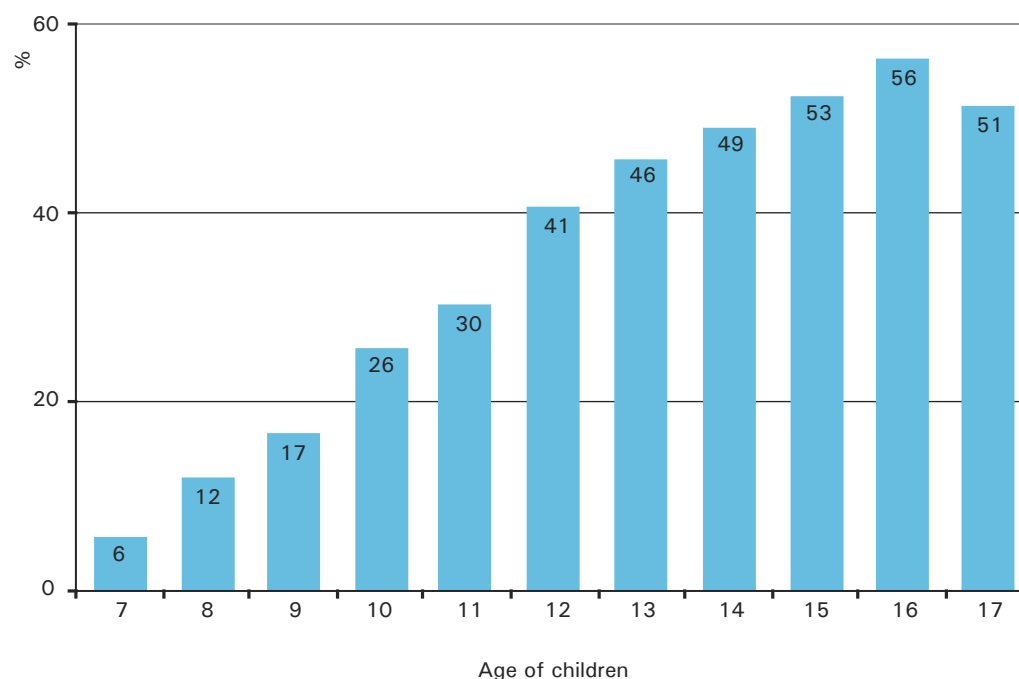
⁷² Child work refers to children that are working but not in exploitative situations and who are attending school.

The survey indicates that 32 per cent of children between 7 and 17 years old are engaged in some form of economic activity, with significant differences between urban areas (16 per cent) and rural areas (40 per cent).

The survey shows that the vast majority of children working are in unpaid work for the family and girls and boys are involved in equal proportions.⁷³ This finding corroborates the findings of the 1999/2000 Ministry of Labour Rapid Assessment of child labour, which indicated that poverty, the desire “to contribute” and family problems were the major factors forcing children into work. In many respects, the second and third motivations are manifestations of the first (2000a; 2000b).⁷⁴ This finding also corroborates the observation of the Committee on the Rights of the Child, that “Despite the legal restrictions, given their extreme poverty and the shortage of schools and professional training centres, particularly in rural areas, their situation obliges many Mozambican parents and guardians to put their children to work (from the age of seven) in order to complement the income/subsistence of the household” (CRC 2002: para. 7).

At seven years of age, 6 per cent of children are already engaged in productive activity. This proportion rises steadily, with around half of children from the age of 14 onwards being economically active (range of 49 per cent to 56 per cent in the age band 14 to 17).

Figure 5.2: Children economically active by age



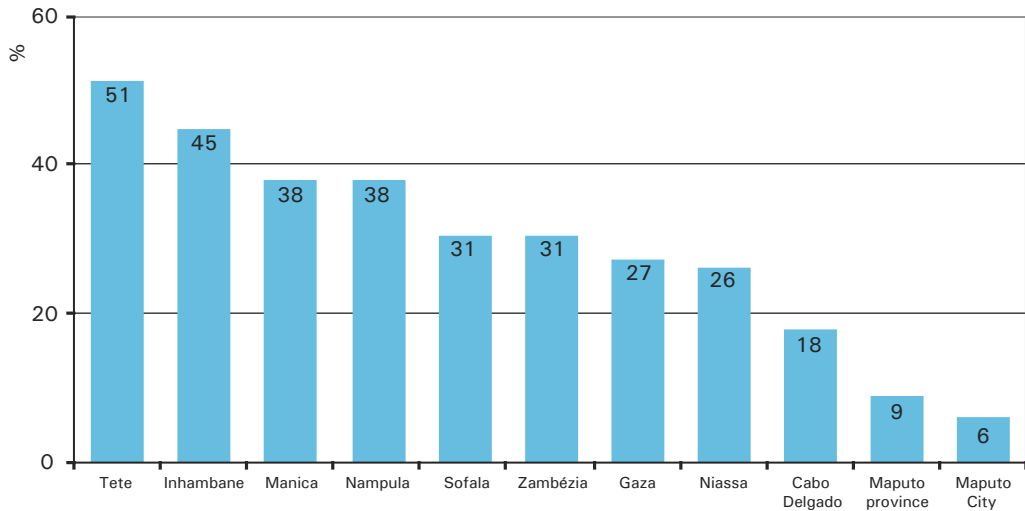
Source: IFTRAB 2004/2005

There are significant differences between provinces in the proportion of economically active children, with the highest proportion in Tete province (51 per cent) and Inhambane province (45 per cent) and the lowest in Maputo Province (9 per cent) and Maputo City (6 per cent).

⁷³ Previous evidence has indicated that there is a clear gender dimension to child labour: a rapid assessment of children already in the labour force conducted by the Ministry of Labour in 1999-2000, for example, indicated that girls are more likely to work as domestic servants or to be exploited as sex workers, while boys are more likely to work in street trading (GoM 2000a).

⁷⁴ The assessment was based on a sample of 823 children, in seven provinces and Maputo City. Other key informants included teachers and Government representatives.

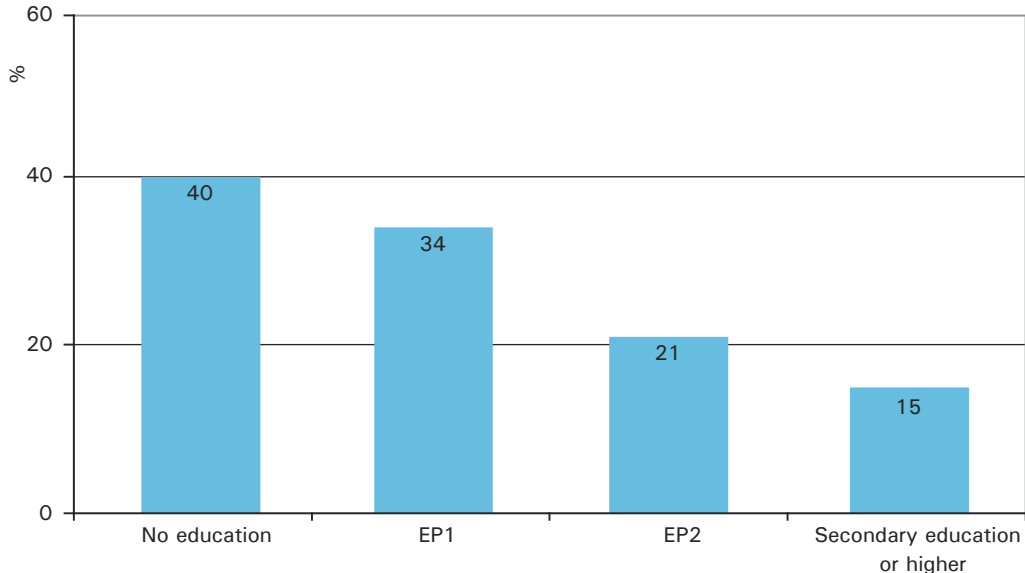
Figure 5.3: Children economically active by province



Source: IFTRAB 2004/2005

In line with the trend in many other areas of child well-being, there is a strong correlation between the probability of a child working and the level of education of the household head. In households where the household head has no formal education, up to 40 per cent of children are economically active. This contrasts with 15 per cent of children being economically active in households where the household head has secondary level education or higher.

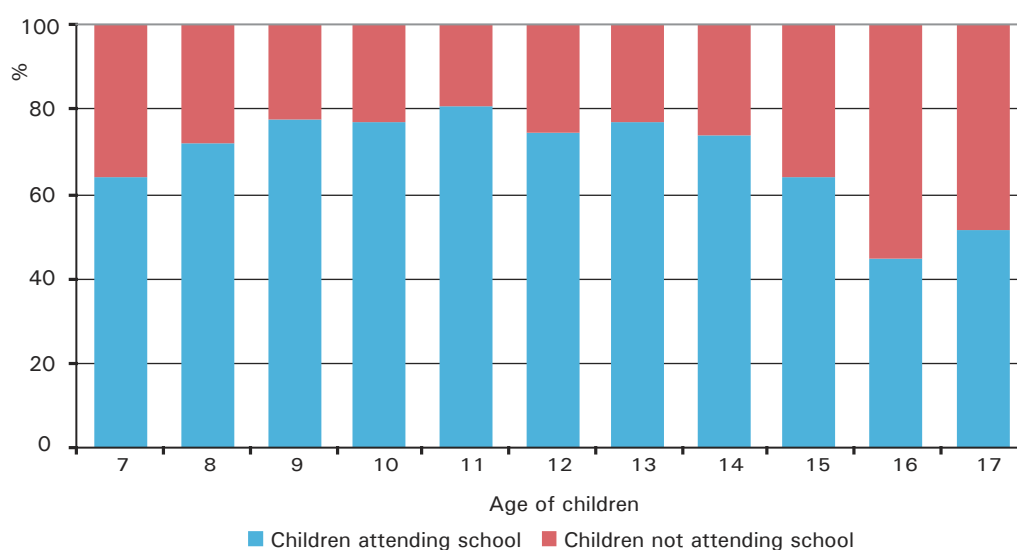
Figure 5.4: Economically active children (7-17) by level of education of household head



Source: IFTRAB 2004/2005

Over two thirds of children 7 to 17 years of age who are working do attend school (68 per cent). This reflects the fact that the majority of the work undertaken by children is unpaid work for the family, which is carried out in addition to schooling activities. Of those children who are working and who do not attend school, there are significant variations in distribution by province. In Niassa and Cabo Delgado provinces, over 40 per cent of children engaged in productive activity are not attending school. However, whilst Inhambane province has one of the highest proportions of working children, it also has the lowest proportion of children working who are not attending school (20 per cent).

Figure 5.5: School attendance among working children



Source: IFTRAB 2004/2005

Box 5.5: Daily routine and activities in the life of children and young people

The daily routine of children and young people varies across gender, age, location and school attendance. What is consistent, however, is that young people and adolescents in all locations help with daily family and household tasks. Outside school time, young people clean the house, help to cook, fetch water, look after siblings and help when a family member is sick. Many use what time and skills they have to try to supplement the household income in money or in food production. Boys and girls are assigned different tasks, with a tendency for boys to do more physical tasks such as cutting wood, and girls carrying out more home-based tasks centred around cooking and cleaning, although boys and girls both help to carry and fetch water. The age and number of healthy siblings and parents are also important factors in who conducts which tasks. If there is no older male for example, and the father has died, a boy may have to engage in some very tough tasks.

In the rural areas boys and girls help in the “machamba” (agricultural plot). In the district town, the machamba features less in family life, although many children still help. The actual sequence of tasks and activities in a day depends a great deal on the school timetable and whether a child studies at all. Some children and young people complain, saying the tasks are too many, long or hard, or that the distances to fetch water or go to the machamba are too great. However, helping the family is also a source of pride. Girls are required from a young age to be child carers. It is normal in rural areas for all the young children to be left with a child of around 7 or 8 years of age, while the older members, including adolescents, work in the machamba, which can be for up to half a day.

**Daily routine of out of school girls
(Vladimir Lenin Locality, Xai-Xai district)**

- 5:00- Work on machamba
- 11:00- Prepare lunch
- 12:00- Eat lunch
- 13:00- Rest
- 14:00- Grind maize
- 14:45- Fetch water
- 15:30- Cook for meal
- 18:00- Wash
- 19:00- Eat meal
- 20:00- Sleep

For boys, activities get more physically demanding as they get older. Boys in Manica referred to building houses or stalls, and cutting wood as 'older boys' tasks, whereas making a trap for rats, for example, is for younger boys. In Tete, it is far more common than in other places for children to herd cattle, and this is a common cause of not attending school.

Many of the older boys do some kind of work for money ('biscato') so many of the household chores are undertaken by younger siblings or girls. Girls do this to a lesser degree but many reported that some girls gain money at times through sexual encounters. A significant proportion of older boys and girls help carry the burden of working in order to get money to keep themselves or siblings at school. This ties in with other findings such as the importance of school for young people, and the fact that by far the largest reason for having to leave school is lack of money (see also QUIBB 2000/1 - INE). It is common, particularly from EP2 level, for children to have to contribute or even pay entirely for their own schooling expenses.

Source: Situation Analysis of Youth and Adolescents in rural districts of Mozambique, Ministry of Youth and Sport, 2006

The impact on children's labour of chronic illness in the household was researched in a rural district of Zambézia province in 2003 ('When someone is sick in the house, poverty has already entered: A research study on home-based care, Morrumbala Centre, Zambézia Province, Mozambique', SCUK, 2003). As well as the usual domestic responsibilities expected of children, they were also expected to help the chronically ill household member by:

- Cooking and feeding them porridge
- Changing and washing their clothes
- Washing sheets
- Giving them a bath
- Sitting by them and attend to any need they have
- Sleeping close to them
- Taking food and water to them in the hospital
- Giving them medicine
- Attending to their needs while admitted in the hospital.

The right of the child to be protected from inappropriate forms of labour is established under Article 32 of the Convention of the Rights of the Child, as well as the main conventions of the International Labour Organisation (ILO) relating to child labour: C138 Minimum Age Convention, 1973 and C182 Worst Forms of Child Labour Convention, 1999. Both were ratified by Mozambique on 16 June 2003.⁷⁵

The 2004 review of Mozambican law relating to children led by the Ministry of Justice concluded that reforms are required to harmonise national law with international obligations. Specifically:

- While labour law forbids employers from hiring minors under the age of 15, in keeping with Article 2 of the ILO Minimum Age Convention C138, "there are no apparent criminal provisions when employers breach this legislation" (Sloth-Nielson and Gallinetti 2004: 31).

⁷⁵ The Conventions are posted at <http://www.ilo.org/ilolex/english/convdisp2.htm> Mozambique has not signed a Memorandum of Understanding with the International Programme on the Elimination of Child Labour (IPEC), which is the ILO's child labour monitoring programme.

- Labour law does not define the “worst forms of child labour”, nor does it specifically prohibit these forms of labour, as required by Article 1 of the ILO Convention on the Worst Forms of Child Labour C182. There are no provisions for assistance to and removal of children in cases where they are working in situations that fall within the ILO definition of the worst forms of child labour (ibid: 31).
- Mechanisms to enforce existing laws on child labour are weak. Ministry of Labour inspectors have responsibility for monitoring child labour, as do other rule of law institutions, however, their capacity to carry out this task appears limited. No employer has ever been convicted on a charge related to child labour.

Responses to child labour must, at a minimum, focus on four areas: the development of national legislation that reflects the international standards to which Mozambique adheres; the effective enforcement of this 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. In Mozambique, the Ministry of Labour is responsible for guiding and coordinating actions related to child labour. The 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 forthcoming Children’s Act reinforces the prohibition of any form of work for children under 15 years of age, and provides for punitive measures to be taken against any employer using the labour of children under this age. The Act sets out standards to be met by institutions employing children aged 15 to 18 (in relation to the conditions of work, maximum permitted working hours per week - 38 hours - and remuneration for work), including provision for the education or professional training of the child. The Act also defines prohibited forms of work, including child prostitution and work that could be harmful to the health and well-being of the child. These standards are to be monitored through regular and ad hoc visits to workplaces by labour inspectors (RM 2006c: 23-25).

The Children’s Act will go some way to addressing the concerns raised in regard to legislation in the area of child labour. Its effective enforcement, however, will require the dissemination of the Act to all stakeholders, and considerable strengthening of the capacity of all authorities with the responsibility for implementing its provisions.

In the longer term, just as child labour is closely associated with poverty, so too reducing the burden of work on children depends on ensuring that children and their families, particularly the poorest, benefit from poverty reduction. For as long as work remains an economic necessity among children in some types of 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 or development.⁷⁵

⁷⁶ *The Eliminating Child Labour in Tobacco-growing (ECLT) Foundation is a multi-stakeholder initiative by the tobacco industry that joins trade unions, tobacco growers, tobacco processing companies, tobacco manufacturing companies and, as advisors, the ILO/IPEC International Programme on the Elimination of Child Labour of the International Labour Organisation. ECLT Foundation supports projects aimed at the progressive elimination of child labour in the tobacco-growing sector.*

Box 5.6: Informal child labour among small-scale tobacco farms

In 2005, a study was undertaken by the ECLT Foundation to assess the incidence and nature of child labour among small-scale tobacco-growing farms in several districts in the provinces of Tete and Niassa, which are two of the seven tobacco-producing provinces in Mozambique.⁷⁶ The study found that:

- **Prevalence of child labour:** 80% of the tobacco-growing households put their children to work on the tobacco farms. This represents 68% of the children aged 6 to 14 years old and 90% of the children aged 15 to 17 years old.
- **Activities and working conditions:** More than half of working children aged 15 to 17 contributed to all tobacco related activities during the crop season, while 75% of the children aged 6 to 14 performed tobacco related tasks occasionally. The children were engaged in tasks such as picking, curing and marketing of tobacco leaves. Assessment of the working conditions of the children found that there were various hazards faced by the children, ranging from simple cuts to exposure to chemicals or extreme climactic conditions.
- **Payment for work:** 40% of smallholder tobacco growers gave a wage to working children aged 15 to 17. 18% of working 6 to 14 year-olds were paid.
- **School attendance:** 81% of the surveyed children aged 6 to 14 and 63% of the children aged 15 to 17 were attending school. All of the school-going children were attending only one shift (of a maximum of five hours a day). The age against grade (distortion) rate was found to be very high (on average it took 10 years to reach level five). Drop-out was also a significant problem and many children were not able to complete a basic education. The main reasons given for not sending children to school were the distance from school (40%), the failure to meet cost requirements (21%) and early marriage or pregnancy (20%).
- **Main reasons given for child work:** 39% of the interviewed households considered that child labour was necessary to help the family and to increase the work force. 23% indicated that working was a learning process for the children.
- **Gender issues:** Overall, 65% of the families had boys working on small-scale tobacco farms and 51% had girls working. Girls were much more involved in domestic work than boys.

Three main variables were identified as determining the frequency of child labour among the surveyed farms:

1- Use of non-family labour

Overall, more than half of the smallholder tobacco growers hired permanent and/or seasonal adult workers (57%). Comparing households that did not employ additional labour from outside the family with households that did employ additional labour the study found that:

- Households that did not employ non-family labour were more likely to make use of the labour of children aged 15 to 17 compared with households that did employ non-family labour (51% versus 39%).
- Households that did not employ non-family labour were more likely to put their children to work on the farm all year long compared with households that did employ non-family labour (children aged 6 to 14: 28% versus 23%; children aged 15 to 17: 54% versus 47%).

2- Distance from school

Approximately 40% of the respondent families lived more than 1.5 km from a primary school. Those tobacco-growing households living more than 1.5 km from a school were found more likely:

- To have their children out of school (children aged 6 to 14: 23% at over 1.5 km versus 9% at under 1.5 km; children aged 15 to 17: 35% at over 1.5 km versus 30% at under 1.5 km).

- To use child labour (children aged 6 to 14: 72% at over 1.5 km versus 63% at under 1.5 km; children aged 15 to 17: 54% at over 1.5 km versus 38% at under 1.5 km).
- To put their children to work all year long on the farm (children aged 6 to 14: 31% at over 1.5 km versus 25% at under 1.5 km; children aged 15 to 17: 65% at over 1.5 km versus 41% at under 1.5 km).

3- Tobacco income level

The majority of the families received an income from the tobacco production in 2004/05 (only 15% of the families did not make any profit from tobacco). Children (aged 6 to 17 years old) of families whose work in tobacco was not profitable were found more likely:

- To work than children of families who received a tobacco income (73% versus 61%).
- Not to go to school than children of families who received a tobacco income (44% versus 21%).

The study showed that parents thought that combining schooling with work was the most productive way for children to spend their day. In general, they believed that they were doing the best for their children by putting them to work, and that it was the child's 'duty' to help the family. Parents and their children were not at all aware of the hazards that the work involved. It was clear that some parents also wanted their children to work on the farm because they could save money by not hiring non-family workers. In addition, while the parents may have been aware of the benefits of schooling, it appeared that they made little effort to encourage the children to attend school.

In spite of the small sample size, the study provides useful information on the incidence and nature of child labour among small-scale tobacco farms and highlights the need for awareness raising and other practical actions to address this type of harmful child labour.

Source: A study of child labour in Tete and Niassa provinces, Mozambique, ECLT, 2005

3. Strengthening legal protection

A. A comprehensive legal framework for the protection of children

Effective legal protection is an integral part of a protective environment for children. The absence of an adequate legal framework exacerbates a child's vulnerability and increases the likelihood that she or he will be denied a range of rights beyond those strictly associated with protection. The responsibility for respecting, protecting and fulfilling rights is shared among many actors. However the State, as the primary guarantor of rights under international law, must to the fullest extent possible ensure that effective protection exists in law; establish and strengthen effective institutions to enforce the law and work together with civil society and the private sector to promote positive values and practices in society in order to enhance the effectiveness of legal protection.

Mozambique has ratified international and regional human rights instruments relating to the protection of children, including the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and the African Charters on Human and People's Rights and on the Rights and Welfare of the Child. Ratification of these instruments implies a Government commitment to harmonise national legislation with obligations under international law. The commitment to harmonising national law with Mozambique's obligations as a State party to international human rights instruments, led to the legal review process conducted in 2004 (Sloth-Nielson and Gallinetti 2004).

The Five Year Plan 2005-2009 commits the Government to reforming Mozambique's legal framework for the protection of children, as well as to strengthening the institutions charged with enforcing the law and protecting the rights of children (RM 2005a: 44). This commitment is reaffirmed in PARPA II, which prioritises strengthening of the legal and institutional framework for the protection of children and development and consolidation of social protection for the most vulnerable (RM 2006b). The National Action Plan for Children 2006-2010, approved in March 2006 by the Council of Ministers, includes specific objectives, drawn from line Ministries sectoral plans, to increase protection for children⁷⁷ and support children at risk of social exclusion. This latter objective focuses on integrating orphans and abandoned children into families (MMAS 2005c).⁷⁸

The Family Law defines new legal standards for parental responsibilities, guardianship, adoption of orphans and destitute children and inheritance rights. It also increases the legal age of marriage without parental consent from 16 to 18 years of age and with parental consent from 14 to 16 years of age (RM 2003).⁷⁹

The 2004 legal review identified that:

- Important areas of international law have not been integrated into national law. Inconsistencies between national law and Mozambique's international commitments have also been noted by the Committee on the Rights of the Child (CRC 2002: para. 11)
- The legal framework for children remains fragmented. Relevant laws exist in different legal codes that are not easily accessible to those charged with their implementation
- Many laws were drawn up during the colonial period and fail to reflect the social, economic, political and cultural realities of contemporary Mozambique
- Customary law is a vital aspect of Mozambique's legal regime and forms part of the fabric of children's daily lives. It is not, however, always consistent with national laws or the principles of international human rights instruments ratified by the Government. Evidence from a number of case studies documents the failure of customary law in areas such as sexual abuse to protection or redress for children.⁸⁰ Where it is in conflict with international human rights principles, customary law should be limited or amended in order to protect children (Sloth-Nielson and Gallinetti 2004: 33).

The legal review also drew attention to the following issues:

- Inheritance laws. When parents die, children often do not inherit their parents' estate. This results from provisions in customary law, or legal administrative barriers such as lack of birth certificates and can have huge consequences for the survival and development of orphans. While the administration of the estate of the child has been covered adequately in the Family Law, the law is insufficient in defining and conferring in procedural terms how children can inherit intestate

⁷⁷ Objective 1; assure the civil rights, security and protection of children (MMAS 2005b: 21).

⁷⁸ Objective 7; guaranteeing assistance to children at risk of social exclusion, focusing on integrating orphans and abandoned children into families and communities (MMAS 2005b: 41).

⁷⁹ The Family Law was approved by the Assembly of the Republic on 09 December 2003. It replaces elements of the Civil Code dating to the colonial era. Beyond enhancing child protection, the law strengthens the rights of women in both official and customary law marriages.

⁸⁰ For example, a 2004 study by UNICEF and the Ministry of Youth and Sports found that sexual abuse in schools was resolved through discussion between parents and teachers, often resulting in the payment of a fine to the parents. Cases of abuse were not usually reported to authorities (UNICEF and Ministry of Youth and Sport 2005).

from their parents. Thus, the law does not provide specific procedures and responsibilities that ensure that the child's inheritance rights are enforceable.

- Age of majority: Article 122 of the Civil Code states that "Children means persons of one or another sex until they reach the age of twenty-one years old." The age of majority is highly dependent on local culture in any country. However, this definition is not in line with international treaties ratified by the Government, such as the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. The review therefore proposed that in the interests of international consistency and in line with universally accepted norms, the age of majority be set at 18 years of age.

Box 5.7: Legal reform for the protection of children in Mozambique

Areas where legislation is absent in Mozambique:

- A clear definition of childhood that conforms to the CRC;
- Laws that combat child trafficking;
- Laws on child pornography;
- Minimum standards of care for children in institutions. Policy is being developed, but is not yet enshrined in legislation;
- Protection of children from stigma and discrimination due to HIV/AIDS;
- Protection for child offenders between the age of 16 and 18 and for those under 16, who are not criminally liable for their conduct;
- Access to basic services for orphans and vulnerable children;
- Criminalisation of commercial sexual exploitation of children, except where parents facilitate the prostitution of their child;
- A legal definition of orphaned and vulnerable children and legal recognition for child-headed households. Linkages between policy and planning instruments and legislation and therefore mechanisms for protecting children are not clear.

Areas where legislation exists, but is weak:

- Laws to protect children from exploitation, domestic violence and abuse are not well articulated and do not sufficiently protect children as victims and witnesses;
- Definitions of the range of offences (e.g. indecent assault, sexual abuse, and abuse and neglect) generally require more substantive definition to give effect to Articles 19 and 34 of the CRC;
- Legislation on child labour does not define hazardous labour, nor list those occupations that are regarded as the worst forms of child labour. ILO treaties to which Mozambique is a State party need to be given effect under law. Further, penalties and criminal sanctions do not exist to punish those who employ children in hazardous occupations. The regulation of permissible child labour is also not legislated. Mozambican law provides that children above 15 are entitled to work, but the conditions under which such work should be performed have not been articulated;
- The law fails to enumerate a range of placement options for children in need of alternative care and consequently does not meet the standards established under Article 20 of the CRC;
- Inter-country adoption needs to be legislated to strengthen anti-child trafficking laws, as required by the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography, which Mozambique has ratified;
- There are potential conflicts with regard to inheritance rights between customary law and civil law, the former promoting inheritance by adult family members rather than descendant children;
- The law permits punitive responses to children for status crimes such as loitering, not having a proper identity card, and petty theft. The same punitive responses are not legislated for adults committing similar offences;

- Procedural systems for dealing with children in conflict with the law are not child-centred and do not meet standards established under Articles 37 and 40 of the CRC.

Areas where legislative provisions to implement and monitor child laws are inadequate:

- With the exception, to some extent, of the courts, State institutions in this area have not been identified nor have their responsibilities been defined in order to implement the law;
- There is an absence of clear guidelines and procedures for the enforcement of child-related laws;
- Many stakeholders have alluded to the lack of coordination of services for children;
- There is a general absence of monitoring mechanisms;
- The legal environment for birth registration is characterized by cumbersome and bureaucratic procedures. There are penalties for late registration;
- Children under 16 continue to be arrested and detained in adult prisons. There is no adherence to the minimum time stipulated to process such cases and children can be detained indefinitely;
- Legislative provisions extending the powers and functions of a competent legal forum would enhance monitoring and accountability, and ultimately promote children's rights.

Source: Legal Reform for the Protection of Children in Mozambique, Sloth-Nielsen and Gallinetti, 2004

As noted above, the Ministry of Justice has developed a draft comprehensive Children's Act, with the twofold objective of establishing a comprehensive legal framework for children and harmonising national law with Mozambique's obligations as a State party to international human rights instruments. The Children's Act, which is expected to be approved over the coming year, reaffirms the rights of all children in areas including health, education, freedom from torture, violence, exploitation and abuse, and freedom of expression and information, in addition to the right to protection of particularly vulnerable children, such as children in conflict with the law and child refugees. It also outlines the corresponding responsibilities for the promotion, respect and fulfilment of these rights: of Government; non-governmental organisations, communities and children (RM 2006c).

B. Creating effective mechanisms for the implementation of the Children's Act

The 2004 legal review concluded that existing mechanisms for the enforcement of laws in relation to children are weak. There is, "a glaring absence of provisions for the implementation of laws. Roles and responsibilities are poorly defined, co-ordination and monitoring were absent and political accountability was weak" (Sloth-Nielsen and Gallinetti 2004: 6). Strengthening the implementation and enforcement of child laws is a key dimension of wider security sector reforms.⁸¹ In this context, Mozambique is collaborating with the international community to strengthen the police, justice and prison systems. Progress on overall sector reform, however, has been mixed. The 2005 assessment of cooperation between the Government and donors in the justice sector concluded that "despite showing some advances, there has not been a substantial improvement in the justice service delivery ... current constraints will continue to affect the appropriate functioning of the sector, if the reform process is not resumed with a strong impetus" (PAP 2005: 35).

⁸¹ According to UNDP, the "Justice and Security Sector refers to public institutions, organisations, and actors which have the formal mandate to ensure the safety of the state and its people against acts of violence and coercion through the promotion of transparency, the rule of law, accountability and informed debate." <http://www.undp.org/bcpr/jssr/index.htm>

C. Birth registration – guaranteeing the right to an identity

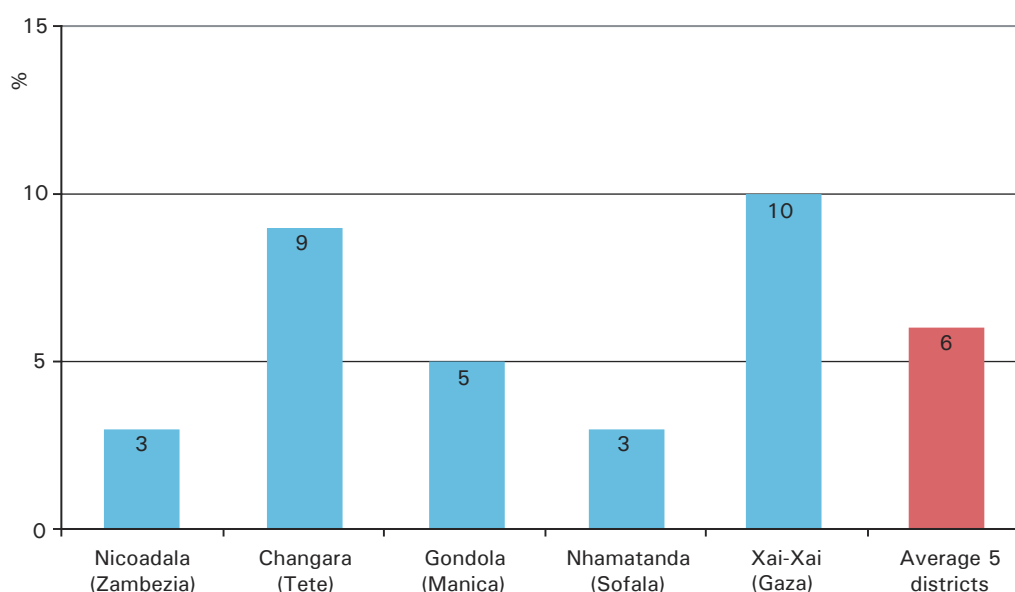
Mozambique's obligation to register children immediately after birth is given legal expression in the Civil Registry Code. Birth registration is the official and permanent recording of the birth of a child by the State. Through the act of registration, the State recognises the legal existence of a child. Registration provides legal proof of a child's identity and is directly tied to a child's claim to citizenship and to the rights, benefits and obligations that accrue from that citizenship. Birth registration is not only a right in itself, but also contributes to ensuring that children enjoy a range of other rights key for their survival, development and protection. It helps to ensure that a child has access to services at the appropriate age, including vaccinations and school enrolment, and enables the acquisition of identity documents. It facilitates family reunification in the event of displacement and separation due to natural disaster.

Birth registration also contributes to reducing vulnerability. The proof of age afforded by a birth certificate offers a degree of protection to the child from a range of age-related abuses including marriage below the legal age, hazardous and inappropriate forms of labour, child sexual exploitation, prosecution of a child as an adult and detention in adult facilities. It can also afford the child protection from identity-based abuses, notably trafficking, and - of particular importance in the context of the AIDS pandemic - reinforce a child's inheritance rights. To the extent that aggregate registration data are made available to the national statistical office, birth registration is also a source of information necessary for good governance. It provides the government with data on demographic trends that support policy development and decision-making on how State resources should be allocated.

There are no comprehensive national data on birth registration in Mozambique. However evidence suggests that registration levels are extremely low. In 2004, the National Institute of Statistics conducted a district level Demographic and Health Survey in five districts in five provinces.⁸² The survey included information on birth registration and indicated that, on average, only 6 per cent of children under five years of age had a birth certificate. There was some variation across districts, from 3 per cent in Nhamatanda (Sofala province) and Nicoadala (Zambezia province) to 10 per cent in Xai-Xai (Gaza province). The main reason quoted by mothers for not registering their children was cost of registration (56 per cent), followed by distance to registration offices (14 per cent) and lack of knowledge about registration (13 per cent). A subsequent qualitative assessment undertaken in the two districts with the lowest levels of birth registration – Nicoadala and Nhamatanda – found that a lack of resources at registration offices was also a reason for low level of registration (Hughes, 2005). Many registration offices do not have the basic material for conducting birth registration activities, such as paper for printing certificates. More complete data will become available as a specific question on birth registration has been included by INE in the 2007 national population census questionnaire.

⁸² INE/UNICEF, *Demographic and Health Survey in Five Districts, 2005*. The survey was conducted from January to April 2004 among 2,764 households in the following districts: Nicoadala (Zambezia province), Changara (Tete province), Gondola (Manica province), Nhamatanda (Sofala province), and Xai-Xai (Gaza province).

Figure 5.6: Children with a birth certificate



Source: INE, 2004

The low levels of birth registration in Mozambique reflect low political prioritisation, a poorly developed network of civil registries and a lack of material and human resources where these offices exist. These challenges are exacerbated by a lack of recognition of the value of birth registration among the Mozambican population and a subsequent low demand for the service.

National efforts for birth registration have accelerated in recent years. The National Directorate of Registration and Notarial Services (DNRN), being the department of the Ministry of Justice responsible for overseeing birth registration, developed a National Plan of Action on Birth Registration in 2003. This Plan has three main objectives: (1) create an enabling environment to ensure that all children, in particular OVC, have access to birth registration; (2) develop an effective, decentralised and simplified birth registration mechanism; and (3) raise public awareness of the importance of birth registration. In August 2004, as a first step towards establishing an enabling environment, the Government amended the Civil Registry Code to remove barriers to registration by extending the free registration period from 30 days to 120 days following the birth of the child.

Within the framework of the National Plan of Action on Birth Registration, the Ministry of Justice launched a National Birth Registration Campaign, in order to clear the backlog of millions of unregistered children. The campaign started in 2005 in 11 districts, across all provinces of the country and extended to 22 new districts in 2006, where it aims to register 1.2 million children under 18 years of age, using both mobile brigades and fixed registration agents.⁸³

In order to bring birth registration closer to communities, the Ministry of Justice also started in 2006 to increase the range of State agents able to carry out parts of the registration process. DNRN provides training on birth registration to teachers, health workers and key members of communities, in collaboration with the Ministry of Education and Culture, the Ministry of Health and the Ministry of State Administration. The participation of all these Ministries is vital to secure the use of existing facilities

⁸³ The Ministry of Justice has developed an expansion plan of fixed posts with the aim of establishing at least one fixed registration post per district. It is expected that State Budget Allocations will cover human resources and equipment costs for the expansion, while MINJUS will be advocating for additional support to cover infrastructure costs.

such as hospitals and schools for birth registration activities. It is also critical to boost registration levels through opportunities created by the delivery of other essential services.

The National Action Plan for Children reaffirmed the political commitment to birth registration and set an objective of registering 90 per cent of new born children by 2010 (MMAS 2005c: Target 1.1). The Action Plan for Orphaned and Vulnerable Children also commits the Government to accelerating registration to ensure that children affected by HIV/AIDS have access to the system (MMAS 2005b: 14).

Successfully promoting birth registration among the population not only requires the Government's commitment to 'supply' this service, but also involves the creation of a 'demand' among the population. Effective efforts to raise awareness in families and communities of the importance of registering a child immediately after birth complement legal and administrative initiatives and are essential for the establishment of this element of the protective environment in Mozambique in coming years.

Until universal registration is achieved in Mozambique, it is important to ensure that lack of registration or a birth certificate does not constitute an obstacle to a child's access to services. For example, in keeping with international human rights standards, children in Mozambique are not required to produce a birth certificate to enter school, however, a birth certificate is an official requirement for admission to grade five examinations. This requirement potentially excludes unregistered children from proceeding with their education.

4. Social protection: access to basic services and social assistance for the most vulnerable children

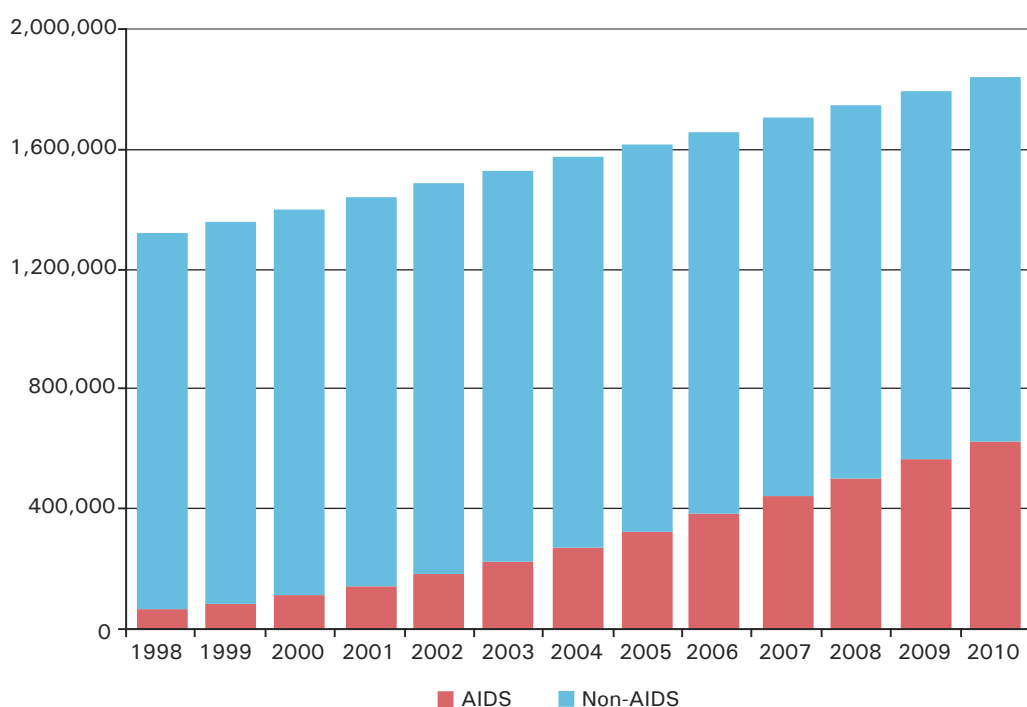
A. Orphaned and vulnerable children

Data on the proportion of children who are orphaned (defined as having lost one or both parents), vary from one source to the other, with estimates ranging from about 12 per cent to 16 per cent of the total population, i.e. up to 1.6 million orphaned children under 18 years of age in 2006. Of these children, projections estimate that 380,000 have been orphaned due to AIDS, representing more than 20 per cent of the total of orphaned children. It is estimated that the total number of children orphaned by AIDS will reach almost 630,000 by the year 2010 (INE et al 2004).

Children orphaned due to AIDS are more likely to have lost their mother (maternal orphans) than their father (paternal orphans).⁸⁴ In 2006, it was estimated that 54 per cent of maternal orphaning was due to AIDS compared to 35 per cent for paternal orphans. Among children who had lost both parents, 60 per cent of orphans had lost their parents due to AIDS. In addition to being affected by AIDS through the loss of their parents, an increasing number of children are themselves living with HIV or AIDS (refer to Chapter III).

⁸⁴ *Maternal orphans due to AIDS are defined as children 0-17 whose mother has died of AIDS, where the survival status of the father is unknown (i.e. he can be alive or dead, of AIDS or other causes). Paternal orphans due to HIV/AIDS are defined as children 0-17 whose father has died of AIDS, where the survival status of the mother is unknown (i.e. she can be alive or dead, of AIDS or other causes). An AIDS orphan of both parents is defined as a child aged 0-17 whose mother and father have both died of AIDS. As per above definition, the total number of AIDS orphans corresponds to the Total number of AIDS maternal orphans (+) Total number of AIDS paternal orphans (-) Total number of AIDS orphans of both parents.*

Figure 5.7: Total orphans 0-17 - projection from 1998 to 2010



Source: Multisectoral Technical Group for the Fight against HIV/AIDS 2004

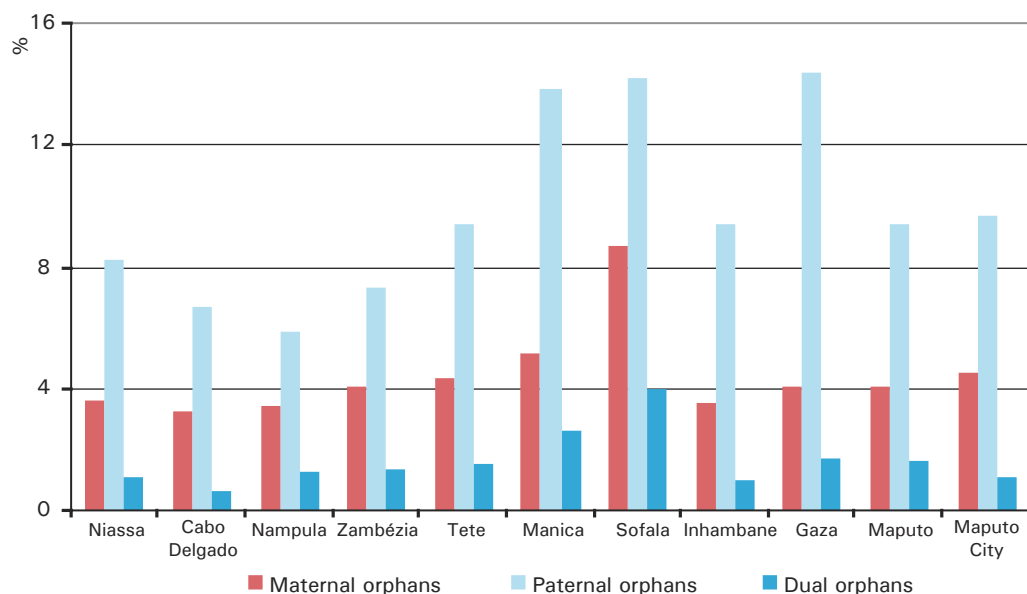
Box 5.8: How many orphans?

In 2004/2005, the IFTRAB survey indicated that 11.9 per cent of children 0-17 years were orphaned, corresponding to about 1.2 million orphaned children in the country. While the proportion of orphaned children is increasing, this finding is consistent with the findings of the DHS, which indicated that in 2003 the proportion of orphaned children 0-17 was 11.6 per cent. The data in the Demographic Impact of HIV/AIDS study (INE 2004) provide a higher estimate. In 2005, data from the Demographic Impact study indicated that there were 1.6 million orphans in Mozambique, i.e. 400,000 additional orphaned children. While orphaned children in institutions are not covered by household surveys such as the IFTRAB and the DHS, the small number of children in institutions in Mozambique, estimated at 11,500 in 2005, cannot account for the difference observed. There are two plausible explanations for this difference: (1) the modelling system used to produce the Demographic Impact projections has inaccurate demographics indicators and/or (2) orphaned children in households are not declared as “orphaned” by respondents to surveys, for a variety of reasons. Large multi-purpose surveys with many topics and modules rarely collect all data with consistent quality.

The impact of the AIDS pandemic is now clearly evident in the central region, particularly in Sofala and Manica provinces (the central corridor). The results from the 2004/2005 IFTRAB indicate that the proportion of orphaned children is the lowest in the provinces with the lowest HIV prevalence, namely Niassa (HIV prevalence 11.1 per cent, orphaning rate 10.8 per cent), Cabo Delgado (HIV prevalence 8.6 per cent, orphaning rate 9.3 per cent) and Nampula (HIV prevalence 9.2 per cent, orphaning rate 8.2 per cent). The proportion of orphans is highest in Sofala province, where almost one in five children is an orphan (19 per cent) and where HIV prevalence is the highest in the country (estimated at 26.5 per cent in 2004).

Sofala province also accounts for the highest proportion of children who have lost both parents, with 4 per cent of all children being double orphans compared to 1.6 per cent at national level, and the highest proportion of maternal orphans, with 8.7 per cent of all children in the province having lost their mother, compared with 4.4 per cent at national level. Manica province has a similar pattern, with the second highest proportion of dual and maternal orphans. The high proportion of orphaned children in Gaza (16.8 per cent of all children) is partly related to the large number of men from the province that have migrated to South Africa to work in the mining industry and have died as a result of AIDS. Gaza has the highest proportion of paternal orphans in the country (14.4 per cent of all children in the province compared to 9.2 per cent at national level).

Figure 5.8: Orphaned children by province



Source: IFTRAB 2004/2005

The proportion of children who are orphaned is slightly higher in urban areas (13.8 per cent) than in rural areas (11.1 per cent). Orphaned children are more likely to live in households where the head has had no education, which might indicate that poor households are disproportionately taking the responsibility of coping with the orphan crisis. For example, 16.6 per cent of children living in families where the head of household has had no education are orphaned. This proportion decreases steadily as the education level of the household head increases. 10.8 per cent of children are orphans in households where the head has reached EP1 level, 9.1 per cent where the head has reached EP2 level and 9.9 per cent where the head has reached secondary or higher education.

Orphaned children are also disproportionately living in households headed by women. Female headed households make up only 30 per cent of all households, but over half of orphans (54 per cent) live in households headed by women (IFTRAB 2006). Women heading households have on average lower levels of education than men heading households and are disproportionately affected by poverty, with 63 per cent of female headed households living below the poverty line compared with 52 per cent among male headed households. Available data also suggest that the proportion of orphans living in households headed by older people is high. A recent survey of 10,177 households in one district (Changara) of Tete province (HelpAge International 2006) found that 1,182 households included at least one orphan. Of these households, 635 were headed by an older person (i.e. just over half of households with orphans).

The OVC Situation Analysis conducted in 2005 found that 0.2 per cent of all OVC households surveyed were headed by a child under the age of 18, with the figure slightly higher for orphan households (0.3 per cent) compared to vulnerable children households (0.2 per cent). In addition, some orphans who did not live in child-headed households were being cared for by other children. Indeed, child caregivers of orphans were ten times as common (3 per cent) as orphan child-headed households (0.3 per cent), meaning that orphaned children outside of child-headed households were being cared for by another child, rather than an adult.

In 2005, a study was conducted in Sofala province to assess the conditions of children living in child headed households, in respect to access to education and healthcare, housing conditions and problems of abuse or stigma faced by the children. Interviews were conducted with the heads of child-headed households, defined as households headed by children under age 18 who were either: 1) living on their own with no adult support, 2) the oldest of a household having no adults living in the home, or 3) serving as the main provider of the material necessities of the household even when adults were present in the home (Cochran and Roby 2005). The study found that:

- **Presence of adults.** 80 per cent of the child headed households did not live with any adults. The reasons given for the absence of adults from households were: the death of both parents (79 per cent), abandonment by both parents although living (12 per cent) and the death of father and abandonment by mother (9 per cent). Twenty per cent of the children lived with adults and were required to act as the main provider due to the fact that they lived with other family members who were too sick or handicapped to care for the children. These adults were parents (7 per cent), grandparents (9 per cent), an adult sibling (2 per cent), or an aunt/uncle (2 per cent).
- **Age and sex of child heads.** 47 per cent of the child heads were aged 17, 25 per cent were 16 and 28 per cent were 8-15, while there were two 12 year-olds and one 8 year-old. Nearly three quarters (73 per cent) of the child heads were males.
- **Siblings.** 34 per cent of the child heads lived with and cared for one or two siblings, while nearly 40 per cent cared for three to four siblings. These siblings ranged from 2-16 years of age.

The challenges typically facing orphaned and vulnerable children are well documented, including:

- Limited access to basic services (such as health, education, food, legal, financial and psychosocial services);
- Very limited choices of livelihood strategies and means of generating income;
- Reliance on negative coping strategies, such as early marriage, commercial sexual exploitation of children or harmful forms of child labour;
- A heavy responsibility for children, especially those who are heads of households, for the survival and well-being of other members of the household.

In addition to these challenges, children orphaned as a result of AIDS are often forced to live with the social stigma and discrimination that accompanies HIV/AIDS and potentially face exclusion from their communities or the extended family unit. As noted in Chapter II, the level of discriminatory attitude among the population towards people living with HIV or AIDS is very high.

Evidence points to worrying increases in vulnerability among maternal orphans. The vulnerability assessment undertaken in 2003 in drought affected areas indicated that maternal orphans were over twice as likely to be severely stunted as the general child population (36 per cent versus 15 per cent) (Martel 2003, see also Chapter II).

The participants in the 2005 Sofala study were asked to identify the main challenges faced in their day-to-day lives:

- **Obtaining food.** 72 per cent of the participants identified obtaining food as a major challenge. In order to obtain food, the children used a variety of methods, such as purchasing food with money, working in exchange for food, asking friends, family and neighbours for additional food or a combination of several of the above. The children spent up to 60 hours each week in trying to obtain food.
- **Lack of money.** 78 per cent of the participants identified lack of money as a challenge. 91 per cent of the children reported that the available money was used to buy food, clothing, and domestic items and to pay rent. 51 per cent of the children obtained money by working: some consistently (in bars or shops, for example); some sporadically. 10 per cent of the children worked more than 60 hours a week.
- **Education.** Over half (51 per cent) of the children did not attend school, mainly due to the opportunity costs of schooling (i.e. the cost of spending time in school that reduces opportunities to use the time for other purposes, such as getting food or earning money).
- **Housing.** 16 per cent of the children identified lack of safe and adequate housing as a problem. Some of the children had no housing at all and slept outside; others had to pay rent of around \$17 per month for 3x5 metre mud shacks.
- **Medical care.** Obtaining medical care was another problem. 28 per cent of the children reported that they did not seek help when they became sick.
- **Physical or sexual abuse.** 8 per cent of the children reported that they had been hurt physically by adults, 90 per cent had not (2 per cent did not respond). 9 per cent of the children reported that there was someone in their lives who currently abused them sexually, while 91 per cent reported that no one was abusing them.
- **Community attitudes.** The children were asked about how they perceived attitudes held towards them by adults and children in the community. Nearly three quarters (73 per cent) reported that adults had shown some form of positive or empathetic responses. 63 per cent reported that other children had shown a positive response, although 8 per cent reported that other children had hurt or mocked them.

Children heading households are more likely than other children to work in exploitative situations, to be stigmatised, to be at risk of being trafficked, to be subjected to violence, abuse and neglect or to be forced to make a living on the streets (MMAS 2004a). There are also specific legal challenges for child-headed households emanating from the 'legal incapacity' of the household head to protect the rights of children in the household in, for example, property inheritance claims by relatives. Under customary law, judgements are more likely to yield land to adult relatives of the deceased, rather than to the deceased's children (Sloth-Nielson and Galinetti 2004).

It is becoming clear that the combination of poverty and the sharp increase in the prevalence of HIV/AIDS is eroding traditional coping mechanisms, contributing to a general increase in vulnerability and exacerbating food insecurity. Research has

shown that the arrival of orphans in a household is not usually accompanied by new resources, resulting in a real increase in poverty for all children in the household.

Box 5.9: The poor helping the destitute by sharing what they cannot afford

In a recent paper, Michael J. Kelly argues that HIV/AIDS is making the poor poorer. The author identifies four driving forces perpetuating the pandemic: poverty, gender disparities and power structures, stigma and discrimination and exploitative global socio-economic structures and practices. As these four driving forces manifest themselves, HIV and AIDS prosper. As the pandemic flourishes, the likelihood of worsening poverty, gender relations, discrimination and global injustice increases and a vicious spiral is established.

Whilst HIV and AIDS by no means affect only poorer people, the poor face greater susceptibility due to generally poorer health and nutrition, high risk survival strategies and inability to meet the costs of health services or cope with the loss of labour or income arising from chronic illness.

Kelly highlights the “myth of coping” in relation to the crisis for orphans and vulnerable children and argues that “underlying the apparent success of family coping is the selfless sharing strategy that frequently characterises those living in poverty - the poor helping the destitute by sharing what they cannot afford. But this is hardly something that can be held up as a good model of coping”.

Source: HIV and AIDS: a justice perspective, Michael J Kelly, Jesuit Centre for Theological Reflection, 2006

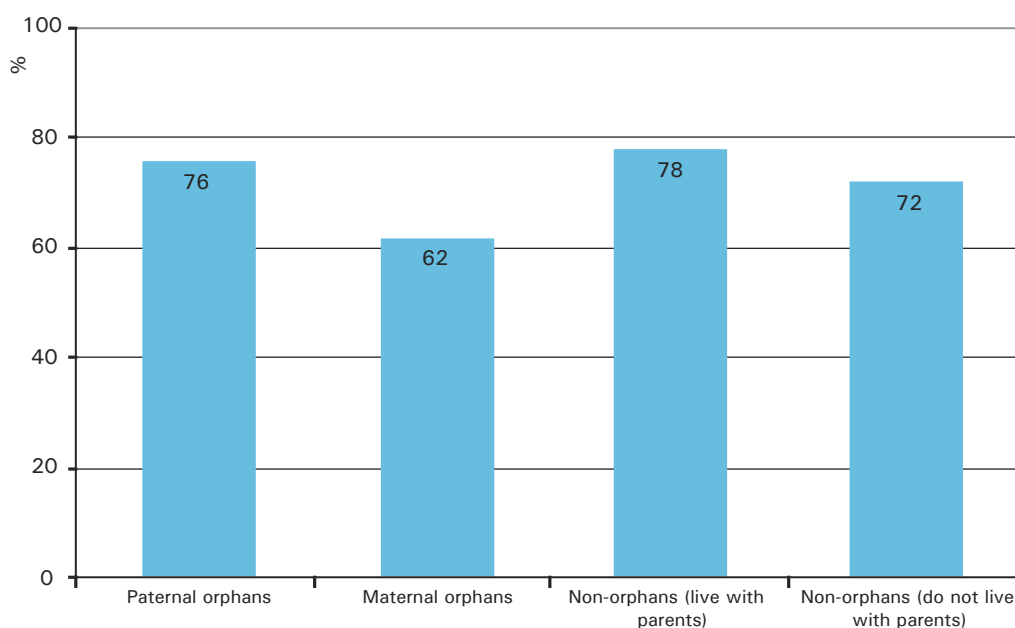
The decline in household income is not generally offset by support from the State or civil society. An assessment on community coping capacities conducted in 2005 as part of a national situation analysis of orphaned and vulnerable children showed that only 12 per cent of the households with orphaned and vulnerable children had received assistance from either the Government or civil society (of which, 6.8 per cent had received support from the Government, 5.5 per cent from NGOs and 4.4 per cent from CBOs) (SIAPAC/AV 2006). The study also found that only 1 per cent of all households had a household member with a poverty certificate (the State mechanism for gaining eligibility to waivers of fees when using health, education or birth registration services).

The 2003 Vulnerability Analysis showed that maternal orphans fare badly in terms of access to education, a trend that has been confirmed by the 2004/2005 IFTRAB. In 2003, the DHS found that only 62 per cent of 10-14 year-old maternal orphans were attending primary school, compared with 76 per cent of paternal orphans and 78 per cent of non-orphans living with their parents (INE 2005). In 2004/2005, the IFTRAB showed that 46 per cent of maternal orphans aged 6-12 years were attending primary school, compared with 71 per cent among non-orphaned children in the same age range (INE 2006).

In addition, a study conducted in 2005 by the Ministry of Planning and Development established that within poor households, discrimination exists in the allocation of resources to children who are not direct biological descendants of the household head. The study found that children with no direct biological relationship to the household head were discriminated against in terms of their access to education, in both rural and urban areas (Nhate 2005: 48).⁸⁵

⁸⁵ In other aspects, such as health, medical consultation and child labour, the study found no evidence of discrimination.

Figure 5.9: Primary school attendance among children aged 10-14 years



Source: DHS 2003

B. Disabled children

There are no thorough data on the number of children living with disabilities in Mozambique and data on disability in general are described as “frail and inconsistent” (Taimo 2003: 2). This lack of information represents a major hurdle to programmatic interventions. The IFTRAB indicated that 1.6 per cent of the population had some form of disability, slightly lower than the 2.6 per cent indicated by the national Population Census in 1997 (cited in Taimo 2003: 4) (INE 2006).

Although neither the 1997 census nor the IFTRAB provided information on the number of children with disabilities, the data did provide information on some of the patterns in disability. There is substantial variation between provinces, ranging from 0.4 per cent of the population with some form of disability in Maputo City to 3.5 per cent of the population in Gaza province. In both the Population Census and the IFTRAB, the level of disability was slightly higher among people in rural areas than in urban areas (1.9 per cent and 1.5 per cent respectively).

The likelihood of physical or mental impairment varied with the level of education of the respondent, ranging from 1 per cent among those with secondary education to 2.9 per cent among those with no education. Given that poorer people are less likely to be educated, this correlation points to the close link between disability and poverty. Malnutrition and micronutrient deficiencies, disease, lack of adequate health care and knowledge, lack of adequate sanitation and safe water, violence and abuse, and insalubrious and unsafe housing all contribute to physical or mental impairment.

With respect to children with disabilities, the National Education Policy foresees the possibility of children with mild disabilities attending regular schools and children with more serious disabilities attending special schools. This requires education services to identify children with special needs before they start their school career and to train teachers to work with such children (MMAS 2000: 11). The obligation of the National Education System to guarantee educational opportunity to all persons with disabilities and the duties of the Ministry of Education in this respect are reconfirmed in the Policy for Persons with Disabilities (MMAS 2000:12).

The Special Education Department has also made efforts to organise statistical data on the numbers of children with disabilities attending school and those who require schooling. In 2005, the Ministry of Education and Culture estimated that 31,000 children and young people with special education needs were being supported, most of them integrated into regular schools. An additional 418 children requiring more specialised attention were attending four special schools (ECSP: 34). At national level, the Ministry for Women and Social Action hosts an inter-ministerial technical commission to coordinate and monitor the implementation of policies for persons with disabilities. This commission includes public institutions and civil society organisations (Taimo 2003:12).

The national Policy for Persons with Disabilities assigns responsibility to the Ministry for Women and Social Action for promoting the effective integration of children with disabilities into pre-school 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 (MMAS 2000: 20). Under Decree 16/93, persons with disabilities are eligible for the State Food Subsidy programme (a small monthly cash payment to especially vulnerable people). However this is only available to citizens over 18 years of age, thus excluding disabled children.

The African Decade of Persons with Disabilities, to which Mozambique adheres and which runs from 1999 to 2009, represents an important opportunity for the Government to join with civil society to promote the rights of children with disabilities in Mozambique. The Plan of Action for the Decade, adopted in July 2002, aims to achieve the full participation of persons with disabilities in Africa, ensure their equality and develop their full capacity. Objective 5 of the Plan of Action refers specifically to the promotion of special measures for children, young persons, women and the elderly. To date, Mozambique has not approved its own national action plan in the context of the African Decade (MMAS 2005d). The Government consequently risks missing an important opportunity to promote the rights of its disabled children.

C. Children in emergencies

Mozambique is a country prone to both chronic and sudden onset emergencies, including the AIDS pandemic and natural disasters such as protracted drought, floods, cyclones and earthquakes. In this context, the protection of children is a particular challenge, as such emergency situations can lead to increased reliance on negative coping strategies, reduced access to basic social services or the displacement of children from their families. In addition, an absence of accountability can mean that the very people responsible for the protection of children may become their abusers. Although there has been little research conducted on the impact of emergencies on child protection concerns in Mozambique, reports from a mission of the Vulnerability Assessment Committee (VAC) in 2005 indicated protection concerns including the use of negative coping strategies by children in drought-affected areas, such as 'survival sex' for money, increasing their vulnerability to HIV or STIs. The National Action Plan for Children notes the importance of sectors responsible for the management of natural disasters integrating special measures for the protection and assistance of children affected by emergencies (MMAS 2005c: 21).

The Government and its development partners have implemented various initiatives to prevent and respond to child protection concerns in the context of emergencies, including the training of humanitarian workers on issues surrounding sexual abuse and exploitation of children and support to community-based surveillance systems for the monitoring of child rights. There is a need, however, for ongoing advocacy and social mobilisation around the vulnerability of children in times of emergency, in addition to

activities to strengthen the capacity of communities to protect children from violence, abuse and exploitation.

D. The policy and institutional framework for the social protection of orphaned and vulnerable children

In spite of the progress noted in the development of Government policy and planning instruments, the reach of services aimed at preventing violence, abuse and exploitation of children remains limited, as does the capacity of judicial and police institutions to enforce protective measures. Access by the most vulnerable children to social assistance that would enable them to benefit from basic social services also remains extremely limited, with only 12 per cent of households caring for OVC having received any type of external support (MMAS 2006). The adoption of new policy and planning instruments has not yet been accompanied by increases in allocations in the State budget to social assistance for children.

Social protection is defined as “the public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society.” Social protection thus includes support provided by government, non-governmental actors or a combination of both. The concept covers immediate support to those who are currently in extreme poverty and insurance for those who are not currently amongst the poorest in order to protect them from the impact of potential future shocks. The objective of social protection is two-fold: (i) to reduce variations of income; and (ii) to buffer the consumption of chronically poor individuals who cannot benefit from the opportunities that economic growth provides for earning income. Among the groups in society targeted by social protection measures are older people, disabled people, chronically ill (including those living with HIV/AIDS) and orphaned and vulnerable children (Johnson 2006).

Strengthening mechanisms for the social protection of the most vulnerable children has been identified as a priority action by the Plan of Action for Orphaned and Vulnerable Children (PoA OVC). The process of development of the PoA OVC began in 2004, with the implementation of a Rapid Assessment, Analysis and Action Planning Process (RAAAP) and culminated in the approval of the PoA OVC in March 2006 by the Council of Ministers. The Ministry for Women and Social Action has defined twelve groups of children as vulnerable and in need of protection and support (MMAS 2005b:13, definition quoted at start of this chapter).

A crucial aspect of the PoA OVC is the recognition that the needs of orphaned and vulnerable children are inter-dependent and that planned actions need to address these needs as a whole if they are to make a significant difference in the quality of children’s lives. The PoA OVC defines a set of six basic services to be provided to orphaned and vulnerable children: health, education, nutritional and food support, legal and psycho-social support as well as financial support (defined in the PoA OVC as unconditional cash transfers for households caring for OVC). The Ministry for Women and Social Action defines the provision of at least three of these services as the minimum standard for the care of orphaned and vulnerable children in Mozambique. Providing access to basic services is closely linked in the PoA OVC with the strengthening the capacity of families and communities to respond to the needs of orphaned and vulnerable children. Families and communities represent the first line of the national response and government policy promotes community-based, rather than institutional care for orphaned and other vulnerable children.

The following three targets have been included in the PARPA II document, to be achieved by the year 2009, for reducing the vulnerability of orphaned children and redressing existing discrimination:

- The ratio of school attendance of maternal orphaned children to non-orphaned children is equal;⁸⁶
- The ratio of stunting prevalence among orphaned children to non-orphaned children is equal;
- Thirty per cent of households with orphans and vulnerable children have received free external support for the care of the children in the household (RM 2006b: 110).

In 2006 alone, the PoA OVC identified 1.2 million orphaned and vulnerable children, defined as children living below the poverty line who are (1) orphaned children (maternal, paternal or double); (2) children infected or affected by HIV/AIDS, including children living in households headed by other children, women or elderly persons and children living in households headed by a chronically ill adult. A costing exercise conducted as part of the development of the PoA OVC defined costs of OVC support for all sectors: education, health, justice, state administration and social action. These increase progressively in line with the coverage targets set for each year from US\$45 million in 2005 to US\$160 million in 2010.

While the importance of direct social assistance as a strategy to increase the well-being of the most vulnerable children has been acknowledged by the Government, the debate around the most effective social protection modalities to reach orphaned and vulnerable children is still in its initial stages within the Ministry for Women and Social Action. In the context of increasing vulnerability of children, families and communities in the context of HIV/AIDS, momentum has been building around the provision of unconditional cash transfers to households caring for orphaned and vulnerable children. The PoA OVC specifies unconditional cash transfers to households caring for orphaned and vulnerable children as the modality for providing financial support to these households. According to a recent analysis of the impact of unconditional cash transfers in Sub-Saharan Africa (Making Cash Count, Institute of Development Studies, HelpAge International and Save the Children UK, 2005), the regular provision of cash to the most vulnerable households:

- (i) had a positive impact in reducing childhood poverty rates (Barrientos and De Jong);
- (ii) was preferred by households themselves as it gave them a choice in the terms of expenditure and the flexibility to spend cash in appropriate ways to enable children to access basic services; and
- (iii) was often cheaper and more cost effective to deliver than other forms of household level support.

An analysis of existing social protection schemes (Johnson 2006), provides a comprehensive overview of social protection in Mozambique, divided into the categories of:

- (i) Obligatory social protection (social security);
- (ii) Basic social protection (delivered through government institutions);
- (iii) Complementary Social Protection (delivered through non-governmental bodies).

⁸⁶ In addition to the Plan of Action for OVC, and as noted in Chapter IV, the Ministry of Education and Culture is working towards a policy to remove

The responsibility for implementing social protection programmes within Government rests with the Ministry for Women and Social Action and its implementing arm, the National Institute for Social Action (INAS), which currently runs five principal programmes: (i) Food Subsidy, (ii) Direct Social Action, (iii) Social Benefit for Work, (iv) Income Generation, and (v) Community Development. While the first two programmes mentioned target individuals unable to carry out productive activities, the latter three programmes target the most vulnerable who are able to engage in some form of activity for their own support. At the moment, none of these schemes targets households caring for orphans and vulnerable children directly. Although the Food Subsidy Programme targets older people, disabled people, highly vulnerable women heading households and the chronically ill living in extreme poverty and with no other source of support, there are presently no data on the proportion of beneficiaries caring for orphaned and vulnerable children.

The fact that the Food Subsidy Programme is the main social protection scheme operated by the National Institute for Social Action (in terms of geographical reach, financial resources allocated by the State Budget for its implementation and being the only State social assistance scheme defined in legislation), combined with the probability of considerable overlap between beneficiaries of the Food Subsidy and carers of orphaned and vulnerable children has created significant interest among government institutions, bi-lateral and multi-lateral partners and civil society organisations in taking action to ensure that the Food Subsidy Programme becomes an effective mechanism for social assistance reaching the most vulnerable children. Funding has currently been secured by the Ministry for Women and Social Action (Multi-AIDS country Programming funds through the National Council for the Fight Against HIV/AIDS) to revise targeting criteria (to include households caring for orphaned and vulnerable children), rationalising the system to disburse cash (clarifying the roles of DPMAS, DDMAS, the National Institute for Social Action delegations and community based volunteer representatives (permanentes) and of civil society in monitoring usage). Piloting a more effective method of disbursing the Food Subsidy over 2006 and 2007 and analysing its impact on the well-being of children, would be crucial to have a full understanding of its potential to be taken to scale at the national level as a means of improving the living conditions of children.

Box 5.10: Food Subsidy Programme

The Food Subsidy Programme has the largest coverage of all the INAS social protection schemes, reaching 82,631 beneficiaries in 2005. Of these, 91% were elderly people, 6% were disabled people, 1% were chronically ill and 0.5% were women heading households.

Since its introduction in 1993, the Food Subsidy Programme has been financed solely through the State Budget. Its geographical coverage has gradually increased, from its urban origins to current coverage reaching vulnerable rural households at district level and sub-district level.

Financial execution of the Food Subsidy Programme has improved from 2003 at 18.5% and 52% in 2004 to 90% in 2005 (Johnson, K. 2006).

While the monthly value of the payment made per beneficiary represented 30% of the minimum wage in 2003, by 2004 the current maximum level (MTZ 140,000) had fallen to below 10% of the minimum wage (MTZ 1,450,000 for public and private sector employment, except in agriculture).

Sources: Options Paper for Social Protection, Johnson, 2006.

E. Institutional capacity to implement social protection schemes

Government policy and planning instruments such as the National Strategic Plan to Combat HIV/AIDS 2005-2009 (PEN II), the PoA OVC or the Strategy for Social Action assign responsibility to the Ministry for Women and Social Action for coordinating efforts to mitigate the impact of HIV/AIDS on orphaned and vulnerable children. The implementation of the PoA OVC is coordinated by the Ministry for Women and Social Action with the support of a Multi-Sectoral Technical Working Group on Orphaned and Vulnerable Children, which brings together civil society and development partners. The Technical Working Group is mandated to support the Ministry for Women and Social Action, by collaborating with the Ministry to develop, coordinate, implement and monitor the PoA OVC (MMAS 2005a). The creation of this group creates opportunities to strengthen the overall national response to orphaned and vulnerable children. However, the initial findings of a Functional Analysis of the Ministry for Women and Social Action undertaken in 2006, within the overall framework of public sector reform, indicates that a sustained effort to build the capacity of the Ministry at both central and provincial levels is fundamental if it is to play an effective coordination role in the framework of the PoA OVC and effectively implement social protection measures to benefit the most vulnerable children.

CONCLUSIONS AND RECOMMENDATIONS



Conclusions

Mozambique is one of Africa's success stories in terms of post-war reconstruction, national reconciliation and economic recovery and growth. Since the signing of the peace agreement in 1992, the country has experienced a relatively smooth transition to political stability and democracy, established macro-economic stability, enjoyed sustained real growth and a significant reduction in poverty on both consumption-based and deprivations-based measures. The Government has engaged in a process of public sector, legal and financial management reform and an ongoing programme of decentralisation, which have progressively contributed to enhancing accountability and stimulating participation at the local level.

At the same time, significant progress has been made in developing an enabling national policy and legislative framework to prioritise child development concerns, with the development of national and sectoral legal and policy instruments that are in line with the Government's commitments under international human rights treaties. In addition, notable improvements have been witnessed against key indicators of child development. The country has seen significant reductions in the child mortality rate and the maternal mortality ratio. A rapid increase in primary school enrolment means that more children are enrolled in school than ever before.

Despite this progress, the sheer depth of poverty from which Mozambique is emerging means that many children are still living in poverty. Using the consumption-based measure, an estimated 58 per cent of children were living in poverty in 2003. Using the deprivations-based measure, 49 per cent of Mozambican children were living in absolute poverty, defined as those deprived of two or more basic rights. In addition, it is evident that the development gains and poverty reduction of recent years have benefited some children more than others: children from rural areas, for example, are consistently worse off than their peers in urban areas. The proportion of children living in absolute poverty in rural areas stood at 63 per cent in 2003, compared with 20 per cent for urban areas (using the deprivations-based measure). Some groups of children are particularly marginalised, including orphaned and vulnerable children (OVC) and children living in female-headed households, which are increasingly taking on the burden of caring for OVC. These children are often beyond the reach of development programmes: the evidence shows, for example, that orphaned children, and particularly maternal orphans, are less likely to be attending school and more likely to be chronically malnourished than other children.

In contrast with the strong positive trends in growth and poverty reduction, there are several key areas of child development in which little improvement has been witnessed in recent years, such as the nutritional status of children, access to water and sanitation, the prevention and treatment of malaria and the quality of education, all of which threaten attainment of PARPA II targets and the Millennium Development Goals. While the causes of childhood poverty are many and varied, the analysis shows that progress in relation to the reduction of childhood poverty is being seriously undermined across all sectors by the AIDS pandemic and the resulting weakened capacity of duty bearers to care for and protect children. In other areas, the limited availability of data precludes comprehensive analysis of the situation of children, such as the causes of child mortality and the status of a range of child protection concerns.

The evidence suggests that concerted efforts are required from all those responsible for the reduction of childhood poverty – including Government, civil society and international development partners – in order both to reduce the incidence of childhood poverty and mitigate its impact, and also to ensure that specific strategies are in place to reach the most marginalised and excluded children. Tackling childhood

poverty is particularly important, as poverty affects children disproportionately in comparison to the population as a whole and the effects of childhood poverty can be not only lifelong, but can also have an intergenerational impact. Supporting all children, particularly the most vulnerable, to access basic services and social protection mechanisms will enhance children's well-being and give them the basic tools to escape childhood poverty and break the intergenerational poverty cycle.

Recommendations

This Situation and Trends Analysis highlights the following priorities in tackling childhood poverty:

1- Ensuring adequate and equitable resource allocation

Given the impact and extent of childhood poverty, it is particularly striking that State Budget allocations for key sectors often do not correspond to the pattern of child development indicators. For example, the provinces presenting the highest levels of childhood poverty - including the provinces of Zambezia and Nampula, in which 40 per cent of Mozambican children live - receive lower allocations for sectors which are key to child well-being, such as health and education, than provinces with lower levels of childhood poverty, such as Maputo City and Maputo Province. 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 of the available resources.

In order to ensure adequate and equitable financing for the reduction of childhood poverty and increase understanding of the impact of budgeting on children, comprehensive and periodical analysis of budget mechanisms, allocations and expenditures is required. Moreover, there is a need for a more accurate and efficient method of tracking expenditure in key sectors for children. Within the context of the ongoing public financial management reform, specifically the roll-out of the integrated financial management system (e-SISTAFE), focus needs to be placed on the disaggregation of budgetary classifiers to monitor investment for childhood poverty reduction in sub-sectors and at the provincial level. In addition, it is important that the Ministries of Planning and Development and Finance take on the public expenditure review function currently being led by the World Bank, so as to strengthen Government's leadership in establishing linkages between allocations, expenditures and outcomes.

2- Strengthening Government capacity at national and sub-national levels

Increased investment for children and a thorough understanding of the availability, allocation and expenditure of resources available to children are critical. They must, however, be matched by strong Government capacity for the efficient utilisation of available resources. The analysis shows that one of the major factors impeding the reduction of childhood poverty is the weakened capacity of government at both national and sub-national levels to manage increasingly complex organisations effectively. This limited capacity has seen several sectors struggling to maintain the existing quality of services in the face of substantial expansion of access (e.g. health and education). It is clear that significant, sustained investment is required to strengthen the institutional capacity of Government at the national and sub-national levels.

Particular attention needs to be paid to strengthening the capacity of district level authorities. Within the framework of the Law for Local State Organs (LOLE) and associated Regulations in 2005, the district is, for the first time, the base unit for

planning in Mozambique, and has the status of a “budgetary unit” within the State Budget. There is therefore an urgent need to support capacity to access and absorb funds at the district level through efforts to build capacity in planning, monitoring and evaluation, and financial management.

In addition, the analysis indicates that the underlying causes of childhood poverty are complex and interrelated, requiring holistic and multi-sectoral interventions. It is critical that significant efforts be made to ensure that those agencies or multi-sectoral communication bodies responsible for the coordination of multi-sectoral interventions benefiting children are supported to develop their institutional capacity.

3- Targeting the most vulnerable

The analysis indicates that some children are significantly more disadvantaged than others. Understanding the situation of the most vulnerable children and the factors behind their marginalisation and then targeting initiatives towards these children need to be an integral part of the national development agenda. It is therefore necessary to:

- Ensure that strategic information on the rights of the most vulnerable children is made available to and used by all those involved in the fight against childhood poverty. This includes the collection of reliable data, disaggregated by sex and other relevant variables to show existing disparities, and the use of these data in the formulation of policies and strategies to reach marginalised children and ensure the removal of barriers to their access to basic services. There are currently a number of areas in which sufficient data on the most marginalised children are not available, including information relating to the most harmful forms of child labour, the nature, extent and causes of violence, sexual abuse and exploitation within and outside the family environment and the situation of children with disabilities.
- Ensure that existing social protection programmes, such as the unconditional cash transfers provided under the National Institute for Social Action Subsídio de Alimentos scheme, are effectively reaching the most vulnerable households caring for OVC. These protective measures give households the flexibility to cover categories of expenditure which can be crucial to them (such as transport or basic material needs) as a pre-condition to benefit from other social protection schemes, which focus on access to specific basic services (such as the abolition of school fees to facilitate access to basic education). Rendering such schemes more effective may include revising existing criteria for the disbursement of grants to benefit OVC directly, systematising the mechanisms in place for their delivery and increasing both the amounts of cash being transferred and the coverage of programmes.
- Carefully design policy interventions targeted at children living in poverty. This is due to the fact that the poor often live alongside the non-poor and most inequality is accounted for by differences within districts, making the design of programmes to target the most vulnerable children effectively particularly challenging. In the same vein, underlying the many deprivations experienced by children in rural areas is Mozambique’s very low population density. One of the implications of this is that delivering a given level of public services is considerably more costly in rural areas than in urban areas. This calls for innovative policies such as the education sector’s accelerated school construction programme and underlines the need for demand driven programmes, particularly in rural water supply.

4- Accelerating the response to the AIDS pandemic

While Mozambique has achieved significant progress in reducing the under five mortality rate, the gains of recent years are being increasingly threatened by the impact of the AIDS pandemic and capacity constraints continue to impede the national response. Although the available evidence indicates that AIDS is fast becoming a major cause of infant and child mortality, at the end of 2005 only 3 per cent of eligible children were receiving paediatric treatment and only 5 per cent of the total estimated HIV positive pregnant women in the country had received treatment for the prevention of mother to child transmission (PMTCT). Unless there is a significant and accelerated scale-up of interventions in these areas, the development gains of recent years will be dramatically reversed.

5- Managing aid inflows for improved child outcomes

There is a rapidly evolving aid environment in Mozambique, in which donors are increasingly moving away from ad hoc 'project-based' funding towards General Budget Support, accompanied by greater alignment with government policy and strategy and harmonisation between development partners. However, while addressing the complex structural barriers in aid delivery will require long-term, sustained investment in infrastructure and strengthening of institutional capacity, as PARPA II highlights, there is a need to ensure that (potential) additional aid inflows are targeted towards programmes that can deliver 'step change' in child development outcomes. Obvious candidates include large-scale programmes which deliver clear benefits for children, such as the comprehensive scaling-up of the distribution of long-lasting, insecticide-treated nets, vaccination campaigns, or the accelerated expansion of access to paediatric treatment and drugs for the prevention of mother to child transmission of HIV. Since childhood poverty and disease can undermine an individual's lifetime development prospects, there is a clear rationale for addressing these as soon as possible.

6- Strengthening the capacity of civil society and promoting community participation

Given the varying capacity of Government authorities, particularly at the sub-national level, to implement and monitor programmes for children, civil society continues to play a critical role both in creating demand for services and supporting the authorities to expand service delivery. As civil society organisations tend to be based at the grassroots level, they are also often well placed to ensure that the most vulnerable children and women are reached by development programmes and to advocate for children's rights. The work of civil society is vital, for example, in supporting OVC to access basic services: the 2005 Situation Analysis of Orphaned and Vulnerable Children indicated that OVC households are significantly more likely to have been reached by civil society than by Government outreach activities. Civil society organisations also play a vital role in ensuring that government commitments are met, for example through implementation of national action plans and policies and participation in the monitoring of the PARPA.

In tackling childhood poverty, it is also important to recognise that children have the right to participate in matters that affect them and need to be empowered and supported to participate in designing and implementing measures for the reduction of childhood poverty.

7- Implementing social communication strategies

The analysis highlights the importance of social communication strategies in sharing information and knowledge, promoting social and behaviour change and mobilising communities. It is widely acknowledged, for example, that the nationwide immunisation campaign conducted in 2005 would not have achieved such high rates of coverage without the implementation of a complementary and intensive communication strategy. The operationalisation of national communication strategies, such as the National HIV/AIDS Communication Strategy, provides the opportunity to ensure the scale-up of coordinated, focused and effective social mobilisation and communication initiatives nationwide. Implementation of such strategies, however, needs to be tailored to the local context, using a variety of communication channels accessible to communities, such as community theatre and radio networks.

Such strategies are potentially a very important tool in improving child development outcomes that are closely linked to cultural practices and attitudes. For example, ensuring that children receive appropriate nutrition in early life by disseminating information to families regarding healthy breastfeeding practices and diet may help in improving anthropometric measures such as stunting and chronic malnutrition. Such measures have to date failed to register significant improvements and, given their lifelong impact, devising interventions to deliver improvements is a high priority for child development.

ANNEXES

ANNEX I

Adaptation of the Bristol indicators to the Mozambican context

Form of Severe Deprivation	Bristol Indicator	Adaptation for Mozambique	Indicator used for Mozambique	Associated CRC Article	MDG
Food	Children under five years of age whose heights and weights for their age are more than -3 standard deviations below the median of the international reference population, i.e. severe anthropometric failure	Name of indicator changed from "food" to "severe nutrition deprivation" to reflect the fact that malnutrition in children is not only related to the lack of food but also to poor health	Children under five years of age whose heights and weights for their age are more than -3 standard deviations below the median of the international reference population, i.e. severe anthropometric failure	Health: combat of disease and malnutrition 24 (2) (c)	Goal 1: Eradicate extreme poverty and hunger Goal 4: Reduce child mortality
	Children under 18 years of age who only have access to surface water (e.g. rivers) for drinking or who live in households where the nearest source of water is more than 15 minutes away (indicators of severe deprivation of water quality or quantity)	15 minutes walk (30 minute round trip) not regarded as 'severe.' Indicator modified to 30 minutes (1 hour round trip)	Children under 18 years of age who only have access to surface water (e.g. rivers) for drinking or who live in households where the nearest source of water is more than 30 minutes away	Health: provide clean drinking water 24 (2) (c)	Goal 7: Ensure environmental sustainability
Sanitation	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	Unaltered	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	Health: support hygiene and sanitation 24 (2) (e)	Goal 7: Ensure environmental sustainability
Health	Children under 5 years of age who have never been immunised against any diseases or young children who have had a recent illness involving diarrhoea and did not receive any medical advice or treatment	As many diarrhoea cases can be treated at home without the need for seeking medical advice, the treatment of respiratory infection (ARI) is used instead, particularly as ARI is a greater cause of mortality among children in Mozambique. The composite indicator used corresponds to children that had never been immunised or those that had suffered from a severe episode of ARI that was not treated	Children under five years of age that have never been immunised or those that have suffered from a severe episode of ARI that was not treated	Health: right to health and health facilities, combat of disease and malnutrition 24 (1)/(2)(c)	Goal 4: Reduce child mortality

Shelter	Children under 18 years of age living in dwellings with more than five people per room (severe overcrowding) or with no flooring material (e.g. a mud floor)	Having a mud floor was not deemed an indication of severe deprivation, leaving only the overcrowding aspect (i.e. more than 5 people per room). As DHS provides little data on other housing characteristics (i.e. the existence of a roof) it was not possible to agree on an appropriate measure	Children under 18 years of age living in dwellings with more than five people per room (severe overcrowding)	Standard of Living: measures to provide housing 27 (3)	Goal 7: Ensure environmental sustainability
Education	Children aged between 7 and 18 who have never been to school and are not currently attending school	Unaltered	Children aged between 7 and 18 who have never been to school and are not currently attending school	Education: compulsory free primary education 28 (1) (a)/(b)	Goal 2: Achieve universal primary education Goal 3: Promote gender equality and empower women
Information	Children aged between 3 and 18 with no possession of or access to radio, television, telephone or newspapers at home	A telephone was deemed more a means of communication than information and was therefore removed from the definition. The age range was also modified, from 3-17 to 5-17, as it was felt that age 3 was too low	Children aged between 5 and 18 with no possession of and access to radio, television, telephone or newspapers at home	Information: access to information 13/17	Goal 2: Achieve universal primary education Goal 6: Combat HIV/AIDS, malaria and other diseases

ANNEX II

Calendar of the planning, budgeting and monitoring cycle

Month	Planning, Budgeting and Monitoring (Year)	GoM - Donor: Sector Wide Approach, Budget Support and On-budget Exercise (Year)
Jan	<ul style="list-style-type: none"> - Review of PES (n - 1) drafted by Sectors & submitted to MPD by 31st * - Budget Execution Report (n - 1) prepared by MF 	
Feb	<ul style="list-style-type: none"> - Review of PES & Budget Execution Report sent to Parliament by 15th 	<ul style="list-style-type: none"> - Sector Review Processes (n - 1) begin
Mar	<ul style="list-style-type: none"> - CGE (n - 2) appraised & approved by Parliament** - CFMP (n + 1 to 3) preparation by MF & MPD to set total resource envelope & indicative ceilings ("hot phase") 	<ul style="list-style-type: none"> - Sector Review Processes conclude by 31st - Submissions for Joint Review prepared by 31st
Apr	<ul style="list-style-type: none"> - District & Municipality PES & Budget proposals (n + 1) drafting begins - CFMP preparation continues 	<ul style="list-style-type: none"> - Joint Review concluded, including PAPs Performance Assessment***
May	<ul style="list-style-type: none"> - District & Municipality PES & Budget proposals drafting continues - CGE (n - 1) produced & submitted to Administrative Tribunal by 31st ** - CFMP envelope & ceilings approved - Initial budget ceilings, guidelines & methodology for PES & Budget/CFMP preparation distributed to Sectors, Provinces & other state bodies by 31st 	<ul style="list-style-type: none"> - Nearly final Common Fund commitments (n + 1) agreed between sectors & donors by 15th - GBS (n + 1 to 4) & Common Fund (n + 1) commitments made by PAPs (within 1 month after conclusion of Joint Review)*** - Final project commitments (n + 1) communicated to sectors in writing by donors by 31st
Jun	<ul style="list-style-type: none"> - PES & State Budget proposals (n + 1) drafted by Sectors, Provinces & other state bodies 	<ul style="list-style-type: none"> - Project details (n + 1) communicated to sectors by donors & Project List verified in Sector
Jul	<ul style="list-style-type: none"> - PES & State Budget proposals submitted to MPD & MF at Central & Provincial level by 31st * - Half-year Review of PES & Half-year Budget Execution Report (n) drafted 	<ul style="list-style-type: none"> - "Quiet Period" for donor to GoM contact begins (under discussion - not yet formalized)
Aug	<ul style="list-style-type: none"> - Half-year Review of PES & Half-year Budget Execution Report (n) sent to Council of Ministers & to Parliament by 15th - National & Provincial PES & State Budget (n+1) drafted by MPD & MF - Final update of resource envelope & allocations proposed in CFMP & State Budget based on donor commitments by 31st 	<ul style="list-style-type: none"> - "Quiet Period" ends around 15th (not yet formalized) - Submissions for Mid-Year Review prepared - Reconfirmation of GBS & Common Fund commitments by 31st ***
Sep	<ul style="list-style-type: none"> - National PES & State Budget (n + 1) sent to Council of Ministers by 15th & Parliament by 30th 	<ul style="list-style-type: none"> - PAF (n + 1) agreed at Mid-Year Review
Oct		
Nov	<ul style="list-style-type: none"> - CGE (n - 1) & Appraisal by Administrative Tribunal sent to Parliament by 30th ** 	<ul style="list-style-type: none"> - Project Workplans (n + 1) drafted within draft State Budget envelope
Dec	<ul style="list-style-type: none"> - National PES, State Budget & CGE (n + 1) deliberated & approved by Parliament until 31st 	<ul style="list-style-type: none"> - Project Workplans (n + 1) concluded within draft State Budget envelope

Note:

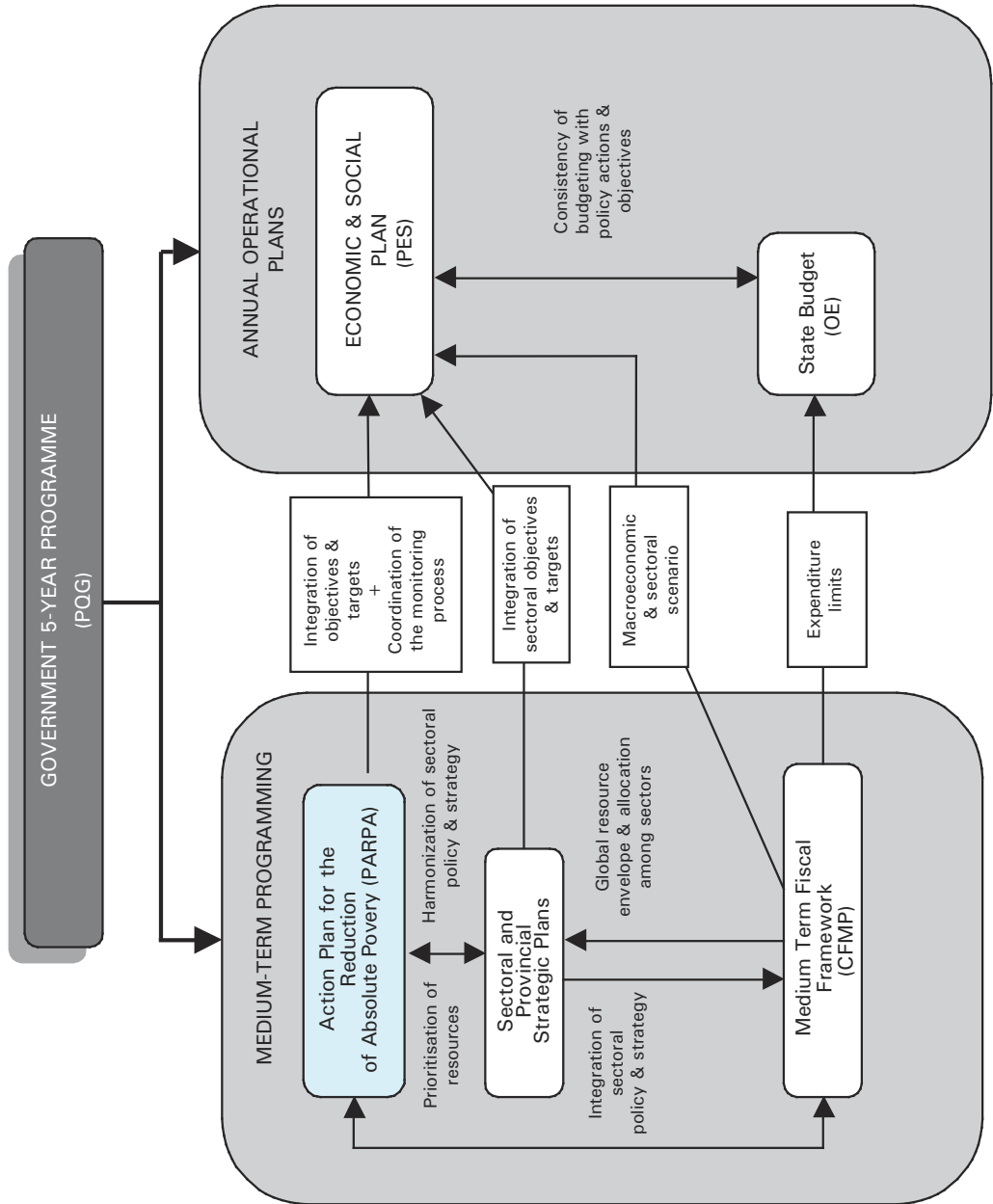
Planning Directorate ("DNP"). In practice, sectors find the January 30th deadline for BdPES submissions particularly difficult – final submissions usually arrive in February.

** See Law Nº 9 of February 12th 2002 ("SISTAFE Law"), Article 50. The Assembly appraises & approves the CGE in the session following the delivery of the Report together with the Opinion from the Administrative Tribunal (submitted on an annual basis since 1998). Parliament ordinarily meets twice a year (in February – May & October – December) for 180 days in total.

*** See Memorandum of Understanding, Annex 3 (GoM & PAPs, 2005).

Source: MPD & MF.

ANNEX III
Public planning system - linkages between instruments



ANNEX IV

State Budget recurrent and investment expenditures

The State Financial Administration System (SISTAFE) Law provides the legal basis for budgeting in Mozambique.⁸⁷ It clearly states that there is only a single, centrally approved State Budget, approved by Parliament each year. However, that budget is divided into two sections: recurrent expenditures (known as *despesas correntes* or *despesas de funcionamento*) and investment expenditures (*despesas de investimento*). The former section contains routine expenditures relating to ongoing operating costs. It is in turn broken down into salaries (*despesas com o pessoal*), goods and services (*bens e serviços*), debt service payments (*encargos de dívida*), recurrent transfers (*transferências correntes*), subsidies (*subsídios*) and other current expenditures (*outras despesas correntes*). The recurrent expenditures are financed by “internal” funds (*componente interna*). Internal financing is predominantly made up of Government revenues, although it also includes aid in the form of General Budget Support (GBS), which is merged with revenues in the Single Treasury Account (*Conta Única do Tesouro*).⁸⁸

As regards the investment expenditures section, it should be noted that it is not exclusively limited to expenditures on physical capital (i.e. those which lead to the creation of physical assets which can be used over a period of several years) - it also includes recurrent items such as salaries and goods and services. Thus, it should not be thought of purely as a “capital budget”, though it does contain most capital and most non-routine expenditure. Thus, the investment expenditures section might, contrary to its name, be better thought of as a “project budget”, where a “project” is defined as an amount of money, for a more or less clearly defined purpose, that is protected and which can be tracked (Orlowski, 2005). The fact that funds in the investment expenditures section are ring-fenced and more easily tracked means that all donor funded “externally” financed (*componente externa*) projects are included in the investment budget, even if they are of a recurrent nature (provision of textbooks and medicines being good examples). The investment expenditures section is not entirely financed externally though, and also includes projects wholly or partially covered by internal financing. It is still possible to distinguish capital-related expenditures within the budget since both the recurrent and investment sections of the budget are classified by type of expenditure (*classificação económica*).

⁸⁷ Law nº 9/2002, of 12th February, approves the State Financial Administration System (*Sistema de Administração Financeira do Estado*, or the “SISTAFE”) and Decree nº 23/2004, of 20th August, approves the SISTAFE Regulations.

⁸⁸ GBS is defined as aid paid to the Treasury which is not earmarked for any particular sector or project. It should not be confused with Direct Budget Support (DBS), which defines any money paid directly to the Treasury going straight into the budget, whether for GBS or for a specific sector.

ANNEX V

Adjusted nutritional data after controlling for missing data and change in child mortality*

Indicator and Ages Group	1996-97 IAF	1997 DHS	2000-01 QUIBB	2003 DHS
Height/Age				
0-0.9 years	23.69	20.67	18.73	19.23
1-1.9 years	52.21	45.57	46.58	46.29
2-2.9 years	47.10	51.89	48.06	39.79
3-3.9 years	47.66	-	50.07	46.33
4-4.9 years	50.41	-	42.70	41.97
Total 0-3 years	38.66	36.21	36.24	33.94
Total 0-5 years	42.17	-	40.42	38.03
Weight/age				
0-0.9 years	16.43	16.00	16.44	15.23
1-1.9 years	36.27	34.69	31.79	31.42
2-2.9 years	25.78	35.54	31.44	26.86
3-3.9 years	21.48	-	23.00	20.91
4-4.9 years	25.20	-	16.78	17.78
Total 0-3 years	25.36	26.75	26.08	24.01
Total 0-5 years	24.50	-	23.82	22.25
Weight/height				
0-0.9 years	7.61	5.68	8.31	2.98
1-1.9 years	10.33	12.76	8.02	6.89
2-2.9 years	5.90	3.55	6.34	4.95
3-3.9 years	3.52	-	3.01	3.30
4-4.9 years	3.05	-	2.78	1.88
Total 0-3 years	8.14	7.51	7.74	4.88
Total 0-5 years	6.48	-	5.86	4.01

Note: *Percentage of target population, below the minimum line.

Source: Simler and Ibrahimo 2005.

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